Oxfordshire
Clinical Commissioning Group

Oxfordshire CCG strategy for 2014/15-2018/19

and implementation plan for 2014/15-2015/16

Introduction

This document is the strategy and plan for Oxfordshire CCG, for the period 2014/15-2018/19. It sets out our strategy for the next five years, and the actions we will be taking to deliver that strategy in the next two years – so combining our 5 year strategic plan and 2 year operational plan in one document.

It is a plan for the whole health and social care community and is designed to deliver our collective vision of a healthier population, with fewer inequalities, and health services that are high quality, cost effective and sustainable.

The plan is based on a thorough analysis of the strengths and weaknesses of the local health and social care system, and the needs of the changing population.

It sets out a strategy for moving Oxfordshire to a position where it can deliver high quality standards of health and social care in all settings, whilst also delivering financial sustainability.

This plan is ambitious for patients and the public. It focuses on improving outcomes for older people, people with chronic diseases and those suffering from the consequences of health inequality. It focuses particularly on improving the access for these patient groups to urgent and emergency services, in order to help them avoid unnecessary hospital admissions.

The plan also recognises the need to improve the quality of people's experiences of health and social care services, and reflects our joint plans with our commissioning partners in NHS England, Oxfordshire County Council and the local district councils.

This plan focusses on reducing demand; streamlining and integrating care to deliver improved quality and greater financial efficiency, and ensuring the system works collaboratively in the best interests of the patient.

All our improvement interventions will contribute to integrating services more effectively around the patient – wherever possible pulling services closer to the patient's home. Over the next five years OCCG and its partners will deliver: improvements in the integration of health and social care; improvements in the integration of people's physical and mental health care and closer working between GP practices so that they can drive the integration of primary, community, secondary and social care around the needs of each patient and their family.

This plan will also result in a significant improvement in our performance against the key pledges in the NHS constitution. This will give people a much better quality of experience when they need to use our emergency services or to have a planned procedure and will help to provide better value health and social care services in the County.

Finally, the plan recognises that we need to do much of our core business more effectively. In particular we have described the steps we will take to tackle health inequalities, to place more equal value on our mental and physical health care, to involve the public in our work and to meet quality and safety expectations.

Dr Joe McManners, Clinical Chair, OCCG

Chapter 1: Ambition & Vision

1.1 Our Strategic Objectives for the Oxfordshire Health and Social Care System

a. In five years' time, the Oxfordshire health and social care system will:

i. Be financially sustainable.
ii. Be delivering fully integrated care, close to home, for the frail elderly and people with multiple physical and/or mental health needs.
iii. 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.
iv. Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
v. Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities.
vi. 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 local satisfaction with services.

b. Over the next two years we will start to deliver this transformation in the patient experience and to achieve financial sustainability through 5 major, detailed, service transformation programmes; development and delivery of a joint Better Care Fund plan with social care; aligned commissioning with NHS England; and a series of important supporting measures:

i. 5 Programmes of Transformation:
- Primary care
- Urgent care
- Planned care
- Mental health
- Medicines Management.

ii. Development and delivery of integration, underpinned by our Better Care Fund Plan.

iii. Supporting measures:
- Improving health and reducing health inequalities
- Delivering parity of esteem in mental and physical health care
- Engaging the public and promoting transparency
- Delivering quality, safety and innovation
- Organisational development, David Smith arrival as Chief Executive in June 2014.
- Provider market strategy

c. In order to deliver the ambitions of this plan we will need to shift activity and resources into different parts of the system. By 2018/19 we will have reduced the amount of time spent avoidably in hospital through the provision of better integrated care in the community by approximately 31% [1]

d. To achieve this we will have increased investment in primary care and in community services. We will have maintained levels of spending in mental health and our running costs by 4%.

[1] National composite measure (EA4) of: unplanned hospitalisation for ACS conditions and u'19s with asthma, diabetes and epilepsy; emergency admissions for acute conditions not normally requiring admission and children with lower respiratory tract infections.

e. Our strategy and plan have the full support and endorsement of the Health and Wellbeing Board and align fully with the agreed Oxfordshire Health and Wellbeing Strategy.

f. The specific changes this plan will deliver for patients are:

i. Improved urgent access to primary care.
ii. Rapid access to same day multi-disciplinary assessment services designed to reduce the likelihood of admission.
iii. Support from locality based, integrated health and social care community teams that:

- Deliver joined up health and social care to the frail elderly, patients with multi-morbidities (particularly the 2% of the population who make most use of health and social care services), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register.
- Enable people to return home from hospital in a timely manner and then to regain their independence.
- Provide same day home based treatment and care services to vulnerable older people, patients with complex co-morbidities and those at end of life, following referral from the rapid access multidisciplinary assessment service.

iv. Access to a primary care led whole person model of care for patients with several long term conditions (including those with mental health needs), focused on the proportion of patients who make the highest use of health and social care.

v. Reductions in inappropriate use of A&E.

vi. Streamlined urgent care pathways resulting in fewer emergency admissions for people with conditions that can be treated without being admitted.

vii. Improved end of life care.

viii. Streamlined planned care pathways, with more opportunities to access planned care closer to home and fewer outpatient referrals.

ix. A reduction in the offer of treatment where it is known to be of limited clinical value.

x. Less medicines waste and more cost effective prescribing in all settings.

xi. Better integration of physical and mental health care across all sectors and in all settings, to ensure better health outcomes for all patients wherever they are receiving treatment.

xii. Reduction in health inequalities, particularly for those groups identified as priorities in the DPH annual report for Oxfordshire.

xiii. Care provided by a system that is working really collaboratively in the best interests of the patient and their carer's.

OXFORDSHIRE CCG PLAN ON A PAGE		
BY WORKING TOGETHER, WE WILL HAVE A HEALTHIER POPULATION, WITH FEWER INEQUALITIES, AND HEALTH SERVICES THAT ARE HIGH QUALITY, COST EFFECTIVE AND SUSTAINABLE.		
OCCG OBJECTIVES	**MAKING MEASURABLE CHANGE**	**HOW WE WILL MAKE THIS CHANGE**
1. Be financially sustainable. 2. Primary care driving development and delivery of integrated care, and offering a broader range of services at a different scale. 3. Provide preventative care and tackle health inequalities for urban and rural patients and carers. 4. Deliver fully integrated care, close to home, for the frail elderly and people with multiple physical and mental healthcare needs. 5. Enable people to live well at home and to avoid admission to hospital when this is in their best interests. 6. Be providing health and social care that is rated amongst the best in the country.	1. Compliance with all NHS financial planning rules within 3 years. 2. Reduce years of life lost from conditions amenable to healthcare by 3.2% in 5 years. 3. Meet all agreed Health and Wellbeing Board targets every year. 4. Reduce the amount of time spent avoidably in hospital by 31% in 5 years. 5. Reduce the number of people delayed on any given day from 155 to below 100 by October 2015. 6. Reduce A&E activity by 10 % in 5 years. 7. Increase the proportion of older people living independently at home after discharge from hospital by 8% in 2 years. 8. In the top 20% nationally for people satisfied with their experience of hospital care in 5 years. 9. Reduce outpatient activity by 4% and planned inpatient activity by 17% in 5 years. 10. Meet all NHS Constitution measures in full. 11. Increase the no. of people with mental and physical health problems having a positive experience of care by 5.2% in 5 years.	1. Deliver more efficient, better quality care in all settings. 2. Integrate commissioning and provision of all aspects of physical and mental health care. 3. Help GP practices work together to improve access and quality. 4. Increase GP capacity to deliver care to most complex patients. 5. Provide community based planned and urgent care services. 6. Provide community and home based integrated health and social care to the most complex patients, including those with mental health needs. 7. Deliver partnership programme with Councils, 3rd sector and NHS England to tackle health inequalities and their underlying causes. 8. Reduce inappropriate A&E attendances by providing viable alternatives and improving 111. 9. Reduce avoidable admissions by: a. Improving pathways for people with chronic conditions needing urgent care b. Improving support to care and nursing homes c. Improving end of life care. 10. Reduce lengths of stay by working together to improve discharge and by contracting across providers for an integrated acute pathway of care. 11. Improve access to diagnostics. 12. Ensure only appropriate outpatient referrals are made. 13. Streamline planned care pathways. 14. Reduce activity known to be of little clinical value. 15. Improve integration of physical and mental health care. 16. Improve dementia diagnosis and care.
ROBUST GOVERNANCE ARRANGEMENTS: 1. Programme Management Office in place in the CCG Partnership programme boards for major change programmes. 2. Effective locality level patient, public and stakeholder forums. 3. Oversight by the Health and Wellbeing Board.		**PRINCIPLES UNDERPINNING DELIVERY** 1. Clinicians and Patients working together to redesign how we deliver care. 2. Reducing health inequalities by tackling the causes of poor health. 3. Commissioning Patient Centred High Quality Care. 4. Promoting integrated care through joint working. 5. Supporting individuals to manage their own health. 6. More care delivered locally.

Chapter 2: Oxfordshire Context

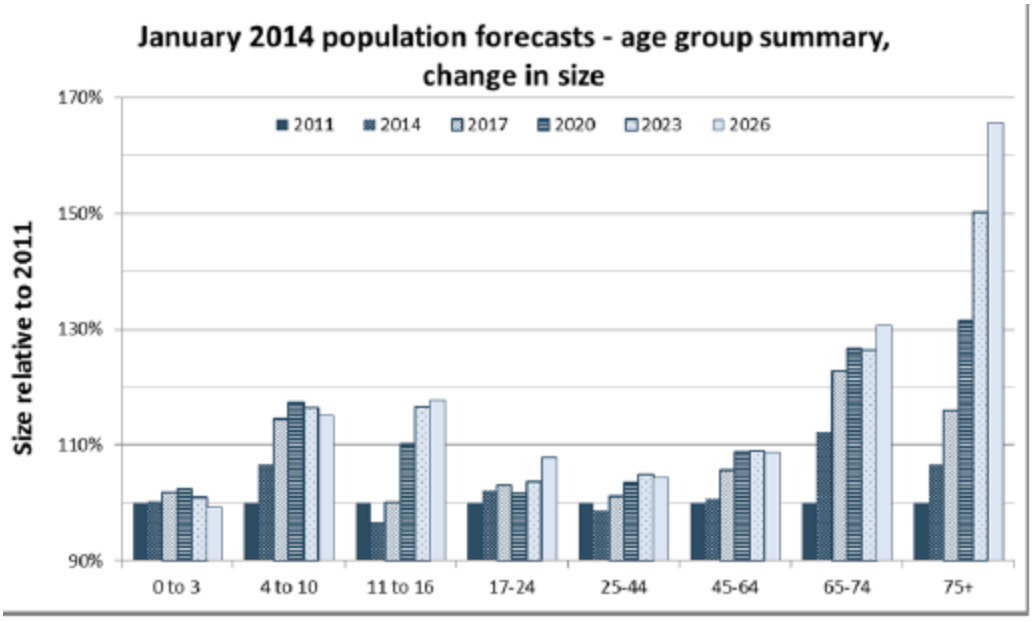
2.1 Our plan has been developed in response to :

i. The data and analysis set out in our JSNA, the joint priorities we have agreed with the Health and Wellbeing Board and the issues identified in the Director of Public Health's Annual Report.
ii. An analysis of the current strengths and weaknesses in the local health and social care economy.
iii. The views of our member practices.
iv. The views of local people.

2.2 Key messages from our JSNA 2014 Annual report , Health and Wellbeing Strategy and DPH Annual Report

a. Analysis of 2011 census data for Oxfordshire presents a picture of an increasingly diverse county, which is, in the most part, a relatively healthy and prosperous place to live. However, it is clear that certain areas of the county experience less benign conditions which are associated with poorer health and wellbeing outcomes. These areas tend to be in the more economically deprived parts of South East Oxford and Banbury but include parts of Abingdon, Berinsfield, and Didcot.

b. The county's population is growing. This is due to increased inward migration, particularly in the urban hubs of Oxford and Banbury, and the increasing life expectancy of the existing population, particularly in the rural areas of the county. The mini baby boom of the past ten years, which has seen numbers of children increasing year on year, is forecast to level off.



Source: 2014 Housing led Population Forecasts, Research and Intelligence Team

c. The proportion of older people is likely to continue increasing and this will have implications for service demand. Recently, demand for both Children's and Adult Social care has been increasing at a faster rate than even that which would be expected by population growth, suggesting that previously unmet need is coming forward.

d. Disability free life expectancy is increasing at a faster rate than life expectancy, meaning that not only are people living longer, in the future they might be expected (at the population level) to be living in good health and free of disability for longer towards the end of their lives. This is particularly true for the male population but will need further monitoring to see if it is a sustained trend, and if so what the implications are.

e. Data on mortality and morbidity suggest that Oxfordshire residents are less likely than those of the wider region to die early from cancers and circulatory diseases but that the identification of cancers is above the regional rate.

f. Assessment data for older people accessing Self-Directed Support gives a picture of the kinds of needs and disabilities people have at the point when they access care. Analysis has shown that close to one third of older people on Self-Directed Support, have dementia, with the proportion being highest among people in the 80-94 age band. For service users over the age of 95 the most common disabling condition was arthritis.

g. Further to analysis of the updated JSNA, the Oxfordshire Health and Wellbeing strategy 2012-2016, and the DPH Annual Report we have identified a number of priority areas for development. These are the need to:

i. Make the patient's journey through all services smoother and more efficient.
ii. Join up health and social care for older people in ways which enable individuals to be in the driving seat of their own care, but which reflect the very different communities and needs across the county.
iii. Reduce inequalities, break the cycle of deprivation and protect the Vulnerable – by working with a wide range of district council, county council and third sector partners on delivery of key prevention interventions
iv. Treat people's mental and physical health needs equally
v. Give children a better start in life.
vi. Reduce unnecessary demand for services.
vii. Help people and communities help themselves.
viii. Improve the quality and safety of services.
ix. Streamline financial systems, especially those pooled between organisations, and align all budgets more closely.

2.3 Five domains and outcome measures

Delivery across the five domains and outcome measures:

The systematic approach to ensuring our delivery on the five domains and national outcomes has been achieved through a prioritisation and development process.

This process comprised:

An analysis of the current strengths and weaknesses in the local health and social care economy including: NHS Constitution measures, national outcomes measures for the five domains of the outcomes framework, local Health and Wellbeing Board outcomes, activity levels and financial performance against contract; benchmarking with national and comparative peers.

There then followed review and development of our initial programme proposals against clear prioritisation criteria:

- Delivery of national outcomes
- Delivery of CCG objectives
- Delivery of financial savings
- Scale of anticipated impact
- Viability of initial proposal

The Health and Wellbeing strategy over seen by the Health and Wellbeing Board has been designed to ensure comprehensive coverage across the Oxfordshire system. Later this report describes the OCCG specific contributions to the Well-Being approaches.

Following agreement of business cases and approval by the Project Management Office our plan will contribute to delivery of the improvements against a set of 7 nationally defined outcome measures as set out below. Delivery is being tightly managed through programme management processes.

	NHS Outcome ambition	**Actions in the plan that will impact**
1	*Securing additional years of life for the people of England with treatable mental and physical health conditions*	• Improved psychiatric liaison in all settings • Pro-active identification and care management of those 2% of patients who are the highest users of the system • Integrated health and social care teams • Outcomes based contracting for mental health • Ambulatory care acute pathways
2	*Improving the health related quality of life of the 15 million + people with one or more long term condition, including mental health conditions*	• Improved psychiatric liaison in all settings • Pro-active identification and care management of those patients who are the 2% highest users of the system, • Integrated health and social care teams • Outcomes based contracting for mental health • Improved dementia diagnosis and care
3	*Reducing the amount of time spent avoidable in hospital through better and more integrated care in the community, outside of hospital*	• Practices working together to support patients with planned, urgent and complex care needs • Pro-active identification and care management of the proportion of the population, who make the highest use of health services (2% highest users). • integrated health and social care teams • Rapid access community based MDT assessments • Consultant and specialist GP led community based clinics • Improved dementia diagnosis and care • Full sub-acute care functionality from community health and social care community bed providers • Better Care Fund initiatives.
4	*Increasing the proportion of older people living independently at home following discharge from hospital*	• Pro-active identification and care management of those patients who are the 2% highest users of the system • integrated health and social care teams • Provision of ambulatory care pathways between acute And community remove need for an admission • Home care support services with built in re-ablement • Enhanced ALERT services • 7 day working in social care
5	*Increasing the number of people having a positive experience of hospital care*	• Fully functioning directly bookable choose and book service supported by streamlined planned care pathways • Ambulatory care acute pathways • Sustainable delivery of all NHS constitution standards • Continuity of care for pregnant women and maximising capacity at the Freestanding Midwifery Led Units. • Will move us up 1 quintile in 2 years and into top quintile in 5 years
6	*Increasing the number of people with mental and physical health conditions having a positive experience of care, outside hospital, in general practice and in the community*	• Development of psychiatric liaison services in primary, community, emergency and inpatient settings • Increased access to psychological therapies for patients with ACS conditions • Multidisciplinary community teams that incorporate older adult mental health workers.
7	*Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care*	• Continue to review Dr Foster data and to take early preventative action where this flags any early warning signs. For example in the course of the last year we have worked with OUHT to improve management of diabetes and pneumonia.

We have quantified, in the outcome template our expected impact on national outcome ambitions from our five programmes of transformation.

2.4 The strengths and weaknesses of our local health economy

a. The Oxfordshire health and social care system is under significant financial pressure and proposing a deficit budget of £1m for 2014/15.

b. There are key areas where significant improvement is required, and these are:

i. The increase in A&E attendances and emergency admissions, particularly for the share of patients with multiple attendances and admissions which is growing fastest.
ii. The unacceptably high numbers of patients experiencing delayed transfers of care.
iii. Meeting waiting time targets for elective care and improving the quality of outpatient referrals.
iv. The pressure on primary care.
v. Achieving financial balance.

c. The NHS Constitution makes a set of commitments to patients and the public about the core standards they can expect from the NHS and the NHS Outcomes Framework provides a means of measuring local performance against a set of fundamental outcomes that the NHS should deliver. The extent to which these standards are being met is a good measure of how well any health and social care system is getting the fundamentals right.

d. OCCG monitors a comprehensive range of indicators on a monthly basis. These include: NHS Constitution measures, national outcomes measures for the five domains of the outcomes framework and local Health and Wellbeing Board outcomes.

e. Oxfordshire is doing well against most national measures. The table below summarises areas where improvement is needed and the proposed improvement actions incorporated in this plan and the programmes which are defined in the CCG's delivery arrangements.

Measures where performance is sub-optimal	Proposed action to address
Delivery of 18 week waiting time targets for planned care	Significantly improve planned care pathways; improve referrals; increase choice; and develop options for accessing planned care in the community.
99% of people waiting less than 6 weeks for diagnostics	Ensure greater choice of diagnostic provider and work with providers to ensure core standards are met.
98% of people spending 4 hours or less in A&E	Reduce the estimated % of A&E attendances that could be treated elsewhere, more appropriately, by addressing the underlying behaviour of frequent attenders and providing acceptable and suitable alternatives that people will use.
Percentage of patients receiving cancer treatments within 31 days of diagnosis or 62 days of urgent referral by their GP with suspected cancer	Work with our providers to ensure performance is recovered to meet these targets. Plans for 2014 include strengthening of the MDT with all tumour sites covered; revising the roles of the patient tracker team; and recruiting to an overseeing audit and validation post, to ensure standards are met; and providing additional radiotherapy capacity at weekends.
Some ambulance call time and hand over standards	Commissioners are incentivising South Central Ambulance Service (SCAS) to increase the number of patients managed appropriately by phone ('hear and treat), while reducing the number of patients taken to hospital where they might be managed in the community- ('see and treat'). SCAS will implement NHS Pathways, the triage tool used within the 111 telephony service, within 999.

Provision of timely alternatives when operations are cancelled for non-clinical reasons	If the provider in question cannot provide assurance that it can meet the Constitutional standards for listing and then treating patients, then the CCG will look to move cohorts of patients to alternative providers.
Estimated diagnosis rates for people with dementia	The Mental Health Programme and the Better Care Fund Plan set out actions to improve the memory clinic pathway and to build the capacity of local communities and local services to support people with dementia.

2.5 The priorities identified by our member practices

a. OCCG is a membership organisation, and a fundamental first step in generating this 5 year strategy and 2 year plan was extensive consultation with member practices. Each of our 6 localities undertook at least 1 planning workshop at which priorities for service transformation were identified.

b. The 6 Locality Clinical Directors then pooled the views of their members, and agreed a set of improvement priorities that were common to all areas of the County.

c. The themes identified as high priority areas for change, and the ways in which these have been addressed in this plan are summarised below.

Priorities identified by localities	Action Incorporated in plan
Developing primary care to enable it to drive a shift of care from hospital into the community, and to meet changing national expectations	• Primary Care Transformation Programme
Improving the range and accessibility of community based services to support admission avoidance and to speed discharge	• Deliver locality based integrated health and social care community teams • Outcomes based contract for the acute assessment/admission/discharge/re-ablement pathway incorporating community , acute and potentially social care, providers • Roll out of EMUs or equivalent pathways across County
Tackling health inequalities by offering targeted support to address lifestyle behaviours and choices	• Partnership plan to tackle health inequalities agreed with Public Health teams in OCC and NHS England • Support to be focussed on small number of practices in each locality where it is agreed need is greatest
Improving the quality of care provided by care and nursing homes	Develop project during 14/15 to: • Review and rationalise care home support services • Increase medicines management support to Care homes • Review care home contracts with Oxfordshire County Council to drive up quality • Improve medical support to care and nursing homes
Developing a “whole person” model of care to support patients with multiple long term conditions	• Development of a pro-active, primary care led, multi morbidity service focussed on those patients who are the top 2% of service users – supported by integrated health and social care teams and improved ambulatory care pathways in the acute

Priorities identified by localities	Action Incorporated in plan
Reducing inappropriate use of A&E	• Agree preferred option for achieving this with providers in Q1 of 14/15 – e.g. primary care at front door of A&E , development of navigator system • Communications programme to improve appropriate use of NHS services
Reducing first OP activity	• On-going support for peer review in primary care • Improved clinic management • Roll out of a GP desktop system that helps ensure referrals comply with best practice
Improve access to, and quality of, diagnostics	• Ensure radiology services meet national and local standards by March 2016 and increase community radiology provision
Improve End Of Life care	• Review and rationalise current End Of Life support services • Increase percentages of patients registered as requiring palliative care • Improve use of Advanced Care Planning and special notes
Improve access to and quality of mental health services, particularly for people with addictions	• Outcomes based contracting for some elements of mental health care • Enhanced psychological support in primary, community and secondary care settings

2.6 What local people told us

a. OCCG is committed to responding fully to the views and concerns of local people. An extensive consultation with the public through a Call to Action consultation programme in the late autumn of 2013 gave rise to a number of commonly shared priorities. The table below sets out the key themes which emerged and summarises how this plan responds to them:

THE PUBLIC SAID	OUR REPONSE
Be open and transparent about the financial challenge	We have set a deficit budget in full recognition of the complexity of our financial situation.
They like the idea of outcomes based commissioning, but we shouldn't rush into it wholesale	We are working steadily with our local providers to develop this approach for mental health and acute care for older people.
They want care closer to home as long as that care is high quality care	We will ensure that community based: urgent care, integrated health and social care and planned care are all of the highest quality and that you get the right care in the right place – which will be hospital when you need it.
The NHS needs to change the public's attitude from "fix me now" to people accepting joint responsibility for their health	We have committed our locality teams to doing targeted outreach, education, patient participation group and other development work to help deliver this long term goal.

We need a comprehensive all ages education programme about how to use the NHS	Our locality teams are working 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.
The NHS should maximise the use of technology to free up GP time for face to face care	The Better Care Fund plan includes increased investment in the ALERT service; our LTC programme commits us to on-going work with the academic community on identifying telehealth solutions and our locality teams are working with local practices to support provision of patient access to records online; on line appointment and repeat prescription services, and text message appointment reminders.
The NHS should reduce duplication and waste	We are improving integration of care around the patient –for example our Better Care Fund plan will deliver a single health and social care assessment and a single health and social care plan with 1 care co-ordinator managing its delivery.

2.7 System values and principles

a. 6 themes characterise our approach to addressing the challenges we face to achieve our vision of a healthier Oxfordshire:

   i. Clinicians and Patients working together to redesign how we deliver care
   ii. Reducing health inequalities by tackling the causes of poor health
   iii. Commissioning Patient Centred High Quality Care
   iv. Promoting integrated care through joint working
   v. Supporting individuals to manage their own health
   vi. More care delivered locally.

b. Our Call to Action Consultation challenged the CCG to live these values and principles more effectively, but did not suggest that they need to be amended.

2.8 Summary of our key priorities for change

a. Analysis of this range of perspectives on where the important issues are in the Oxfordshire health and social care system has given rise to a focus in this plan on**:**

   i. Making major, transformational changes in:
      - Primary care
      - Urgent care
      - Planned care
      - Mental health
      - Medicines management

   ii. Development and delivery of integration, underpinned by our Better Care Fund Plan.

   iii. Delivering an important set of supporting work programmes:

      - Enduring work to tackle health inequalities
      - Delivering parity of esteem in mental and physical health care
      - Engaging the public
      - Delivering quality, safety and innovation
      - Organisational development

b. The remainder of this plan sets out the main components of each of these change programmes for the period 2014/15-2015/16, and the change we want to have delivered by the end of five years.

c. Ensuring we deliver the change we need in the system will be dependent on the CCG working closely with its commissioning partners, Oxfordshire County Council and NHS England, to broker and enable truly collaborative working between all local health and social care providers in the best interests of the patient. A strong partnership with our providers is also our goal.

Chapter 3: Our 5 Major Change Programmes for the Period 14/15-15/16

3.1 Introduction

a. This chapter summarises our main change programmes. More detail on each of the change programmes can be found in Appendix 1.

b. Subsequent chapters of this plan provide more detail on our Better Care Fund plan and supporting improvement measures.

c. These change programmes were arrived at through a prioritisation and development process which comprised:

i. Review of initial programme proposals against clear prioritisation criteria:

- Delivery of national outcomes
- Delivery of CCG objectives
- Delivery of financial savings
- Scale of anticipated impact
- Viability of initial proposal
- Contribution programme makes to improving access.

ii. Work up of selected full business cases.

iii. Review of each of these at several development stages by a Programme Management Board.

iv. Sign off of finalised business cases by the Finance and Investment Committee.

3.2 Primary Care Transformation Programme

This programme aims to build the capacity of primary care to operate at scale, so reducing pressure on individual practices whilst improving patient access, improving the quality of primary care and increasing out of hospital care. The programme will address the five core ambitions identified in NHS England's Improving General Practice, Call to Action Phase 1 report, and will be developed and delivered through a ground breaking co-commissioning partnership with NHS England. A Primary Care programme board will oversee planned initiative.

The primary care programme aims to:

- Deliver fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities.
- 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.
- Routinely enable people to live well at home and to avoid admissions to hospital when this is in their best interests.

This will be delivered by building the capacity of practices to:

- work together to improve access
- work closely with integrated teams to improve management of patients with multi-morbidity,
- enable access to more consultant led clinics in the community
- enable clinical commissioning champions in each practice to engage in locality work and lead work to reduce variation in their practice
- Enable practices to work together on back office efficiencies within and across the 6 locations.

The primary care programme will use a range of contractual levers, service improvement tools, and membership engagement to deliver this programme within a strategic framework which will be monitored by the primary care programme board. Progress already achieved includes the creation of a co-commissioned local improvement scheme with Thames Valley Area Team to maximise benefits from investment in primary care in 2014/15. The CCG plans to build on this experience and develop other co-commissioning opportunities which will support the development of a primary care which both sustains general practice and offers more flexible services.

Working with partners and the public to develop an integrated approach to primary and community services, with joint commissioning as appropriate:

A robust and sustainable primary care is fundamental to achieving the CCG's key objectives of driving development and delivery of integrated care. Local acute and community providers recognise that primary care needs to be actively involved in the design and delivery of services which are wrapped around the patient and primary care. Engagement of primary care as providers will be supported by the establishment of a county wide primary care federation which can offer services at a wider scale than the individual practice level. 88% of practices have signalled their intent to participate in a federation and the CCG plans to use co-commissioning opportunities to support new, more flexible ways of working in primary care.

Local Clinicians have collaborated with CSU statisticians to define selection criteria which GP practices have found effective in identifying a relevant patient cohort. Clinical judgement has been found to be the key ingredient to enhance capabilities of a risk stratification tool to bring a wide range of conditions into the 2% cohort, e.g. frail, elderly, palliative, mental health, asthmatic children. Working relationships amongst local providers has improved collaborating around identifying their shared care planned cohort and agreeing a way forward for care coordination.

Practices are expressing interest and curiosity in learning how to more proactively manage ‘at risk’ patients more pro-actively, as they begin to think through and recognise their practice processes around the DES requirements. OCCG regards this as a positive step toward improving care for this patient cohort and avoiding unplanned admissions.

How we will enable primary care to operate at greater scale to improve access and continuity of care and enable our urgent and emergency care network to function effectively:

The CCG is working on a number of fronts to improve access to urgent/same day appointments in primary care. Analysis has been undertaken to identify patients who frequently and inappropriately attend A&E and locality based support is being targeted to help practices address this problem. Additionally, the CCG is working with general practitioners to identify and test different ways of working which enable practices to manage demand so that patients with complex long term conditions can see their usual doctor and avoid unnecessary admissions. Opportunities to offer extended access through federated working will be considered as part of this process. Enhanced primary care support to 111 is also being explored to reduce attendances at A&E.

One of the CCG QIPP programmes will look at different procurement options around 111 and out of hours, E.g. benefits of horizontal or geographical capacity, the benefits of greater access to clinical advice in 111 and the benefits of greater GP or other clinical input in the SCAS call centre. We are also reviewing the recommended destinations from certain 111 dispositions with a view to increased use of minor injuries and other services with greater capacity, and with increased level of telephone consultations.

The urgent care working group (Whole Systems Programme Board) has identified that information could be provided more easily through web based access points and that the scope of choices for GPs to support their patients outside hospital can be better laid out. This should enable GPs to more reliably source alternatives when visiting patients in their own homes.

3.3 Urgent Care Programme

This programme aligns with the Keogh report[2], in that it comprises 7 projects which will:

i. Reduce activity in A&E by optimising access to alternative local services
ii. Reduce avoidable admissions for patients with conditions that can be treated without an admission
iii. Improve the efficiency and effectiveness of the 111 and Patient Transport Services.
iv. Improve end of life care
v. Improve the management of patients with complex long term conditions in primary care
vi. Support OUHT in its role as a regional stroke and trauma centre
vii. Improve access to the right service in the right place at the right time
viii. Improve the urgent care pathway, particularly at the interface between acute and community
ix. Deliver a net saving of £2.84m in 2014/15.

Additional projects that will reduce avoidable admissions from care and nursing homes and reduce healthcare expenditure on long term nursing care placements will be submitted to the Programme Management Board during 2014/15.

a. Urgent Care Project 1: OOH and 111

The 111 service requires re-procurement for a new service to begin during 2015.

OCCG is considering the most effective manner in which to commission 111 in the future and whether to jointly commission with other CCGs for a regional service, or seek to develop 111 with other urgent care services locally.

There is also the opportunity to consider the future delivery of Out of Hours primary care and Minor Injury / First Aid Units as part of a strategic review of urgent care services with partners across the system, including OUH, Oxford Health, SCAS, OCC and the LMC.

OCCG will consider the optimum strategy for commissioning these services in the future, which may include integration of services.

An integrated service across primary care and 111, or between primary care and Minor Injury Units, could enable:

- Further triage or management of patients once they have been assessed by the NHS Pathways triage tool, for those requiring more investigation;
- Reduction in the number of Out of Hours base visits, where such patients could be managed by telephone
- Reduction in the proportion of patients referred on to other services, particularly A&E and emergency ambulance response;
- Improvement of flow within services;
- As a result, release of associated savings arising from reductions in activity.

[2] Transforming Urgent and Emergency Care Service in England, Urgent and Emergency Care Review End of Phase 1 Report, Nov. 2013. http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

A 111 service commissioned across Thames Valley could allow for increased resilience of call handling and clinical advice within the call centre and offer efficiencies in terms of costs per call being negotiated at large scale.

b. Urgent Care Project 2: PTS

Non-Emergency Patient Transport Services (PTS) will require re-procurement in 14/15 for a new contract to commence during 2015. OCCG and partners are exploring the optimal model for delivery of PTS in the future, including the potential to formally tender across Thames Valley with Buckinghamshire and Berkshire CCGs, to offer a seamless service to patients across boundaries and offer cost efficiencies due to scale.

OCCG is undertaking a public consultation on the current eligibility criteria for PTS between May and August, to determine the future shape of transport and ensure patient transport is both sustainable and supports those with greatest need.

While determining the optimal model for PTS, consideration will also be given to:

- The management of GP urgents via PTS rather than emergency ambulance, for patients that have been assessed by a GP as requiring rapid admission to hospital for further management
- Patients requiring urgent transportation to a GP practice for assessment, including those requesting a home visit, for whom transport to the practice would enable the GP to assess them earlier in the day
- Additional discharge journeys from acute and community bedded settings, to support bedded care flow
- Reducing the current level of aborted journeys, where patients are absent or not ready to travel when transport arrives.

Commissioners will also seek to increase 'Hear and Treat' management of patients within 999, decrease the number of ambulances that are dispatched but do not subsequently convey ('See and Treat'), and improve response to life-threatening conditions (Category RED 8 calls) in rural areas in the South and West of Oxfordshire.

c. Urgent Care Project 3: Minor A&E avoidance

i. OCCG will work with its main acute provider to explore and agree alternative provision (by end Q2) to reduce A&E attendances by 16% by 2015/16. This will incorporate:
   - Measures that prevent inappropriate attendances
   - Measures to redirect rather than treat in the event of an inappropriate attendance, with appropriate contractual protections in place to ensure the service that treats is the service funded to treat
   - Measures to divert to more appropriate services.

d. Urgent Care Project 4: End of Life

i. This project will deliver:
   - Full adoption and implementation of the care plans developed in existing projects (including Advanced Care Plan summaries being accessible Out Of Hours)
   - The moving of community contracts for hospices from activity based cost & volume contracts to block contracts.

e. Urgent Care Project 5 : Improve management of patients with LTCs

i. This project will ensure that:
   - GPs are enabled to deliver the new GMS contract requirement that they identify their 2% highest risk patients and case manage them to avoid unplanned admissions, and that this is informed locally by use of the ACG risk prediction tool.

- GPs are enabled to utilise the full range of interventions to manage patients, for example reshaping practice time to support case management as proposed in the Primary Care Programme; using integrated health and social care teams as defined in our community contract and Better Care Fund plan; and accessing the community psychological medicine service, as set out in the Mental Health Programme).
- We implement revised LTC models/pathways for key conditions in the acute and primary care settings (as described in the Primary Care Programme and Ambulatory Emergency Care pathway project below).
- Patients are effectively supported to manage themselves, where this is appropriate.

f. Urgent Care Project 6: Develop an Ambulatory Emergency Care pathway

i. This project will see further development of pathway in acute hospitals for patients who come to A&E with ambulatory care sensitive conditions, in order to ensure those patients are seen, treated and sent home, rather than being admitted.

g. Urgent Care Project 7: Urgent Care Outcomes Based Contracting for Older People

i. In agreement with our partners, OCCG will continue to apply the principles of outcomes based commissioning across the older people's pathway to capture an improved level of integration (rather than discrete services with boundaries) and delivering the right patient outcomes (rather than focussing on detailed separate clinical service specifications). This will both support the delivery of integration and deliver an overall improvement in cost effectiveness and quality.

3.4 Planned Care Programme

Overview

The planned care programme comprises 5 projects to deliver to provide continuous improvements in health outcomes by:

I. Directing our resources to the services which evidence shows are effective
II. Driving out waste and duplication
III. Describing to patients how they can support themselves to live well improve their wellbeing.
IV. Developing models of care that supports the lives of our local population
V. Delivering a net saving to the system of £8.98m in 2014/15

Underpinning all projects in this programme is a clear commitment to ensure that wherever care is provided it offers value, quality and ease of patient access.

a. Planned Care Project 1: Diagnostics

This project will:

- Optimise GP usage of pathology and radiology imaging services by September 2014
- Improve the quality of radiology performance, access and turnaround times to meet national and local standards by March 2016
- Increase community provision of radiology through commissioning services in a competitive landscape.

b. Planned Care Project 2: Elective Care

We will improve the provision of elective care by refining how, when and where care is delivered through:

- Improving the quality of referrals between professionals
- Optimising efficiency of care pathways once patients have been referred to hospital;
- Maximising the opportunity to deliver care in alternative settings for appropriate conditions
- Expanding of consultant led email advice & guidance
- Expanding of specialist GPs in ways that support intra practice referrals

- Reducing those out-patients where a secondary care assessment provides little or no additional value to the patient

c. Planned Care Project 3: Integrated MSK Pathway

We will undertake a comprehensive review of planned care pathways, starting with Orthopaedics, in order to:

- Design a model of care that explores the various stages of the pathway, identifies potential inefficiencies and variation across inpatient and outpatient activity, as well as scope the effectiveness of wider support services and potential to deliver care in alternative settings. The outcomes of the various work-streams will be considered collectively with potential mechanisms for implementation and realising any opportunities identified. This could include the implementation of robust contracting levers, focussing on service transformation, may include the re-procurement of services.

d. Planned Care Project 4: Secondary Care Prescribing

- We will ensure the most cost effective prescribing in secondary care for diabetic macular oedema; retinal vein occlusion and age related macular degeneration by unbundling a package of eye treatment for which drug costs have been reduced.

e. Planned Care Project 5: Procedures of Limited Clinical Value

This project will:

- Reduce the use of resources to undertake procedures known to be of limited clinical value, thereby releasing funds to be spent where the greatest benefit is realised by the most people.

- Improve the contract disciplines supporting this so that providers and the CCG are assured that all partners are working to the same principles.

- Review the procedures currently regarded as of limited clinical value in Oxfordshire and update guidance and policies in line with national recommendations.

OUHT is the main provider for Oxfordshire patients and has experienced both steep activity growth and performance challenges. OCCG has joined the weekly OUHT meetings to support the on-going work to bring the Trust back within the RTT targets. The teams have worked hard to deliver increased capacity and this is reflected in the improvement against majority of targets. With the exception of completed pathways – admitted. The Trust is committed to maintaining this level of clinical and managerial resource until all targets have been met. OUHT and OCCG have agreed to work together to develop an early warning protocol that will give confidence to the system that we understand capacity and demand fluctuations and have plans in place to support them.

3.5 Mental Health Programme

This programme aims to ensure the integration of phyiscal and mental healthcare along the care pathway and to make improvements in dementia diagnosis and care. It will ensure we meet national targets on dementia and IAPT diagnosis. In addition the programme will focus on the development of an Outcomes Based Contracting Model for Mental Health. The programme is expected to deliver savings of £0.8m in 2014/15, further detail is set out in section 5.2.

a. Mental Health Project 1: Integrated psychological services

i. This project will:
- Pilot anxiety and depression interventions for Chronic Obstructive Pulmonary Disease and cardiac patients
- Provide access to community psychological medicine services for people with complex Long Term Conditions and Medically Unexplained Symptoms.
- Improve identification and management of people presenting with mental health problems in A&E and as inpatients
- Ensure we build on current service provision to gain benefits realised in other areas by improving rapid access to psychological services in the acute hospital setting
- Meet national targets on IAPT referral and recovery
- Support the development of the multimorbidity care model in primary care.

b. Mental Health Project 2: dementia

i. This project will:
- Review and develop the memory clinic pathway to streamline roles and responsibilities for diagnosis and care in primary, community and secondary care settings
- Prioritise investment in carer support to carers of patients with dementia
- Seek further investment in dementia advisors to support newly diagnosed patients
- Enable localities to engage with relevant local partners to develop dementia friendly communities.

ii. This project will take us from a dementia diagnosis rate (against expected rate per 100,000 of the population as defined by the National Dementia Calculator) of 43% in 2013/14, we plan to meet the national target of 67% by the end of 2015/16. We are confident that we can meet this challenging, but realistic, trajectory over two years, by enhancing the ability of Primary Care to offer opportunistic diagnosis through the use of GPCOG or an equivalent tool (in line with the national Dementia DES), and by streamlining the memory clinic pathway so that diagnosis can be rapildy confirmed.

3.6 Medicines Management Programme

This programme wil deliver savings on our drugs bill of £2.46m in 2014/15.

a. Medicines Management Project 1: reducing waste

i. Reduce medicines waste by:
- reviewing “when necessary” and “not dispensed” items
- Pilot “costs on bags” project
- Pilot “not dispensed” project
- Reviewing of repeat prescribing and dispensing (including in carehomes)
- Synchronisation of medications.

b. Medicines Management Project 2: primary care prescribing

i. The focus of this year’s medicines optimisation programme in primary care will be on:
- Chronic Obstructive Pulmonary Disease
- New Oral Anticoagulant Agents (NOACs)
- Diabetes.

c. Medicines Management Project 3: wound care

i. Derive savings from supply of wound care dressings by retendering contract and issuing new useage guidelines in 2014.
ii. Agree other dressings savings with tissue viability team for roll out in 2015.

3.7 Quality Impact Assessment

a. OCCG has an established system of quality assurance of commissioned services in Oxfordshire. Where possible we use validated tools to measure quality and combine this with the 'soft intelligence' we receive. When necessary we take decisive action to address situations where quality falls below the required standard.

b. In order to ensure that our strategic and operational goals are aligned with this approach OCCG undertakes a quality impact assessment on all new business cases. In line with good practice, each project is assessed against 3 criteria: patient safety; clinical effectiveness; and patient experience. The assessor determines the seriousness of potential adverse consequences and assesses the likelihood of the risk being realised.

c. For 2014/15 all projects in our major transformational programmes (as summarised in this chapter), have been assessed by the CCG's quality team in line with the above process.

d. This process has identified:
   i. The need to review the safety elements of the Minor A&E avoidance project once implementation is underway.
   ii. Further consideration of the elective care business case to ensure that the quality of patient care is not affected.
   iii. The need for enhanced patient engagement around medicine waste

e. Recommendations arising from this assessment will be reviewed by the CCG's Programme Management Board.

Chapter 4: Better Care Fund and Delivering a Modern Model of Integrated Care

4.1 Introduction

a. Our major change programmes as described above rely on the delivery of integration of care around the patient throughout the patient pathway.

b. Over £330m is currently shared within a pooled budget arrangements with Oxfordshire County Council across all client groups. This includes a significantly expanded pool covering care for older people and care and outcomes in physical disability, learning disability and mental health and wellbeing.

c. The Better Care Fund investments offers new scope for Integrating social community and acute pathways.

d. We have joint commissioning strategies with our social care partners that set out our shared intentions and mature risk sharing arrangements that mean we have truly pooled budgets, that in the case of older people we believe to be unique in the country. We will be building further on this in our outcome based commissioning programme.

e. We are working closely with our commissioning partners in NHS England to ensure alignment of our respective strategies and investments and delivery of integrated services – particularly in relation to primary care and public health.

f. Our 6 localities each have strong relationships with their local District Councils and we will continue to ensure joint working with them to integrate service provision in areas such as health and housing and prevention and early intervention.

g. The March 2014 Health and Well Being Board for Oxfordshire recognised social care investment is required through the Oxfordshire BCF to protect adult social care. It has been agreed that the investment in protecting adult social care is to be tested through the development and approval of business cases and that this should be on a whole system basis since the implications for acute funding and non-elective activity are profound. The risk to the whole system of removal of social care service would have been significant had the BCF not been available to support it. The role of social care in enabling the acute and community hospital sector to function efficiently and effectively is considerable and has been demonstrated through urgent care summits.
Business cases on the use of funding to protect adult social care will be presented in July and enhancements needed in social care to support system change have been proposed. Anticipated benefits in the business cases include an increase in planned home care packages of 35% over 5 years. We will continue to use the BCF to ensure seven day services to support discharge, data sharing, joint assessment and accountable lead professional. The business cases will demonstrate that this investment will enable acute activity to reduce.

h. **Risk**
OCCG's recently submitted financial plan for 2014/15 to 2018/19 sets out a QIPP requirement of £17.3m in 2015/6, of this £8-10M is not currently supported by detailed QIPP schemes. Around £10M of this requirement is driven by the BCF requirement to protect adult social care. The £17.3M assumes CCG QIPP schemes are delivered in full in 2014/5. This is compounded in that the outcomes based contracting approach to older people, which the CCG plans, subject to contract, relies significantly on reductions in non-elective acute activity (albeit with sub- acute activity also anticipated to reduce through an overall more efficient pathway).

It is clear therefore that the system faces significant challenges and that early identification of the risks of non-realisation of these benefits along with system wide strategies to address them, is a critical piece of whole system work that we are undertaking.

i. **Provider engagement in the discussions on the Better Care Fund**

Providers involved in the discussion to date (OUHT, OHFT, SCAS) are concerned to demonstrate that the business cases supporting the £10M protection of social care generate real net benefit which can be used to improve health and social care in Oxfordshire and reduce costs in non-elective admissions. The level of reduction in non-elective care implied is unprecedented and will require a step change in the whole system response which will need to be modelled and agreed with the OUHT in particular as the acute provider.

j. The whole system programme board has agreed a series of programmes to further source the overall resource envelope these cover

- Primary care
- Integration
- Personalisation/ co-production of personal health and well being

The further development of programmes and joint programme management will oversee implementation; investment in BCF will be tested through business case approval.

k. Our ambition is to build on these very strong foundations to deliver a model of integrated care across the whole patient pathway. The integrated model – as described below – has been built up in consensus with our provider and commissioner partners in health and social care, and each of our major improvement interventions will contribute to its delivery.

4.2 Model for a Pathway of Integrated Care

i. **Prevention and early intervention**

We will work closely with our partners in Oxfordshire County Council, the District Councils and NHS England to deliver an integrated approach to preventing ill health and reducing health inequalities.

We will ensure closer working with NHS England and our partners in the Community Safety Partnership on the care of people in the criminal justice system and other vulnerable groups (see Chapter 5).

ii. **Primary care**

During year 1 of the plan, we will be working with NHS England to support the development of increased capacity in primary care to:

- Enable greater continuity of care to be delivered by GPs to patients with long term conditions
- Develop ways practices can work together to provide better support for patients planned and emergency care needs

The Better Care Fund plan will ensure that each practice will have named community health and social care link workers in its local integrated team.

iii. **Management in the community**

GPs will be supported to develop a whole person approach to provision of care for people with complex long term conditions who are at the highest risk of needing hospital care.

These patients will have access to integrated health and social care community services that ensure each patient has:

- A single health and social care assessment
- A single integrated and personalised care plan (including palliative care where appropriate.)
- A named care-co-ordinator responsible for the delivery and updating of that care plan (who can also link to District Council commissioned services as appropriate).
- The support as required of: specialist sub-acute medical and nursing care, sub-acute therapy care and/or therapist led rehabilitation.
- Increased use of intensive community support, as required to reduce admission to learning disability assessment and treatment services, in line with the Winterbourne View recommendations.

iv. **Urgent care**

In the event that someone with complex health and care needs requires emergency or urgent care, they will be able to get same day access to a multidisciplinary health and social care assessment, and where they can be cared for at home will be discharged to the care of their accountable GP and a named care co-ordinator in the integrated community team.

v. **Admission to a community facility**

In the event that a planned or unplanned admission is required we will ensure that patients can access:

- Intermediate social care and/or sub-acute health care which comprise: Skilled sub-acute medical and nursing care, sub-acute therapy care and/or therapist led rehabilitation.
- Appropriate mental health care

When an individual needs to be admitted the focus will be on returning them to optimal levels of health and getting them back home as soon as possible.

We are building brand new community facilities to deliver sub-acute ambulatory care which will be operational in Bicester in year 1 and in Henley in year 2 of this plan.

vi. **Admission to the acute hospital**

In the event of an admission to an acute hospital bed by patients with physical and mental health care needs, the interplay of those needs will be recognised in the development of treatment plans. So for example, a cardiac patient with anxiety will have access to psychological therapy and an older person with a fracture and dementia will have their dementia needs recognised in the planning and delivery of their orthopaedic care.

vii. **End of Life**

We will work to ensure that:

- All parts of the health and social care system know, and are able to respond to, a patient's palliative care wishes.

- Patients and their families experience seamless end of life care, regardless of the number of voluntary, health or social care organisations are involved in the provision of that care.

4.3 Better Care Fund Plan

a. Our Better Care Fund plan will be an important enabler of delivery of this vision for full Integration.

b. The plan commits us to:

i. Working together to implement an outcome based contract for services for older people. In 2014/15 we are targeting this work on the acute assessment/admission/discharge/reablement pathway - incorporating both community and acute health services.

ii. Exploring the added value that might derive from the CCG and the County Council working together to join up commissioning and integrate the provider services for the benefit of patients.

iii. Delivering locality based integrated health and social care community teams.

iv. Investing money transferred from health to social care to support people to live independently in their own home for as long as possible.

v. Maintaining existing levels of funding in disabled facilities grants and extra care housing.

vi. Investing in:

- Improved information and advice services (including for those who fund their own care)
- Equipment and assistive technology
- A more personalised approach to home support that removes the need for short visits for personalised care, integrates care and rehabilitation and bases care on individual service funds
- 7 day working in social care
- Implementation of a Discharge to Assess care service
- Further development of emergency multidisciplinary assessment pathways to ensure appropriate medical, nursing, social and therapeutic capabilities in both acute and community sectors.
- Preventative work with younger adults with mental health and /or drug/alcohol dependency who are frequent repeat attenders at A&E
- Careers' training, intensive support and breaks
- Building the capacity of care home, nursing home and home care support services to provide care for people with dementia
- Seamless "one stop shop" solutions for crisis, rapid response and enabling support at home
- Support for people to die in their usual place of residence where this is their choice
- Improvements in reablement and rehabilitation services
- Sharing of data.

c. The CCG and OCC as co-commissioners, along with our key acute provider OUHT, are considering how best to ensure:

   i. Good governance of the Better Care Fund and in particular the role of the Joint Management Group for Older People in identifying and managing the risks of reliance upon reduction in acute activity to pursue developments through the BCF.
   ii. Good programme oversight of the initiatives set out in the BCF plan and in particular the role of the Whole Systems Programme Board.
   iii. Production of high quality business cases for the initiatives in the BCF so that they demonstrate 'clear benefits to the wider health and social care sector and reduce costs in acute health care'.

Chapter 5: Key Supporting Measures

Delivery of the transformational change we want to make in the Oxfordshire system will be dependent not only on major change programmes and a formal focus on integration, but will also require the CCG to deliver a number of fundamental supporting work programmes:

i. Improving health and reducing health inequalities
ii. Delivering parity of esteem in mental and physical health care
iii. Engaging the public and promoting transparency
iv. Delivering quality, safety and innovation
v. Organisational development.
vi. Provider marketing strategy

These are all described in this chapter.

5.1 Supporting measure 1: Improving health and reducing health inequalities

5.1.1 OCCG, OCC and NHS England have agreed a joined up approach to improving health and tackling health inequalities in Oxfordshire, which is described briefly below. This model follows the 5 steps recommended in Commissioning for Prevention and is designed to close the gap for those population groups who experience worse outcomes, by supporting delivery of agreed Health and Wellbeing Board targets and trajectories, which can be found here: http://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf. These priorities are derived from the data in the JSNA.

5.1.2 Health inequalities issues have been broadly identified through the Joint Strategic Needs Assessment for Oxfordshire. Further work will be undertaken early in the first year of implementation to identify practices where a combination of poor health in the practice population and relative deprivation mean that work should be targeted to close the gap. Plans will then be drawn up based on the identified needs of each practice population in these target areas. This includes implementation of the 5 most cost effective high impact interventions recommended by the NAO report on health inequalities.

A Health Needs Assessment of Offenders in Thames Valley has been published by the Local Criminal Justice Board. This will be used in the detailed planning for reducing health inequalities, particularly in respect of mental health, (substance misuse services issues are commissioned by the local authority).

5.1.3 The detailed steps we will take are:

a. Each OCCG locality will identify a small number of practices where there are populations that have been agreed as priorities because they have worse outcomes. These populations include:

    i. Children in poverty
    ii. Ethnic minorities
    iii. Carers
    iv. Lonely old people
    v. High number of mental health service users
    vi. People with physical and learning disabilities

b. These practices will then be reviewed using OCC, NHS England and practice data to identify those which also have :

i. Low uptake of core PH prevention interventions (smoking cessation, breastfeeding, weight loss, screening, immunisations, health checks)
ii. Populations with potential to benefit from improved blood pressure, cholesterol, anti-coagulation and blood sugar control. (National Audit Office recommendations)
iii. Low carer registration

c. Those practices which fit both categories (and which we expect to include practices in areas of deprivation) will form the target group for offers of intensive support to tackle health inequalities and provide early intervention and prevention services from OCC's providers, NHS England's screening and immunisation providers and locality teams.

d. Local PPG fora will be asked to endorse the proposed selection of target practices.

e. An implementation group will be established to ensure that OCC, NHS England provider and locality teams will work together in joint teams supported by an equality delivery system.

i. Locality Support Pharmacists will work in priority practices to identify individuals who would benefit from individualised outreach to encourage take up of prevention and early intervention measures.

ii. CCG (City team) will work with CSU and OCC to get a flag on all GP systems for members of the countywide Troubled Families initiative and will ensure GPs have access to contact information for case workers for each member of a Troubled Family, to assist with this identification/outreach work and to support whole system working around our most disadvantaged citizens.

iii. CCG Locality Equality and Access teams will undertake targeted outreach work to encourage identified individuals/families and or communities to take up these services.

iv. ADLs / Locality Clinical Directors will work with GPs in these priority practices to encourage increased delivery of specific clinical interventions , including those recommended by the National Audit Office to reduce health inequalities:
- Increased prescribing of drugs to control blood pressure;
- Increased prescribing of drugs to reduce cholesterol;
- Increased anticoagulant therapy in atrial fibrillation;
- Improved blood sugar control in diabetes
- Registration of carers
- Increased referral to healthy lifestyle interventions
- Early interventions and prevention for maternal and child health.

v. OCC/OCCG joint commissioning lead for children and maternity will be asked to get Health Visitor and breast feeding support services to target work with the priority practices.

vi. OCC will target smoking cessation, and other prevention measure at priority practices/identified individuals.

vii. NHS England will prioritise support to increase uptake of screening and immunisations within targeted practices.

viii. CCG locality teams will manage relationships with practices jointly on behalf of OCC/NHSE/CCG so practices are not overwhelmed.

ix. CCG locality teams will focus PPG development work on the same priority practices.

f. In addition to the above, CCG Equality & Access teams will focus on neighbourhood based strategic partnership programme work, work with carers and work with military and veteran communities.

g. For vulnerable children and adults, NHS England, OCC and OCCG will:

i. Deliver joined up services to prevent, detect and intervene early where children are being exploited or at risk of being exploited.

ii. Deliver a 'core offer' for all children who are Looked After or Leaving Care so that there is consistent assessment of their health needs, early intervention where necessary and speedy access to more specialist services (such as Child and Adolescent Mental Health Services) when required.

iii. Explore the potential for co-commissioning with NHS England to meet the primary and community care needs of our homeless population and to develop services for vulnerable adults in frequent contact with the criminal justice system.

5.2 Supporting Measure 2: Delivering Parity of Esteem in mental and physical healthcare

a. OCCG is committed to achieving parity of esteem for mental health services and the people who use them in Oxfordshire by 2019. We will
    a. Ensure that the experience of patients with mental illness meets the same standards that we expect for patients with physical health problems. This will include responsiveness of service in terms of waiting times and quality of care both in planned and urgent care situations
    b. Ensure that the physical health of people with mental health problems receives the same attention as their mental health needs: we will eliminate "diagnostic overshadowing" and begin to reduce the mortality gap for people with severe mental illness
    c. Ensure that the mental health needs of people with physical health problems are addressed to support recovery and self-management of physical health needs.

b. To achieve these outcomes we will
    a. Implement outcomes based contracting for adult mental health services for those people assessed as meeting the thresholds for HoNOS PbR clusters 4-17
    b. Integrate primary care based psychological therapy services into one service that can act as a more preventative service for both mental and physical health care
    c. Develop psychological medicine services that will improve outcomes for people with co-morbid mental and physical health problems in acute, community and primary care settings
    d. Improve the rates of dementia diagnosis and support better management that allows patients to live as long as possible independently in their own homes
    e. Improved identification and support for children and young people with mental health problems.

c. We aim to demonstrate parity of esteem in mental and physical health in our plan and we set out in detail for the first two years and in outline in the final years of our plan, how we intend to do this through our investment decisions: this will be reflected in spending in specialist mental health services as well as at the primary care level where we know that for example, patients with long term conditions commonly also experience mental health problems.

5.2.1 Outcomes Based Contracting for adult mental health services

a. We will deliver the following outcomes for people over the age of 18 living with mental health problems by 2019 via a joint commissioning approach with Oxfordshire County Council.

b. These outcomes will be delivered using outcomes based contracting funded through a Section 75 NHS Act 2006 Pooled Commissioning Budget, driving the following objectives.

Outcome	Measured by
People will live longer	• Mortality rate • Suicide rate
People will have an improved level of wellbeing and recovery	• Improved score against recovery star • Reduction in intensity score against HoNOS PbR cluster tool • Sustained recovery 6 months post discharge
People will receive timely access to assessment and support	• Time from referral to establishment of care plan • Timely support in crisis
Carers will feel supported in their caring role	• Carer Strain Index • Carer satisfaction
People will maintain a role that is meaningful to them	• Increased numbers of people in work • Increased numbers of people volunteering • Increased numbers of people in education • Numbers of people able to perform caring/home management role
People will continue to live in suitable and stable accommodation	• Increased numbers of people living independently • Increased throughput of people from hospital to supported housing
People will have better physical health	• Improved scores for people with severe mental illness against key health screening (BMI, smoking cessation etc.) • Reduced use of urgent care system

5.2.2 Psychological therapy services in primary care

We will redesign and procure our primary care based psychological therapy services for people with mild to moderate anxiety and depression to

- Achieve national targets around meeting morbidity and recovery
- Improving mental and physical outcomes for people with long term conditions
- Improve the capacity of the Oxfordshire system around preventing escalation of mental health problems

5.2.3 Integrated psychological medicine services that address co-morbid physical and mental health problems

- OCCG will review and develop the range of integrated psychological medicine services that support people with co-morbid conditions to reduce impact on planned and urgent care pathways

5.2.4 Improved rates of dementia diagnosis and care that enables people to live longer in their own homes

- OCCG will create a dementia register to identify people who can be supported in dementia friendly communities to live in their own homes and avoid unnecessary admission to hospital and reduce the need for a longer term placement in nursing or residential care
- OCCG will support carers so that they are more able to support people with dementia to remain in their own homes

5.2.5 Improved identification and support for children and young people with mental health problems

a. OCCG will improve identification, support and outcomes for children and young people with mental health problems by achieving the following ambitions as set out in our Joint Commissioning Strategy with Oxfordshire County Council.

Ambition	What will we do to achieve this?
Improve transitions from children's to adult mental health services	• Review of gaps in provision for young people aged 16-24 years resulting from eligibility thresholds and transition from Child and Adolescent Mental Health Services to adult services, particularly young people with Attention Deficit Hyperactivity Disorder, Autistic Spectrum Disorder, or with conduct disorders.
Better outcomes for children with Autism	• Co-ordinate the review of the ASD diagnostic pathway for 5-18 year olds across all relevant providers including schools. • Prioritise actions in the Oxfordshire Autism Strategy.
Ensure support is available to children and young people with mental health issues	• Develop mental health support in community settings such as schools, clubs, hubs (Youth counselling and joint working with Public Health).
Improve existing mental health services for children and young people	• Develop an outcomes based approach to contracting for CAMHS services from 1st April 2015.
Improve targeted support for children and young people at particular risk of developing mental health problems	• Identify clear pathway of prevention, early intervention, treatment and support for young people Looked After and those leaving care (up to 25 years).

5.2.6 Milestones

a. The major milestones for these two initiatives and our major mental health improvement intervention are:

	2 year implementation plan
Improved outcomes for people living with severe mental illness	• Agreement on outcomes and measures (OCCG) by April 14 • Negotiation into OH contract and CQUIN and/or implementation plan April 14 • Design/procurement solutions July 14 (OCCG) • New OBC services in place Jan 15 • Evidence of impact from April 15
Psychological medicine services in primary care	• Evaluation of current IAPT/LTC projects (OCCG and OH) July 14 • Procurement activity to Sep 14 • New services in place April 15
Improved mental health of people living with physical health problems	• Implementation of revised urgent psychological medicine service from April 14 (OH) • Review of current psychological medicine services across acute and community settings • Evaluation of the mental health needs of high cost and frequency users of services in the urgent care pathway • Design and implementation of evaluated services by April 15
Improved rates of dementia diagnosis that supports people to live at home	• Increase the number of people with dementia supported to live at home via the creation of a dementia register from July 14 • Identify people to be supported in the community from August 14 • Improve the level of memory assessment services in Oxfordshire by June 2016 • Increase the number of carers breaks by 200 per year by March 16
Identification and support for young people with MH problems	• Evaluate new transition model from April 14 • Design and procurement solutions to Sep 14 • Implement new model from April 15 • Review of PCAMHS/CAMHS against overall strategy direction and in preparation for end of Oxford Health NHS contract (2014 / 2015) • Roll out of Performance By Results for CAMHS (2014/15)

5.2.7 Further developments to support parity of esteem

OCCG will explore how it might further support the drive towards parity of esteem and support the wider system resilience that is needed in Oxfordshire. Commissioners have reviewed "*Closing the Gap: priorities for essential change in mental health"* and identified the following initiatives that will be developed and delivered to 2019:

- Develop an outcomes based contracting approach to Children and Young People's mental health services.
- Implement the Crisis Concordat for Oxfordshire.
- Increased integration of psychological medicine in primary, planned and acute care to improve efficiency of urgent and planned care pathways.
- A focus on psychological medicine to improve outcomes for people with severe mental illness
- A renewed focus on the most complex mental health presentations (e.g. people living personality disorder, who are homelessness and who have drugs and alcohol co-morbidities).
- More dementia screening and management closer to primary care.
- Increasing the range of housing and support options for people with severe mental illness.
- Exploring further preventative approaches for people at risk of hitting mental health payment by results cluster thresholds.

5.3 Supporting Measure 3 : Engaging the Public and Promoting Transparency

5.3.1 Engaging the public

a. OCCG has developed a pro-active approach to patient and public engagement, designed to ensure that the commissioning process and decision making is informed by citizen participation. The CCG uses a number of approaches, reflecting the fact that patients, the public and stakeholder groups have differing preferences regarding how they wish to be involved.

b. Key approaches include supporting the development of Patient Participation Groups (PPGs) at practice level, and the establishment of patient and public forums at locality level. Each of the six localities now has a forum in place, with a lay chair. The Governing Body of the CCG has a lay member with responsibility for patient and public engagement and regular meetings are held with the lay chairs.

c. This approach is supported by the use of Talking Health, an innovative online engagement and consultation tool. There are currently 2,000 public members of Talking Health, who, on signing up, are asked which issues they are interested in and how they would like to be engaged/involved. This includes invitations to meetings, participation in surveys and in online discussions. The Talking Health system allows for rapid analysis of responses, to feed real time decision making. Members are given feedback on the overall responses and are kept up to date through a Talking Health newsletter.

d. The Governing Body meetings in public are seen as an opportunity both to demonstrate transparency of decision making and to hear and reflect on feedback from patients and the public. Questions are invited in advance of the meeting and answered during the meeting. The questions and written answers are published on the CCG website.

e. In addition the CCG undertakes specific programmes of engagement to support decision making on particular issues. For example, the CCG has over the past twelve months engaged with users of mental health and maternity services and services for frail elderly people in order to co-design outcomes measures which will begin to be built into the contracting process. This has involved close working with voluntary sector and patient groups as well as with individuals. Over the past three months the CCG has led an active programme of work under the Call to Action banner to hear feedback on the strategy which has informed this five year plan.

f. The CCG works in close partnership with healthcare providers and Oxfordshire County Council and a number of engagement exercises are run jointly.

5.3.2 How we will promote transparency in local health services

a. The CCG promotes transparency in local health services in a number of ways. Senior CCG staff meet regularly with the medical and nursing directors of its major providers to discuss key issues and operate a “memorandum of understanding” to ensure potential clinical concerns can be raised and intelligence shared between organisations’. Ongoing discussion take place promoting provider board reports to be more explicit particularly where services fall below acceptable standards.

b. All serious incidents are reviewed by the CCG prior to their closure to ensure lessons are learned and that patients and relatives have been fully informed of the incident and the preventative action taken.

c. The CCG patient experience team contact details are displayed in GP practices as is a CCG web site address if people wish to contact the CCG to discuss aspects of healthcare.

d. The CCG produce a Quality and Performance report every 2 months which describes the quality of health services good and bad which is available on the CCG web site.

e. The CCG plans to further promote transparency in local health services in a number of ways:

i. The CCG will develop a “candour statement” that describes how both commissioners and providers should communicate with each other and with the public. It is intended that this document will be signed by all Chief Executives and displayed on both provider and commissioner web sites.

ii. The CCG will develop its web site to include a section on the “quality of healthcare services” that are being provided in Oxfordshire. This will include clinical audit reports, quality and performance reports and links to other websites such as Dr Foster and NHS England that show performance of acute hospitals and GP practices respectively.

iii. The CCG will continue to work with stakeholders such as Health Watch and CCG Localities to share information on the quality of health services and how they are being improved.

5.4 Supporting measure 4: Delivering Quality, Safety and Innovation

5.4.1 Quality of Healthcare

A. The centrality of quality for NHS commissioner’s priorities has been eloquently and amply set out, most recently in the reviews by Berwick, Keogh, Winterbourne view reports and Francis inquiry. Put simply the quality of NHS commissioned services should influence everything we do.

B. All Oxfordshire Health and Social care organisations recognise that any organisation will have quality and safety issues. We accept this and will focus on learning from incidents in order to improve quality continuously. We acknowledge that systems and process, not individuals, are predominantly the cause of safety incidents and quality concerns.

C. Cultures in which staff are supported, empowered and trusted are crucial for the delivery of high quality care. Increasing resource constraints and demographic pressures may have an impact on the quality of services.

D. Learning Disability services are commissioned by Oxfordshire County Council under a section 75 pooled budget arrangement. OCC and OCCG have increased the scrutiny of this type of service and are using service users and their families to co-design pathways of care and to quality assure commissioned services.

E. Oxfordshire patients had been placed in Winterbourne view prior to the exposure of abuse. Commissioners have sought to understand the systems and pressures which contributed to the abuse. We have looked at the placement of patients out of area and are, wherever possible repatriating patients and increasing the quality assurance for this type of service, in area as well as out of area

OCCG aims to:

- Develop a focus on quality that transcends organisational boundaries and covers all aspects of care, from birth to death;
- Ensure quality is everybody’s business: public, patients, NHS staff, family and carers;
- Support all stakeholders to raise concerns and/or lead improvement;
- Use measurement for quality where possible while acknowledging that not everything which is important can be measured;
- Strive for continuous improvement.

F. These aims have been agreed by the governing body and are detailed in our Quality Statement approved in November 2013.

G. In order to capture the learning from recent NHS reviews of service quality, The CCG operates a "Clinical Assurance Framework, approved in January 2014. This framework sets out the mechanisms used by Oxfordshire CCG to ensure patients using NHS services in Oxfordshire receive safe, good quality care with a positive patient experience, and the actions the CCG will take where quality and performance does not meet acceptable standards. It supports the CCG vision "By working together we will have a healthier population, with fewer inequalities, and health services that are high quality, cost effective and sustainable."

H. We will continue to develop this framework and where possible in 2014/15 publish all quality and performance reports and related documents on the CCG web site.

5.4.2 Patient safety

a. The CCG reviews a wide range of information relating to patient safety and it would be impractical to detail all initiatives, but key areas of improvement for 2014/15 are detailed below:

i. Zero tolerance to avoidable MRSA bacteraemias, by undertaking Root Cause Analysis on all cases and taking corrective action when it is identified;

ii. Reduce the number of C. diff cases below the NHS England trajectory by implementing the action from the CCG Risk Summit in November 2013;

iii. Increase the number of medication errors reported by working with key providers including primary care. The CCG will work with NHS England to increase the reporting and collating of medication errors with GPs, Pharmacists and Dentists. Plans are in place with Oxford Health to increase reporting by community nursing and community hospital staff;

iv. Reduce the number of avoidable pressure ulcers utilising the patient safety thermometer and implementing actions from serious incidents;

v. Improve the quality of care for inpatient diabetic patients by improving staffing levels and roll out of "Think Glucose"

vi. Improve the safety and effectiveness of diagnostic imaging services by improving staffing and roll out of an independent quality management system.

5.4.3 Clinical Effectiveness

a. The CCG reviews a wide range of clinical audits and NICE guidance. Key areas of improvement for 2014/15 are detailed below:

i. Continue to reduce mortality rates in the acute sector by enhancing the mortality review process;

ii. Improve nutrition for patients in hospitals by working with providers;

iii. Ensure patients with complex mental health needs receive appropriate care by redesigning mental health services in Oxfordshire, as detailed above.

iv. Improve care for inpatients suffering from pneumonia by redesigning the patient pathway.

5.4.4 Patient experience

a. The CCG reviews a wide range of information relating to patient experience. Key areas of improvement for 2014/15 are detailed below:
   i. Continuously review and improve the ways in which we seek, collect and respond to patient experience information;

   ii. Ensure clear link between knowledge about patient experience and action, both macro and micro, taking action to address areas for improvement;

   iii. Use patient experience data as a lever to drive up quality; (for instance the OCCG governing body begin each meeting with a patient's story.)

   iv. Improve quality of care for patients using the district nursing services;

   v. Improve access to elective care at the OUH and increase access to directly bookable services by re-profiling outpatient capacity to match demand;

   vi. Enhance the discharge process for patients.

5.4.5 Compassion in practice

a. OCCG is working with all provider organisations' to ensure compassionate care is central to the work of clinicians. Compassion, care, communication and competence are frequently mentioned in patient feedback and complaints. Addressing these areas with clinical staff will have an impact on complaints and ensure an improved patient experience which should ultimately be reflected in an improvement in Friends and Family scores.

b. There are active discussions with senior leaders in nursing to develop a culture of partnership with patients and careers where the patient /carers' needs are central to care. All Trusts have nursing strategies which includes the 6 C action areas (Care, Compassion, Competence, Communications, Courage, and Commitment). OCCG will work with the Trusts to turn aspirations into action and to include all staff groups in the agenda. This will be enabled by the Director of Nursing & Medical Directors of NHS England supporting this approach.

c. The 5 Year ambition for this work is to have this embedded across all staff groups achieving an outcome of where difficulties with communication, care and competence are cited less frequently in patient feedback and complaints.

5.4.6 Staff satisfaction

a. OCCG recognises the importance of staff satisfaction to the delivery of high quality services. There is good evidence that happy, well-motivated staff deliver better care and that their patients have better outcomes. Trust Boards recognise that staff satisfaction is key to delivering high quality care. The CCG reviews staff surveys and benchmarks across similar providers. OCCG encourages Trusts to learn from other Trusts and other organisations' to adopt innovative initiatives to improve staff satisfaction. A Friends and Family question will be asked of staff in 2014 asking them if they would recommend their organisation.

b. OCCG uses the results of staff and patient surveys in conjunction with other quality metrics to evaluate the quality of services being provided.

5.4.7 Seven day services

A. We are committed to delivering 7 day access to health and social care services, and have already implemented 7-day working across a number of elements of the health and social care system. This includes social work teams in hospitals, covering wards and all front doors to services (Accident and Emergency, community and acute hospitals and Emergency

Medical Units). We have also incentivised social care providers to begin care to clients within 72 hours of referral, including on Fridays and over the weekend in order to reduce delays. The Emergency Duty Teams also ensure there is support available 24 hours a day, 7 days a week. This will be developed further in partnership with OCC as part of our Better Care Fund plan.

B. The primary care programme will improve urgent access to primary care in normal and extended hours. Adjustments to 111 and Out of Hours contracts will further improve 7 day access to primary care.

C. Seven day working in our main community and acute providers is being progressed by the CCG through negotiation and collaboration with our providers. Service Delivery Improvement Plans will have clear objectives and milestones incorporated into contracts with our main providers. The CCG will monitor progress through contractual arrangements to assure itself that robust 7 day working plans are implemented as per agreed timescales.

D. The development of 7 day working plans is being informed by evaluation of the projects delivered under the Winter Pressures Programme 2013/14 under the leadership of our Whole System Programme Board (formerly the Urgent Care Working Group).

5.4.8 Safeguarding

A. We plan to work in partnership with the local children and adult safeguarding boards to support and safeguard the vulnerable through a more joined up approach to addressing their needs, working across organisations and in partnership with others involved in the provision of health and social care. OCCG will achieve this by ensuring it focuses on quality, acting swiftly to eliminate poor care to make sure that care is centred on patient's needs and protects their right.
B. OCCG will provide leadership to all provider organisations and support clinical decision making within the organisation. We will ensure that all organisations from which we commission have effective safeguarding arrangements in place, and that there are clear lines of accountability within organisations and across health services in line with the accountability and assurance framework.
C. It is the aim of OCCG that consistent, safe, effective and respectful care is provided to every patient. All staff must be able accurately to assess patients to identify those at risk of harm. Primary care services, alongside other commissioned providers, will be supported by the CCG to make improvements in care. Where a child or adult is identified as at risk or vulnerable then safe care of the highest possible standard will be provided. This will be achieved through strong local leadership, investment in effective co-ordination as a committed partner in care provision, and robust quality assurance of safeguarding arrangements
D. Learning and developments in safeguarding will be disseminated with support of OCCG to inform and drive quality improvement in safeguarding practice, informing training programmes learning activities and service developments.

c. The actions we will take in the next two years are:

i. Identify and agree what is required to ensure a safe system that safeguards children and adults at risk of abuse or neglect across the NHS community locally.
ii. Ensure active involvement of all health commissioners and providers in the functioning and development of the Oxfordshire Safeguarding Children Board and the Oxfordshire Safeguarding Adults Board.
iii. Ensure that representation and involvement in the work of the Health and Well-Being Board is integrated into safeguarding.
iv. Working closely with the Oxfordshire Community Safety Partnership Board, ensure health services are effectively contributing to the delivery of whole system strategies to meet the health and care needs of vulnerable adults and children, particularly where they are in contact

with the criminal justice system, are vulnerable to exploitation and/or have a drug or alcohol dependency.

v. Develop and agree clear and robust arrangements between CCG, Thames Valley Area team and OCC Health Promotion Commissioning teams to ensure that the health commissioning system as a whole is working effectively to safeguard and improve outcomes for children and adults at risk and their families, thus promoting their welfare.
vi. Review and develop assurance frameworks that demonstrate all providers have effective safeguarding arrangements, using safeguarding schedules to be assured that they are meeting their safeguarding responsibilities. We will monitor how these roles are fulfilled through our assurance processes by assessing their compliance with national and local standards.
vii. Review and develop assurance frameworks that demonstrate all providers are conversant with the Mental Capacity Act, using it appropriately and whenever it is required. Providing an Adult Safeguarding leadership and supporting policy and training developments alongside the local adult safeguarding board.
viii. Ensure all providers are complaint with the Prevent Agenda, monitoring provider activity and contributing to the local panel as appropriate.
ix. Work with partners and colleagues to develop a learning and development framework that enables lessons to be learnt and shared across the locality.

5.4.9 Innovation

Oxfordshire CCG's aspiration is for the local health economy to be defined by its commitment to innovation, demonstrated both in its support for research and its success in the rapid adoption and diffusion of the finest, transformative, most inventive ideas, products, services and clinical practices.

a. The CCG has a duty under Section 14Y NHS Act 2006 to promote research and the use of evidence obtained from research. To this end, the Quality and Performance Committee (a subcommittee of the Governing Body) has a specific role to promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience.

b. The NHS Chief Executive's report, 'Innovation Health and Wealth', published in December 2011, committed the NHS to spread at pace and scale the number of existing technologies and innovations, with the potential to transform both quality and value across the NHS. This is reflected in the CCG's creativity value (visionary, resourceful, excellent) which informs how the CCG works and makes decisions. Our plans have been based on these principles.

c. Oxfordshire CCG is a founding partner of the Oxford Academic Health Science Network. The Medicines Optimisation network project initiation document has been developed by the Thames Valley Lead Pharmacists and links to local plans for medicines waste reduction and reducing unwanted variation in medicines.

d. Translation of research into practice: A priority area has been a county wide evidence-implementation project to enhance the number of patients with atrial fibrillation who are anti-coagulated in order to prevent stroke (which is a highly effective intervention to prevent a disabling and expensive condition). The average number of high risk Oxfordshire patients who are now anticoagulated has risen from 55% in March 2011 to 64% in March 2013. This improvement might be expected to prevent around 20 strokes annually in Oxfordshire. As a result of our success, we are part of a national working group led by Sir Muir Gray to inform and improve stroke prevention across the UK.

e. Collaborations for Leadership in Applied Health Research (CLAHRC): The Oxford CLAHRC comprises a new collaboration of leading applied health researchers, alongside the users of research, including commissioners, clinicians, patients and the public.

f. This collaboration spans several boundaries between primary and secondary care, between commissioners and providers, and across the translational continuum by linking with the Oxford Academic Health Consortium, the Oxford Academic Health Science Network and the Oxford Biomedical Research Centre.

g. With science excellence and strong collaborative leadership, the Oxford CLAHRC will address areas of high importance and relevance for patients as well as key NHS priorities: delivering the most effective and best value services and focussing on those with greatest need - the frail elderly presenting to acute medical services, people with dementia in care and nursing homes, and those with chronic enduring illnesses and comorbidities, the highest users of NHS services.

h. We will research new ways of providing services, the potential for patient self-management, and more integrated care across organisational boundaries. We will provide robust evidence of the effectiveness and efficiency of these services and facilitate rapid implementation of evidence based changes for the benefit of patients. Importantly, we also plan the Oxford CLAHRC as enhancing UK applied research training capacity and ensuring local priorities factor into the research agenda and implementation of evidence in the service agenda.

i. OOxfordshire CCG will use the Thames Valley Priorities Committee to assess the evidence and make local commissioning recommendations for innovative treatments and technologies not covered by NICE. OCCG has a lead for NICE guidance responsible for making commissioning recommendations based on NICE guidance. OCCG will continue to implement the NICE Compliance Regime in Innovation, Health and Wealth. OCCG will make full use of other NICE guidance in accordance with the NICE Policy including identified disinvestment opportunities. New interventions and technologies recommended by NICE will be assessed for local implementation as they are published. OCCG will be proactive in the use of the IH&W CoLab Portal.

j. The actions we will take to progress this agenda in the next two years are:
    i. Use the Area Prescribing Committee (APCO) to embed automatic incorporation of NICE recommendations into local formularies.

    ii. Regularly monitor compliance with Technology Appraisals including national benchmarking information when this is available, for example the Innovation Scorecard.

    iii. Use available metrics to monitor procedures defined by Dr Foster as Ineffective Procedures (Groups 1, 2 and 3).

    iv. Implement an organisational assessment of local relevance of innovative technologies including those recommended by NICE

    v. Innovation CQUINs from the 13/14 contract will be integrated into service delivery plans for each contract including initiatives relating to “digital by default” and telehealth.

5.5 Supporting measure 5- Organisational development.

5.5.1 Our Approach – Embracing Clinical Commissioning as a New Force for Change and Sustainability across the Oxfordshire System as a Whole

a. The role of Organisational Development

i. Our OD Plan must be in complete service of the successful delivery of our core purpose; a healthier population with fewer inequalities alongside health services that are high quality, cost effective and sustainable. Quality and affordability has to be achieved both by doing our business as usual better in the here and now - especially ensuring consistent delivery of the core NHS pledges - and in the future as we build an integrated care system across Oxfordshire, underpinned by primary care operating at scale and more intensive and acute services closer to home.

ii. One year on from our formation, our firm belief is that we will only succeed if we truly embrace and unlock the power of clinical commissioning by embedding it properly into a professional commissioning organisation.

iii. This means forging strong complementary working between clinicians and managers within the CCG itself, so that vision, strategy and delivery plans are linked and followed through, whilst also playing our part as broker with all partner organisations in Oxfordshire, building better trust, support and challenge to turn our joint vision and plans into a truly owned, accountable and tangible joint venture in which we can engage our population.

iv. We need to challenge ourselves to draw together the aspirations of our member practices in the localities into one overall compelling narrative for the future heath and care system, be explicit about how we will implement the changes in practice and how county-wide sustainability and appropriate local differences will be balanced and reconciled. By getting this balance right with our GP membership and with our partners, we will be much better able to work with and gain the confidence of local people.

v. This means that we are now explicitly regrouping to make our own organisation effective and fit for purpose as well ensuring that we have the credibility to inspire and execute across the wider system. We are intent on becoming an organisation with a clear and engaging vision, grounded strategy and excellent delivery. A detailed OD plan is in production which will ensure that we take a structured approach to developing our CCG, with clear programmes and milestones that will be led at Director Level on behalf of the Governing Body and which will be monitored as a key element of our delivery by it.

b. **OD Action Taken so Far**

As a very young organisation, OCCG therefore has a number of key capabilities to develop in addition to establishing an organisational culture which will support the very highest standards of health care commissioning. We have already taken a number of clear and pragmatic actions to develop the organisation whilst we firm up our OD strategic priorities:

i. We have already adjusted our governance and leadership structure, following a period of review. In February 2014 and with the support of NHS England, the Governing Body implemented its new arrangements, replacing the post of Clinical Accountable Officer and Lay Chair, with those of Clinical Chair supported by a lay Vice-Chair and a full time executive Accountable Officer.

ii. In January 2014, following three months' operation of our Financial Challenge Board and establishment of its sub programmes, with the support of its financial recovery consultants, Deloitte UK and following a period of internal consultation,

OCCG strengthened its business core team.

We identified two key challenges:

- Improving capability to deliver agreed goals
- Improving key skills especially in programme and project management, contracting, procurement and formulation of business questions and subsequent adept utilisation of business intelligence.

We have therefore established a revised Directorate under the leadership and direction of the Chief Financial Officer, adding to the existing senior professional finance support posts, the following:

- A re –shaped post of Head of Business Intelligence
- A new post of Head of Contract and Procurement
- A new post of Head of Programme Management Office.

iii. A further review of the organisational structure was initiated in February 2014 and key objectives have been identified as follows:

- Ensuring proportionality between the size and scale of programmes of delivery for this plan and the clinical and managerial resources identified to deliver them.
- Ensuring that the full potential of clinical leadership and sound management combine for the CCG and that each group makes its distinct and critical contribution in partnership with the other.
- Ensuring that locality based plans strike a fair balance between supporting the agreed county-wide major priorities & implementing them in the way that best suits the local environment – along with addressing any priority local needs that are genuinely different and disseminating locality level innovation across the CCG as a whole.
- Ensuring that there is a transparent flow of good enough data demonstrating concordance with agreed measures and behaviours, variation (both warranted and unwarranted) and performance at practice and locality level – good enough meaning in which practising clinicians have confidence and sufficient to make good business decisions.
- Ensuring that the workforce – managerial and clinical – has the skills and expertise to commission to the very highest standards.
- Establishing fit for purpose arrangements with our co-commissioners, notably Oxfordshire County Council, NHS England's Direct Commissioning Team and the Wessex Specialised Commissioning Team.

iv. In October 2013, we established our immediate organisational development priorities and in the ensuing months began to execute them as follows:

- **Executive Team Development:** a six month plan was put in place in late October 2013. Once the new structure is implemented, a development programme for the **Intermediate Tier** will also put in place a coaching offer.

- **Clinical Leadership**: two away days have taken place on October 22nd 2013 and 4th February 2014. Organisational development interventions have since been agreed; these include coaching and mentoring for Locality Clinical Directors (LCDs), coaching and mentoring for succession plan candidates for the LCD and key clinical commissioner roles; and LCD group organisation.

- **Governing Body**: the Governing Body is restructuring following the revision of chairmanship arrangements and once these are implemented, including for example the addition of a new lay member, organisational development initiatives will be put in place to ensure that it functions effectively. The Governing Body continues to spend workshop time together between formal meetings and this has continued to serve both a business and developmental purpose.

v. The aims of this review were to test the degree of consensus and buy-in to the current OD priorities within the CCG, whilst opening up to feedback from partner organisations, as well as describing in more detail what the programmes of intervention will look like in practice. in March 2014 we also commissioned a rapid "support and challenge" review of these priorities by an experienced former PCT Chief Executive who has just completed interviews with 23 top and senior managers and clinicians from within the CCG, organisations across Oxfordshire, including the Local Medical Committee, County Council and NHS providers, as well as the Local Area Team and Commissioning Support Unit.

The CCG new Chief Officer and Chair have agreed to lead the OD personally giving it the weight it needs to engage the whole system across Oxfordshire and create a community of senior leaders with a common vision and practical risk sharing to turn the five year plan into tangible delivery. Further information on the OD Is set out on Appendix 3, A business case to fund the OD Plan interventions will be produced by the end of July to fund a mutual programme of peer leadership OD for CEOs and top clinical leaders across Oxon that will enable them to align all organisations' 5 year plans/strategies, the Better Care Fund proposals, also working with HEE to draw together a common workforce strategy and practical plan.

Our Sustainable OD Priorities for 2014/15 – 2018/19

i. The table in Appendix 3 sets out the core components of our OD Plan. This will be further refined and firmed up by the CCG's OD Steering Group chaired by the Interim Chief Operating Officer – by the end of June 2014, following further dialogue with stakeholders who contributed to the Support and Challenge review.

ii. The Oxfordshire wide component of the plan in particular will be developed with partners following the arrival of the new Chief executive in June 2014 to ensure effective peer dialogue, support and challenge. Initial 2014/15 milestones and example interventions are included.

5.6 OCCG Provider Market Strategy

1. Oxfordshire CCG's current provider landscape

OCCG commissions the majority of healthcare services for Oxfordshire residents from two organisations – Oxford University Hospitals Trust (OUHT) for acute services and Oxford Health Foundation Trust for community and mental health services. However, for some services other providers of healthcare services are offered, for example the Royal Berkshire Foundation Trust, or private sector providers such as Ramsay or BMI. Due to geographical proximity, patients in the South East of Oxfordshire tend to choose Royal Berkshire Foundation Trust for their acute care needs.

For community services, for example District Nursing and Health Visiting, OCCG's main provider is Oxford Health Foundation Trust. The Trust is also the provider of mental health services.

The remaining element of OCCG's service expenditure is directed to continuing care which largely funds individuals in non-NHS care homes, or home-based packages of NHS care. Oxford County Council undertakes regular market assessments of the local care home providers.

2. Current contracting mechanisms

OCCG has historically worked to achieve change with its two principal providers through negotiation and contract variation, however alternatives are being sought to the traditional contract construct to enable an innovative outcomes based approach to commissioning. OCCG is liaising with Monitor and the Trust Development Authority to support these for the purposes of older people and mental health services. The new approach to contracting is intended to support improved clinical and quality outcomes for patients by encouraging providers to work more closely together with payment made on clinical outcomes being met. Development of outcomes based contracting will require the engagement of existing and new partners to secure services that meet local needs.

OCCG has developed relationships with other key partners including Oxfordshire County Council to ensure we pool our commissioning efforts to secure good quality services for our residents. In some instances OCCG and Oxfordshire County Council have pooled health and social care budgets to deliver better services for patients to improve capacity and resilience. Through this mechanism partners have also worked and contracted with a number of voluntary sector organisations and this is an area OCCG would like to develop further, recognising the benefits and support voluntary sector organisations can offer local residents.

3. Developing the market and the Provider Market Strategy

To secure the best available services to the local residents of Oxfordshire, OCCG acknowledges work is required to develop the provider market. This is particularly important in light of work underway to;

- Review best clinical practice that may generate new service models, for example; the Keogh report on the future of Emergency Care; a move to seven day working; delivery of outcomes-based commissioning for older people's services; increased use of information technology to support and inform care delivery; local and national models of managing elective care through Integrated Clinical Assessment & Treatment Services and; Referral Support Services.

- Establish clinical collaboration between practices within localities to develop 'centres of excellence', supporting enhanced delivery of local diagnostics and integrated care teams. OCCG's work with NHS England to co-commission general practice services will support this.

- Deliver the existing Quality, Innovation, Productivity and Prevention (QIPP) programme and support the development of new QIPP schemes that maximise efficiencies in service delivery going forward, particularly through models of integration.

To support this, OCCG has instigated a 3 month programme of work due to conclude in September to:

- Establish a comprehensive baseline of existing provision which includes organisations which deliver or support the delivery of healthcare services. Not all of these are directly commissioned by OCCG, for example Pharmacies, however it is important that these are reflected to ensure OCCG is in a position to influence change and work in partnership with lead commissioners as appropriate, particularly NHS England and Oxfordshire County Council.

- Map providers in terms of service provision and geographical coverage.

- Establish any fixed estate/infrastructure that may need to be considered when scoping any changes to existing service models/provider landscape.

- Create a vision of the provider landscape required to support Oxfordshire's five year strategic plan, highlighting any gaps that may need addressing. To support commissioning decisions a summary of the contracting and procurement options available will be included, reflecting the requirements of Monitor's publication "Substantive guidance on the Procurement, Patient Choice and Competition Regulations". In addition, a summary of public/patient engagement activities will

be provided for consideration, recognising the importance of co-design and the patient voice to informing the services we commission.

- Develop a market engagement strategy to ensure OCCG attracts the most capable providers to deliver services to local residents. This will require OCCG to clearly articulate the service requirements, be clear on the anticipated outcomes, including clearly defined performance measures.

The development of the provider market strategy will be informed by a number of engagement activities, the first of which was a Governing Body workshop held on the 10th June 2014.

Until this work has concluded it is difficult to clearly articulate the provider landscape envisaged through the duration of the plan, however it is acknowledged that the existing provision may not be the most sustainable or clinically effective in its current form.

OCCG is keen to ensure services, wherever possible, reflect patient need and preferences in terms of service model and mode of access. With the development of information technologies, OCCG plans to develop a market which is encouraged to respond flexibly and quickly to these opportunities.

OCCG will continue to work closely with providers and partners to understand the impact of any service changes, as demonstrated through the work undertaken to support the outcomes based commissioning proposal for older people and mental health services and Better Care Fund plan.

Chapter 6: Impact

This plan will deliver:

i. Financial sustainability
ii. Changes in activity levels and the balance of activity provided in different care settings
iii. A new and deeper commitment to collaboration in the interests of patients and the tax payer between providers and commissioners
iv. The 6 characteristics every system must have to be sure it can deliver sustained transformational change
v. Local improvements against the 7 national outcomes defined for the NHS in England
vi. The outcomes being sought from integration between health and social care as defined in the Better Care Fund scheme.

6.1 Leading change across the system landscape

a. Our plans for Oxfordshire are ambitious and they will require the CCG and its partners to work in concert to change the landscape of our system in order to deliver the improvements we seek together. Over the next three months we will work with our partners to ensure that we have the relationships, the shared expectations about investment and activity shifts and the governance structures in place, to assure the public that we will deliver our plans.

b. In particular we will:

i. Implement the agreed partnership structure with our colleagues at Oxford University Hospitals NHS Trust (OUHT) to ensure that the plans underpinning our changes in demand and location of services are truly shared, are overseen by a joint group of clinicians and managers and achieve their intended impact.

ii. Progress negotiations on an Outcomes Based Contract in mental health services with our partners in Oxford Health Foundation Trust (OHFT) and their partner providers with the goal that a highly coordinated service delivers the outcomes local patients need and the activity and financial ramifications are well understood by all partners.

iii. Progress negotiations on an Outcomes Based Contract in Older People's Care with our co commissioners at Oxfordshire County Council (OCC) with the goal that a stream lined and high quality pathway is in place and the activity and financial ramifications are well understood by all partners.

iv. Establish effective programme delivery arrangements for our Better Care Fund Plan and ensure that they are highly coordinated within the governance of our Whole System Programme Board (the former Urgent Care Working Group) which already oversees implementation of our Urgent Care Improvement Plan and the Older People's Programme Plan and that the activity, financial and risk management ramifications are well understood by all partners.

v. Work closely with NHS England to develop our primary care transformation programmes in concert with each other so that clear and practical signals can be given to primary care in Oxfordshire to enable them to play a leading role in system re-design and the activity and financial ramifications are well understood by all partners.

vi. Develop the CCG's Procurement Strategy so that we can give clear signals to our providers and prospective providers about our commissioning and procurement intentions over the period of the plan and the activity and financial ramifications are well understood by all partners.

vii. Develop our whole systems leadership role as set out in our organisational development plan so that there is a vibrant leadership forum in place for jointly leading improvement in our County's services.

c. This will enable the CCG to resubmit its Strategic Plan in June 2014, with confidence that the implications have been fully worked through and understood across the system.

6.2 Delivering financial sustainability

a. The Oxfordshire health and social care system is challenged financially, and this plan sets out to achieve run rate balance within the next two years, and then a sustained financial balance thereafter.

b. The full financial plan is set out in chapter 7. The estimated financial impact of our major programmes in 2014/15 is :

Programme	Executive Owner	Clinical Lead	Programme Manager	Project	Project Manager	Planned Net Savings	Planned Invest-ment
MED MGMT	Sula Wiltshire	Miles Carter	Julie Dandridge	1. MEDS WASTE	Claire Critchley	£39K	£3K
				2. PRIMARY CARE PRESCRIBING	Hannah Copus /Louisa Griffiths	£2.4M	£0
				3. PROCURING MEDS	Nikki Shaw	£25K	£0
					PROGRAMME TOTAL: £2.47M		
PLANNED CARE	Gina Shakespeare	Stephen Attwood	Philippa Mardon	4. DIAGNOSTICS	Beccy Clacy	£221K	£0
				5. FIRST OUTPATIENTs	Sarah Bright	£900K	£723K
				6. PLANNED CARE	Ruth McNamara	£2.82M	£0
				7. SECONDARY CARE PRESCRIBE	Julie Dandridge	£664K	£0
				20. PLCV	Jackie Masters	£4.38M	£100K
					PROGRAMME TOTAL: £8.99M		
URGENT CARE	Ian Wilson	Andrew Burnett / Gavin Bartholomew	Diane Hedges	8. OOH & 111	Matt Staples	£515K	£0
				9. PTS	Matt Staples	£325K	£23k
				10. MINOR A&E AVOIDANCE	Lisa Foweather	£223K	£0
				11. END OF LIFE	Damian Haywood	£82K	£0
				12. CARE HOMES	Sara Wild	£TBC	£TBC
				13. LTC MANAGEMENT	Terri Brunne	£739K	£35K
				17. OLDER PEOPLE OBC	Catherine Mountford	£TBC	£TBC
				19. AEC PATHWAY	Lisa Foweather	£253K	£0
				21. FUNDED NURSING CARE	Diane Hedges	£TBC	£TBC
				UNIDENTIFIED	TBC	£636K	£0
					PROGRAMME TOTAL: £2.77M		
MENTAL HEALTH	Gareth Kenworthy	David Chapman	Ian Bottomley	14. INTEGRATED PSYCH SERV	Juliet Long	£801K	£0
				16. DEMENTIA	Sonja Janeva	£0	£0
				22. MENTAL HEALTH OBC	Ian Bottomley	£TBC	£TBC
					PROGRAMME TOTAL: £0.80M		
PRIMARY CARE	Gina Shakespeare	Joe McManners	Rosie Rowe	18. GOING FURTHER FASTER	Rosie Rowe	£43K	£22K
					PROGRAMME TOTAL: £0.04M		
EFFICIENCY	Gareth Kenworthy	Paul Park	Head of Contracting / Procurement	23. CSU SLA	Head of Contracting/ Procurement	£630K	£0
				24. EoL Contract	Damian Haywood	£75K	£0
				24. Procurement Register	Hannah Mills	£TBC	£TBC
					PROGRAMME TOTAL: £0.71M		
					OVERALL TOTAL: £15.14M		

c. This plan will deliver a substantial shift in activity and resources from acute services into community and primary care.

d. Over five years we will shift resources as follows:

	13/14 actual investment '000	18/19 planned investment, '000	% change
Acute	342,117	349,344	2%
MH	63,588	63,588	0%
Community	63,836	63,457	-1%
Continuing care	33,722	88,310	162%
Primary care	89,621	117,540	31%
Running costs	15,093	14,440	-4%

6.3 Delivering a sustainable NHS for future generations in Oxfordshire

a. As described in our Organisational Development Programme (see chapter 5.5 and Appendix 3) OCCG is fully aware that achieving and maintaining a sustainable financial position is about more than delivery of major cost saving programmes: it requires a step change in the way providers and commissioners in the Oxfordshire system work together in a mature and interdependent way.

b. The current state of readiness of the local system to deliver this change is good:

i. The CCG and Oxfordshire County Council already have one of the largest pooled budgets in the country (c£300m), £200m of which relates to older people, who are a key focus of this plan.

ii. The CCG and OCC are building on these existing arrangements to work closely together to agree and deliver a Better Care Fund plan along with providers, to ensure that the overall impact of the plan is maximised and that risks are maturely managed.

iii. Oxford Health Foundation Trust and Oxford University Hospitals Trust are continuing to work actively with the CCG and OCC to achieve integrated, outcomes based contracts in 2014/15 to support service transformation for patients and improved sustainability for the system as a whole.

iv. The primary care community has embarked on a primary care development programme which will increase its capacity to operate at scale as a provider of integrated services within 12 month and the CCG and Thames Valley Area team are working closely together to ensure that their respective commissioning of primary care is joined up and makes sense to practices as they rise to the challenge of working in a constantly better integrated health and social care system.

v. Work to develop an outcomes based approach to contracting has engaged a wide community of providers (community, acute, voluntary sector and others) in building a greater understanding of the pressures on the local system and our mutual responsibilities for working together to address those with finite financial resources.

c. Ensuring this potential is exploited will require strong system leadership by the CCG.

d. The CCG's internal capacity and capability building programme has delivered a highly capable interim leadership team, who are now helping to secure the formation of a new permanent leadership team for the organisation.

e. The CCG has successfully appointed a Clinical Chairman, Chief Executive and Lay vice Chair. Early in 2014/15 this team will then extend the review of the organisation structure and skill set.

f. The interim leadership team is laying strong foundations for the new team to build on, in terms of:

i. Defining expectations, with co-commissioners and providers across the system about the kind of system leadership the CCG will be providing over the life of this plan.
ii. Improving the core business skills and capabilities within the CCG, with help from independent advisers, to provide the basis for sustained financial and reputational recovery.

6.4 The 6 characteristics of a high quality and sustainable system

a. This plan will help move Oxfordshire towards being a system that has the six nationally defined characteristics of a high quality and sustainable system.

	Characteristic	Change we have promised in this plan
1	*Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care*	• Continuous consultation with the public as we annually refresh this plan • Engagement of patients, carers and other members of the public in programme boards • Continuous support to develop PPGs
2	*Wider primary care, provided at scale*	• Long term strategy for federation and capacity building • Short term programmes to improve joint practice working to: reduce non elective admissions, A&E attendances and Out Patient referrals
3	*Modern model of integrated care*	• Care integrated along the pathway from prevention to palliative care
4	*Access to the highest quality urgent and emergency care*	• Meeting NHS constitution standards sustainably • Reduction in the estimated 40% of A&E attendances that could be better cared for elsewhere • Service delivery that ensures people who need hospital care but don't need a bed after coming to A&E, are assessed and treated without being admitted
5	*A step change in the productivity of elective care*	• Improving Quality of first Out Patient referrals • Streamlining planned care pathways • Developing consultant and specialist GP led care in alternative settings • Delivering NHS constitution standards for diagnostics
6	*Specialised services concentrated in centres of excellence*	• We will work with NHS England to ensure patients requiring specialist care are treated by the most appropriate provider

6.5 Improving health outcomes in alignment with the seven NHS outcome ambitions

a. The whole of the NHS in England is working to deliver improvement against a set of 7 nationally defined outcome measures. Our plan will contribute as set out below:

	NHS Outcome ambition	Actions in the plan that will impact	Measure	% improvement in 2 years	% Improvement In 5 years
1	*Securing additional years of life for the people of England with treatable mental and physical health conditions*	• Improved psychiatric liaison in all settings • Pro-active identification and care management of those patients who are the 2% highest users of the system • Integrated health and social care teams • Outcomes based contracting for mental health • Ambulatory care acute pathways In accessing the level of ambition the CCG should target, Dr Jonathon McWillaim, Oxfordshire Director of Public health has advised the following: The suitability of this data for the planning purposes is questionable on a number of points 1. The data does not go back far enough in time to establish a reliable trend. 2. There is a considerable year on year variation in the data with wide confidence intervals. It is unwise to use such data for target setting. 'Good' results or 'bad' can easily be due to random statistical fluctuation. 3. One would normally combine this data into 3 year rolling averages to reduce the random fluctuation, but there are insufficient data points to do this. 4. Unless a longer time trend with their lower confidence can be found, the DPH view is that the CCG's plan is reasonable.	Potential years of life lost from conditions considered amenable to healthcare (no of amenable deaths divided by population)	-1.37%	3.20%
2	*Improving the health related quality of life of*	• Improved psychiatric liaison in all settings • Pro-active identification and care management of	Health related quality of life for people with LTCs (measured using the EQ5D	Various	Various

	NHS Outcome ambition	Actions in the plan that will impact	Measure	% improvement in 2 years	% Improvement In 5 years
	the 15 million + people with one or more long term condition, including mental health conditions	those patients who are the 2% highest users of the system, • Integrated health and social care teams • Outcomes based contracting for mental health • Improved dementia diagnosis and care	tool in the GP patient survey) 1. The reduction in unplanned admissions that will be delivered through the risk assessment and care management of LTC amongst the 2% highest risk primary care population. This is measured via the QIPP programme (Urgent Care, unplanned admissions) 2. % of mental health service users to have their cluster reviewed within the agreed timescale (target 95%): OH contract KPI 3. Percentage of people who have completed IAPT treatment having attended at least 2 treatment contacts and are moving to recovery. OH contract KPI and national measure (target 50%) 4. Percentage of initial assessments and working diagnosis of dementia that are completed within 8 weeks. OH contract KPI-target 95%		
3	*Reducing the amount of time spent avoidable in hospital through better and more integrated care in the community, outside of hospital*	• Practices working together to support patients with planned, urgent and complex care needs • Pro-active identification and care management of those patients who are the 2% highest users of the system, • integrated health and social care teams • Rapid access community based MDT assessments • Consultant and specialist GP led community based clinics • Improved dementia diagnosis and care • Full sub-acute care functionality from community health and social care community bed providers	Composite rate: -Unplanned hospitalisation for: • chronic ACS conditions • u19s with asthma, diabetes or epilepsy - Emergency admissions for : • children with lower respiratory tract infections • adults with acute conditions not usually requiring admissions	33%	31%
4	*Increasing the proportion of older people living*	• Pro-active identification and care management of those patients who are the 2% highest users of the system,	See Better Care Fund Further modelling is required in response	9%	BCF indicator so not developed to 5

	NHS Outcome ambition	Actions in the plan that will impact	Measure	% improvement in 2 years	% Improvement In 5 years
	independently at home following discharge from hospital	• integrated health and social care teams • Provision of ambulatory care pathways in the acute that remove need for an admission • Home care support services with built in re-ablement • Enhanced ALERT services • 7 day working in social care	to BCF and outcome based contract impacts from 2015/16.		years
5	*Increasing the number of people having a positive experience of hospital care*	• Fully functioning directly bookable choose and book service supported by streamlined planned care pathways • Ambulatory care acute pathways • Sustainable delivery of all NHS constitution standards • Continuity of care for pregnant women and maximising capacity at the Freestanding Midwifery Led Units. • Will move us up 1 quintile in 2 years and into top quintile in 5 years	Patient experience of inpatient care (friends and family test)	4.8%	9.8%
6	*Increasing the number of people with mental and physical health conditions having a positive experience of care, outside hospital, in general practice and in the community*	• Development of psychiatric liaison services in primary, community, emergency and inpatient settings • Increased access to psychological therapies for patients with ACS conditions • Multidisciplinary community teams that incorporate older adult mental health workers.	Composite indicator comprised of GP and GP OOH services	2.08%	5.2%
7	*Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care*	• Continue to review Dr Foster data and to take early preventative action where this flags any early warning signs. For example in the course of the last year we have worked with OUHT to improve management of diabetes and pneumonia.	Indicator in development nationally		

6.6 Better Care Fund Outcomes

a. In addition the NHS and its social care partners across England are working to deliver change against a commonly agreed set of outcomes measures through each Better Care Fund Plan.

b. Our jointly agreed trajectories for these outcomes are set out below:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	534	N/A	473
	Numerator	582		546
	Denominator	109000		115000
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. This should correspond to the published figures which are based on a 3 month period i.e. they should not be converted to average annual figures. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	71.70%	N/A	80%
	Numerator	345		400
	Denominator	480		500
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	13497.9	4896.4	3427.8
	Numerator	70324	25853	18099
	Denominator	521000	528000	528000
		Time period April 2012 to June 2013 15	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	1471.7	595	738.7
	Numerator	10031	4057	5035
	Denominator	681593	681593	681593
		(State time period and select no. of months) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*		*(State time period and select no. of months)* 1	N/A	*(State time period and select no. of months)* 1
Local measure *Increase the proportion of older people (aged 65 and over) with an ongoing care package supported to live at home Numerator: Number of people receiving home care or an on-going direct payment from an older person's budget Numerator + people funded Number of people funded in a permanent care home place from a council budget*	*Metric Value*	60.0	61.9	62.4
	Numerator	2122	2301	2348
	Denominator	3537	3716	3763
		Snapshot figure for end of 2012/13 12	*Snapshot figure for end of 2014/15* 12	*Snapshot figure for end of Sept 2015* 6

6.7 Local Quality Premium Indicator

a. As part of the CCG drive to reduce healthcare associated infections, reduce antimicrobial resistance and improve the quality of care, OCCG together with its providers is actively promoting antimicrobial stewardship and cost-effective prescribing of antimicrobials. OCCG remains a low prescriber of antimicrobials when compared nationally and has done much work to reduce the prescribing of cephalosporins and quinolones. The CCG now wishes to ensure co-amoxiclav is prescribed appropriately and in line with guidance.

b. After due consultation with the Health and Wellbeing. Board, OCCG has therefore selected the following local QP indicator:

- To reduce the number of prescriptions of co-amoxiclav as a proportion of all antibacterial prescriptions to 8% measured at CCG level in Q4 14/15 (data available May 15) in line with current guidance, and to 6% in q4 of 2018/19.

- Q2 13/14 data indicate that the CCG is currently at 10%.

Chapter 7: Financial Plan

7.1 The key drivers of the CCG's financial plan for 14/15 are as follows:

a) 13/14 Underlying Recurrent Position
   i. In managing its 13/14 position and as mitigation against the cost pressures on acute contracts and continuing healthcare spend the CCG has utilised a number of non-recurrent benefits and underspends. Adjusting for these means that the CCG's underlying, recurrent baseline for 14/15 is a deficit position of £18.9m.

b) Changes to the CCG's allocations.
   i. The CCG has received a significant increase is its programme allocation for 14/15. This reflects the transition to the new national funding arrangements for CCG's and the CCG's distance from its target allocation. For 14/15 this results in an additional £4.5m of growth funding above the expected level.
   ii. Based on the increasing population in Oxfordshire the CCG may have expected to receive an increase in its running costs allocation. However, due to the methodology adopted nationally this has not been the case and the running cost allocation is slightly below the 2013-14 allocation (-£0.1m)

c) 13/14 Deficit Recovery
   i. Any deficit the CCG made in 13/14 would have been repayable in 14/15 as a non-recurrent adjustment to the allocation. The outturn reduced from a forecast £6.1m deficit to a small surplus of £0.3m. The CCG has not been allowed to carry forward the surplus generated.

d) Delivery of CCG operational planning assumptions
   i. Financial planning good practice would dictate that the CCG should set its plans with sufficient headroom to be able to manage and mitigate in-year risks as and when they crystallise. This good practice is contained within the operational planning guidance issued to CCG's by NHS England. The key elements of this and impact on the financial plan are:

      - 1.0% planned surplus, £6.2m.
      - 1.5% non-recurrent headroom, £9.3m.
      - 0.5% contingency reserve, £3.1m.
      - 1.0% 'Call to Action' Fund, £6.2m.

   ii. It has not been possible to comply with good practice guidance in full in either 2014-15 or 2015-16 The plan for 2014-15 is a deficit plan of £1.0m with a contingency held of £3.1m (0.5%) plus non recurrent headroom/Call to action fund/over 75's primary care funding of £3.1m (0.5%). The plan for 2015-16 is for a small surplus of £2.2m (0.3%) with a contingency held of 0.5% and 1% non-recurrent headroom. By 2016-17 the CCG is able to comply in full with the requirements and deliver a 1% surplus.
   iii. A bridge from the £0.3m surplus generated in 2013-14 to the underlying deficit of £18.9m and then to the £1.0m forecast deficit for 2014-15 is shown in the following table:

Source / Application of Funds

14/15 Sources of Funds	%	£'m
13/14 Month 8 Allocation		629.8
Less Non Recurrent - Winter pressures allocation		-10.2
Less Non Recurrent - PCT surplus b fwd		-5.6
14/15 Recurrent allocation baseline	96.6%	614.0
Programme costs growth	3.1%	19.8
Running costs growth (population)	0.0%	-0.1
Prior Year RAB Adjustment	0.0%	0.0
IAT Adjustment for specialised comm		0.7
	99.7%	634.4

14/15 Application of Funds	%	£'m			
13/14 Month 8 FOT		629.5		Surplus	0.3
Remove winter pressures NR		-10.2			
Remove QIPP investment NR		-0.9			
Run rate adjustments 1		9.2			
Non recurrent adjustments 2		4.9			
14/15 Baseline before CQUIN out	99.6%	632.9		Deficit	-18.9
Inflation	2.4%	15.1			
Efficiency	-3.2%	-20.2			
Demographic Growth	0.8%	5.4			
Identified QIPP (Investment)	0.3%	1.7			
Identified QIPP (Gross Saving)	-2.1%	-13.6			
Manual Adjust - running costs/prescribing	0.8%	5.3			
Contingency	0.5%	3.2			
Other Reserves	0.5%	3.4			
CQUIN in	2.2%	13.8			
CQUIN out	-1.8%	-11.5			
	100.0%	635.5		Deficit	-1.0

e) 14/15 Demand and Activity Growth

i. The current estimated impact of demand related activity growth in Oxfordshire is 0.9%, £5.4m. If this not funded in contracts with providers or unmitigated through QIPP initiatives then it would materialise as in-year activity over-performance.

f) Ability of the CCG to drive cost savings or limit financial risk in contracts.

i. The development of the 2014-15 schemes has been overseen by the Financial Recovery Programme Board with input from Deloitte. Schemes totalling £15m gross have business cases and have been subject to detailed external challenge. Further additional/stretch schemes have been identified - these have a potential value of £4 - £20m. The financial plan for 2014-15 currently assumes delivery of £9.6m savings from schemes with business cases and £4.0m from contract negotiations with providers. The additional savings identified from the business schemes are planned to mitigate increases in activity from main providers. The CCG continues to work with its partners in the CSU and Deloitte to work the identified opportunities for savings through to delivery.

ii. The CCG will seek to agree appropriate, balanced financial risk shares with providers through procurement, contracts, and use of business rules.

iii. An updated activity plan for 2015/16 will be uploaded to Unify by 27 June, in accordance with the NHSE timetable.

7.2 QIPP Programme

QIPP schemes totalling £15.75m for 2014/15, and £8.8m for 2015/16, have been identified. A Programme Management Office has been established, with Programme Managers in place for each of the 5 programmes (Planned Care, Urgent Care, Mental Health, Medicines Management, and Contract Efficiencies), and project managers have been appointed to lead each of the subsidiary projects. Progress is overseen by a monthly Programme Management Board, chaired by the Chief Finance Officer, with reports on progress against milestones and financial targets submitted to the Finance & Investment Committee and Governing Body.

A Joint QIPP Steering Group has been established between OCCG and OUHT to work on a shared programme of priority actions. The Terms of Reference include a commitment to:

- Develop a joint approach to the challenges we share across Oxfordshire – agreeing priorities, resourcing, implementation plans, and methods of delivery and communication
- Share a patient focus and commitment to improving quality of care while delivering better value
- Operate with transparency of costs and income for each party, in establishing QIPP schemes
- Prioritise schemes so that the overall capacity available to implement change at OCCG and OUHT (and other partners) is used to obtain the best impact

Further work is commencing shortly to expand the QIPP Programme for 2015/16. This will build on the foundations in 2014/15, and test OCCG's performance against a number of national and local comparator benchmarks, including NHS Network, Right Care, Atlas of Variation, and our comparator peers. The locality structure of our CCG also enables practices, with their clinical leads, to tackle unwarranted variations in performance at locality level.

7.3 Taking all these into account at this stage of the financial plan the current position of the CCG is shown in the table below:

NHS Oxfordshire CCG	10Q	Contents	Quality Checks			
Financial Position						
Revenue Resource Limit						
£ 000	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Recurrent	614,023	634,433	661,364	681,043	701,160	721,885
Non-Recurrent	15,781	-	(1,044)	2,161	6,866	7,112
Total	629,804	634,433	660,320	683,204	708,026	728,998
Income and Expenditure						
Acute	342,117	348,995	341,427	340,683	346,158	349,344
Mental Health	63,588	62,177	61,577	61,901	63,830	63,588
Community	63,836	61,521	59,341	57,967	59,353	63,457
Continuing Care	33,722	35,781	64,759	76,485	82,769	88,310
Primary Care	89,621	92,515	95,239	103,387	109,383	117,540
Other Programme	21,570	15,156	17,994	18,025	17,900	17,761
Total Programme Costs	**614,454**	**616,144**	**640,337**	**658,447**	**679,393**	**700,000**
Running Costs	15,093	16,159	14,510	14,475	14,440	14,407
Contingency	-	3,174	3,312	3,416	7,080	7,290
Total Costs	**629,547**	**635,477**	**658,159**	**676,338**	**700,914**	**721,697**
£ 000	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Surplus/(Deficit) In-Year Movement	(5,317)	(1,301)	3,205	4,705	247	189
Surplus/(Deficit) Cumulative	257	(1,044)	2,161	6,866	7,112	7,301
Surplus/(Deficit) %	0.04%	-0.16%	0.33%	1.00%	1.00%	1.00%
Surplus (RAG)	AMBER	RED	AMBER	GREEN	GREEN	GREEN
Net Risk/Headroom		(3,975)	(3,093)	(1,068)	2,797	3,215
Risk Adjusted Surplus/(Deficit) Cumulative		(5,019)	(933)	5,798	9,910	10,516
Risk Adjusted Surplus/(Deficit) %		-0.79%	-0.14%	0.85%	1.40%	1.44%
Risk Adjusted Surplus/(Deficit) (RAG)		RED	RED	AMBER	GREEN	GREEN

7.2 The context for the CCG requires a medium term approach to improving financial performance and standing. Taking into account the baseline activity pressures, national planning assumptions, cost of demand, investment requirements and the need to deliver financial turnaround, the CCG draft financial plan shows an improvement trajectory of a planned deficit of £1.0m in 2014/15, a return to a small surplus 2015/16 and a 1% surplus thereafter, including compliance with national financial planning requirements.

7.3 The plan demonstrates the clear incentive for the CCG to return to financial balance through its QIPP plans and contract agreements. Avoiding deficit repayment requirements in future years, means that there is a greater level of recurrent funding available to support the position.

7.4 In approving a financial plan that includes a deficit position in 2014/15 the CCG is declaring that it is likely to be in breach of its statutory financial duty, which is to operate within its notified allocation from NHS England. This requires approval.

Chapter 8: Conclusion

a. This plan is the culmination of much work within the CCG, supported by our colleagues in the CSU and independent advisers and based on our relationships with local providers to ensure that we understand their perspectives and recognise fully that without coherence across the whole system the desired changes to which we are all committed, cannot happen.

b. The CCG has grasped the magnitude of the challenge that it is facing in terms of service and financial pressures. It has recognised the change it must make in the way it operates in order to contribute the necessary system leadership to become truly sustainable. We will know we have been successful when the organisations that make up Oxfordshire's health and social care economy are truly collaborating and that as a result:

   i. Patients get high quality standards of health and social care in all settings, within a financially sustainable system.

   ii. Older people, people with chronic diseases and those suffering from the consequences of health inequality have better health outcomes.

   iii. Patients have access to the primary and community care, and the urgent and emergency services that they need to help them and unnecessary hospital admissions are avoided

   iv. Patients who need an admission to hospital return quickly to independent living

   v. GP practices are working together to drive integration of primary, community, secondary, mental health and social care around the needs of each patient and their family

   vi. People with complex health and care needs get "whole person care" instead of separate treatments with parity of esteem between physical and mental health

   vii. The CCG is doing its core business to the very highest standards

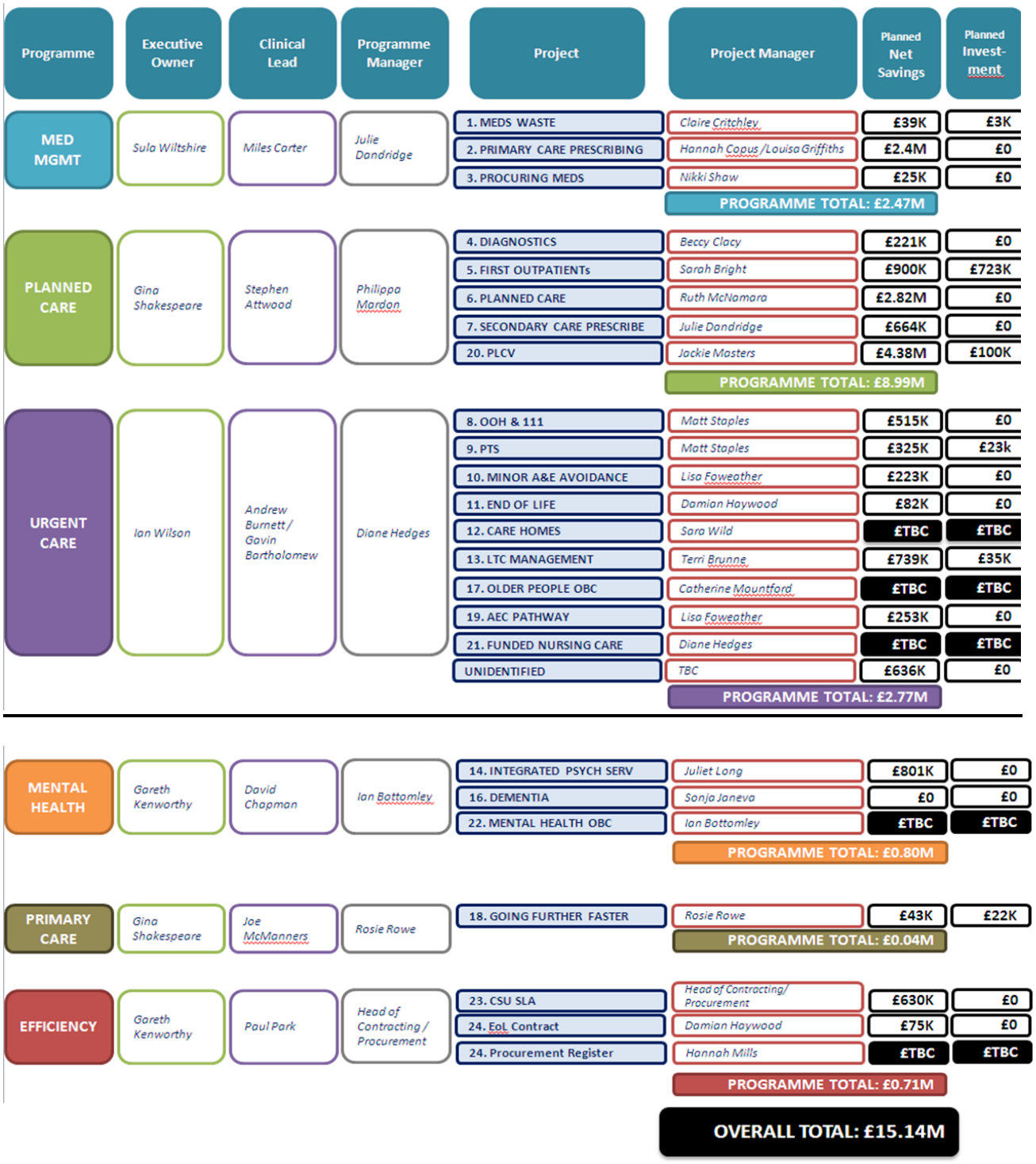
   viii. Health inequalities have reduced

   ix. The patient and public voice palpably informs everything that we do, and we are sustainably meeting NHS Constitution pledges and standards on access to services, safety and quality.

   x. The system is financially sustainable.

Appendix One; Change programmes (Detail required for national Key Lines of Enquiry Assurance)

1. Planned investment and savings from the 5 programmes



Programme	Executive Owner	Clinical Lead	Programme Manager	Project	Project Manager	Planned Net Savings	Planned Invest-ment
MED MGMT	Sula Wiltshire	Miles Carter	Julie Dandridge	1. MEDS WASTE	Claire Critchley	£39K	£3K
				2. PRIMARY CARE PRESCRIBING	Hannah Copus /Louisa Griffiths	£2.4M	£0
				3. PROCURING MEDS	Nikki Shaw	£25K	£0
					PROGRAMME TOTAL: £2.47M		
PLANNED CARE	Gina Shakespeare	Stephen Attwood	Philippa Mardon	4. DIAGNOSTICS	Beccy Clacy	£221K	£0
				5. FIRST OUTPATIENTs	Sarah Bright	£900K	£723K
				6. PLANNED CARE	Ruth McNamara	£2.82M	£0
				7. SECONDARY CARE PRESCRIBE	Julie Dandridge	£664K	£0
				20. PLCV	Jackie Masters	£4.38M	£100K
					PROGRAMME TOTAL: £8.99M		
URGENT CARE	Ian Wilson	Andrew Burnett / Gavin Bartholomew	Diane Hedges	8. OOH & 111	Matt Staples	£515K	£0
				9. PTS	Matt Staples	£325K	£23k
				10. MINOR A&E AVOIDANCE	Lisa Foweather	£223K	£0
				11. END OF LIFE	Damian Haywood	£82K	£0
				12. CARE HOMES	Sara Wild	£TBC	£TBC
				13. LTC MANAGEMENT	Terri Brunne	£739K	£35K
				17. OLDER PEOPLE OBC	Catherine Mountford	£TBC	£TBC
				19. AEC PATHWAY	Lisa Foweather	£253K	£0
				21. FUNDED NURSING CARE	Diane Hedges	£TBC	£TBC
				UNIDENTIFIED	TBC	£636K	£0
					PROGRAMME TOTAL: £2.77M		
MENTAL HEALTH	Gareth Kenworthy	David Chapman	Ian Bottomley	14. INTEGRATED PSYCH SERV	Juliet Long	£801K	£0
				16. DEMENTIA	Sonja Janeva	£0	£0
				22. MENTAL HEALTH OBC	Ian Bottomley	£TBC	£TBC
					PROGRAMME TOTAL: £0.80M		
PRIMARY CARE	Gina Shakespeare	Joe McManners	Rosie Rowe	18. GOING FURTHER FASTER	Rosie Rowe	£43K	£22K
					PROGRAMME TOTAL: £0.04M		
EFFICIENCY	Gareth Kenworthy	Paul Park	Head of Contracting / Procurement	23. CSU SLA	Head of Contracting/ Procurement	£630K	£0
				24. EoL Contract	Damian Haywood	£75K	£0
				24. Procurement Register	Hannah Mills	£TBC	£TBC
					PROGRAMME TOTAL: £0.71M		
					OVERALL TOTAL: £15.14M		

2. Expected impact on national outcome ambitions from the 5 programmes

National outcome ambition	% Improvement in 2 years	% Improvement In 5 years
1	-1.37%	3.20%
2	0.13%	0.39%
3	33%	31%
4	9%	
5	4.8%	9.8%
6	2.08%	5.2%
7	Indicator in development	

3. The 5 programmes
   a. OCCG's 5 major transformational programmes are:

      i. Primary care
      ii. Urgent care
      iii. Planned care
      iv. Mental health
      v. Medicines management

   b. Each programme is summarised overleaf, in a format compliant with the national Key Lines of Enquiry Assurance Template. Our confidence levels on delivery for each programme were assessed as part of the process to complete business cases. Assessment was, on the basis of our ability to mitigate the potential barriers to delivery. A green rating indicates a high level of confidence in our ability to deliver al outcomes within the proposed timescales. Amber indicates that there is a moderate degree of risk on timescales/and or completeness of impact. Red indicates a high degree of risk on timescales/and or completeness of impact.

Intervention 1: Primary Care Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme aims to build the capacity of primary care to operate at scale, so reducing pressure on individual practices whilst improving patient access, improving the quality of primary care and increasing out of hospital care. The programme will address the five core ambitions identified in NHS England's Improving General Practice, Call to Action Phase 1 report.

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to deliver:
A net saving to the system of £43k by 31st March 2015

i. Improved management of patients with multiple long term conditions
ii. Provision of consultant led ENT and dermatology clinics in the community
iii. Improved urgent access to primary care
iv. Clinical commissioning champion in each practice who will:
    - address unwarranted variation in that practice
    - engage in locality work
    - ensure delivery of practice based targets required by the whole plan

Implementation timeline

i. Final agreement of business case March 2014
ii. Contract agreed and signed with primary care April 2014
iii. Programme board established April 2014
iv. New services commence by end q2
v. Long term development strategy agreed and launched Sept 2014

Enablers required

- Arrangement with primary care that wraps national unplanned admissions DES funding into single local "Des +" scheme
- Integrated health and social are teams in place and able to meet all requirements of this development
- Practice capacity to engage with change
- Support of LMC

Barriers to success

- Ability to get all practices to agree to a local DES+ scheme instead of the national DES
- Maintaining practice commitment
- Speed with which implementation can be achieved
- Patient satisfaction with planned changes

Confidence levels of implementation

Intervention 2 : Urgent Care Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme comprises 8 projects which will reduce A&E attendances and emergency admissions. They are:

i. Contract variation to improve interface of 111 and out of hours
ii. Retender PTS services to improve efficiency and reduce cost
iii. Agree model to reduce the c40% of patients attending A&E who would be better treated elsewhere
iv. Better integration of EOL services
v. Improving quality of care in care and nursing homes
vi. Improving management of patients with LTCs
vii. Developing an emergency care pathway for patients who need urgent care, but do not need admission to a bed
viii. Older people's Outcomes Based Contracting

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to:

i. Deliver a net saving to the system of £2.84m by 31st March 2015
ii. Reduce activity in A&E
iii. Reduce avoidable admissions for patients with conditions that can be treated without an admission improve the efficiency and effectiveness of the 111 and PTS services.
iv. Reduce no's of people admitted with LOS < 1 day
v. Improve end of life care
vi. Reduce avoidable admissions from care and nursing homes (beginning in year 2)
vii. Improve the management of patients with complex long term conditions in primary care
viii. Improve access to the right service in the right place at the right time

Implementation timeline

i. Final agreement of business cases March 2014
ii. Appropriate expectations agreed in contracts by end March 2014
iii. Preferred options and service spec for reducing A&E attendance and for AEC pathways agreed by end q2
iv. Preferred options for streamlining care home support services agreed and contract variations in place by end yr. 1 for roll out in year 2
v. Delivery plans for reducing A&E attendance and for AEC pathways finalised July 2014
vi. Implementation of plans for reducing A&E attendance and for AEC pathways from September 2014
vii. Roll out of NE pilot EOL ACP project across all localities from August 2014
viii. Have ACP plans for all patients on palliative care register by October 2014
ix. Hospice at Home service live by October 2014
x. Primary care risk stratification and identification of top 2% - from April 2014
xi. Integrated community teams fully functioning and meeting business case requirements – by end q1 2014
xii. New multimorbidity model to be delivered by primary care and integrated teams being implemented in full by end q2

Enablers required

- Agreement of public and HOSC to service changes
- Contract changes (including element of integrated OHFT/OUHT contract)
- Clinical engagement and commitment from all partners to deliver change
- Increase in primary care capacity
- Full implementation of ACG tool
- Electronic palliative care co-ordination system
- Integrated health and social care teams in place and able to meet all requirements of this development

Barriers to success

- HOSC do not agree changes to PTS threshold criteria
- Contract variations cannot be agreed
- Ability to get all practices to agree to a local DES+ scheme instead of the national DES
- Keogh Review identifies further required/recommended changes
- Changing patient behaviour
- Care and nursing homes not obliged to implement

Confidence level of implementation

Intervention 3 : Planned Care Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme comprises 5 projects which will improve the productivity of planned care. They are:

i. Diagnostics
ii. First outpatients
iii. Planned care pathways
iv. Secondary care prescribing
v. Procedures of limited clinical value

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to:

i. Deliver a net saving to the system of £8.98m by 31st March 2015
ii. Ensure compliance with national and local standards for diagnostic services
iii. Improve patient experience and access to services
iv. Reduce waste and duplication
v. Reduce first outpatient referrals by: 7902 by 31st March 2016

Implementation timeline

i. Primary care peer review of referrals – continuous
ii. Business cases approved March 2014
iii. Appropriate expectations agreed in contracts by end March 2014
iv. Sign off all relevant service specifications and contract variations by end q1
v. Start implementation of service changes from beginning q2
vi. Identify actions to reduce OUH internal radiology requesting by Sept 2014
vii. GP pathology dashboard in use by July 2014
viii. All referral guidelines updated and uploaded on DXS by July 2014
ix. All new and revised diagnostic guidelines completed by end Sept 2014
x. Transfer some services to new community radiology providers by start Dec 2014
xi. Independently accredited quality management system for OUH radiology services - March 2015
xii. Review MSK hub in time to implement conclusions by end July 2014
xiii. Agree policies and contracts for procedures of limited clinical value by April 1st 2014 and upload them onto DXS in time to realise savings by q2.

Enablers required

- Contract changes with OUHT, OHFT, private providers and primary care
- Completion and agreement of new guidelines
- Fully functioning DXS system
- Delivery of full ICE radiology requesting system by OUHT
- Clarity on criteria for day case vs. outpatient procedures
- Alternative qualified providers available in the local market
- Funding for new NICE indications
- Agreement of public to planned changes

Barriers to success

- Unexpected changes to tariff
- Contract variations cannot be agreed
- Inability to engage clinicians
- Inability to identify/train GPs with necessary skills
- Service capacity to change
- Ability to get all practices to agree to a local DES+ scheme instead of the national DES
- DXS and ICE do not get fully implemented
- NICE guideline changes impact on schemes

Confidence level of implementation

Intervention 4 : Mental Health Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme comprises 2 projects which will, between them, ensure much improved integration of people's physical and mental healthcare. They are :

i. The integration of psychological services with physical healthcare in primary, community, emergency and secondary care settings
ii. Improvements in dementia diagnosis and care

In addition the programme will develop an outcomes based contracting model for Mental Health.

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to:

iii. Deliver a net saving to the system of £0.80m by March 2015
iv. Enable the system to meet national dementia and IAPT diagnosis targets
v. Deliver improvements to the quality of life for people with MH and PH needs
vi. Reduce LOS/Excess bed days and avoidable admissions resulting from A&E attendances
vii. Reduce presentation at A&E
viii. Improve outcomes for people with mild-moderate anxiety, particularly where they also have an LTC
ix. Reduce volume of primary care support currently required by this patient cohort
x. Deliver the national target to reach 67% of the expected dementia diagnosis rate for the population by the end of 2015/16.

Implementation timeline

i. Complete spec for re-procurement of IAPT by end August 2014 and mobilise new service by April 2015
ii. Decision on future model of Psychological medicine support in acute and ED by end Sept 2014
iii. Agree future model for community Psychological medicine support by end Sept 2014
iv. Revisions to memory clinic pathway agreed by June 2014
v. Dementia advisors in place by July 2014

Enablers required

- Commitment of relevant partners to change
- Completion and agreement of new guidelines
- Agreement to new memory clinic pathway by OUHT, OHFT and primary care
- Fully functioning DXS system

Barriers to success

- Capacity of IAPT service to extend into LTC
- Main change programmes may have adverse unintended consequences
- Failure to re-procure and /or re-procurement complicated by OBC for MH.

Confidence level of implementation

Intervention 5 : Medicines Management Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme comprises three projects which are aims to deliver savings on the drugs budget:

i. Reduction in medicines waste
ii. Optimising primary care prescribing for COPD, new oral anticoagulant agents and diabetes
iii. Re- procuring wound care dressings

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to:

i. Deliver a net saving to the system of £2.46m by 31st March 2015

Investment costs (time, money, workforce)

This programme requires investment of £2700.

Implementation timeline

i. Complete and evaluate separate pilot "waste" projects by July , September and November 2014 respectively, with roll out if agreed from September 2014 and January and February 2015.
ii. Disseminate annual prescribing report to localities by April 2014
iii. Agree objectives and deliverables for primary care prescribing with each locality by April 2014.
iv. Initiate joint formulary by June 2014 and have fully functioning and visible to all prescribers by July 2015
v. New contract and guidelines for wound care in place by end May 2014
vi. Agreement to savings from other dressing categories with tissue viability team by May 2015

Enablers required

- Review of IT prescribing solutions
- Joint formulary
- Ability to recycle some savings from prescribing costs into incentives for prescribers
- Commitment of providers

Barriers to success

- Prescribing advice from secondary to primary care may be inappropriate
- National guidance may change practice
- Main change programmes may have adverse unintended consequences on prescribing behaviours
- CCGs can no longer use LES's to drive change in community pharmacies
- Failure to fund and/or achieve a CQUIN for the joint formulary
- Engagement of Oxford Health

Confidence level of implementation

Appendix 2 – National Key Lines of Enquiry Assurance template

Segment	Key Line of Enquiry	Organisation response	Supported by:
Submission details	Which organisation(s) are completing this submission?	Oxfordshire CCG	***All page refs refer to 5 year narrative plan document***
	In case of enquiry, please provide a contact name and contact details	Regina Shakespeare Gina.shakespeare@oxfordshireccg.nhs.uk	
a) System vision	What is the vision for the system in five years' time?	By 2018/19 the Oxfordshire health and social care system will: i. Be financially sustainable ii. Be delivering fully integrated care, close to home, for the frail elderly and people with complex multimorbidities. iii. 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. iv. Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests. v. Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities vi. 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 local satisfaction with services	*The plan on a page,*

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr>
<td></td>
<td>How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance?
Specifically:
1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care
2. Wider primary care, provided at scale
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step-change in the productivity of elective care
6. Specialised services concentrated in centres of excellence (as relevant to the locality)</td>
<td>[
<table>
<tr><th></th><th>Change we have promised in this plan</th></tr>
<tr><td>1</td><td>• Continuous consultation with the public as we annually refresh this plan
• Engagement of patients, carers and other members of the public in programme boards
• Continuing support to develop PPGs</td></tr>
<tr><td>2</td><td>• Long term strategy for federation and capacity building
• Short term programmes to improve joint practice working to: reduce non elective admissions, A&E attendances and OP referrals</td></tr>
<tr><td>3</td><td>• Care integrated along the pathway from prevention to palliative care
• Using contracting changes (OBC) to underpin integration</td></tr>
<tr><td>4</td><td>• Meeting NHS constitution standards sustainably
• Reduction in the estimated 40% of A&E attendances that could be better cared for elsewhere
• Pathways in the acute sector that ensure people who need hospital care but don’t need a bed after coming to A&E, are assessed and treated without being admitted</td></tr>
<tr><td>5</td><td>• Improving quality of first OP referrals
• Streamlining planned care pathways
• Developing consultant and specialist GP led care in alternative settings
• Delivering NHS constitution standards for diagnostics</td></tr>
<tr><td>6</td><td>• We will work with NHS England to ensure patients requiring specialist care are treated by the most appropriate provider</td></tr>
</table>
</td>
<td>Details provided within the activity and financial templates which will be triangulated.</td>
</tr>
</table>

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr>
<td></td>
<td>How does the five year vision address the following aims:
a) Delivering a sustainable NHS for future generations?
b) Improving health outcomes in alignment with the seven ambitions
c) Reducing health inequalities?</td>
<td>A) From a resources perspective, what will the position be in five years' time? Is this position risk assessed?
By 2018/19 the system will be fully compliant with all financial planning rules. We will have reduced avoidable admissions by 31% and planned care activity by 17%. To achieve this we will have increased investment in primary care by approximately 31% and in community services by approximately 5%. We will have reduced investment in acute care by some 6% and will have maintained existing investment in mental health.

B) You should explain how your five year strategic plan will improve outcomes in the seven areas identified, within the context of the needs of your local population and what quantifiable level of improvement you are aiming to achieve]
<table>
<tr><th>National outcome ambition</th><th>% Improvement in 2 years</th><th>% Improvement In 5 years</th></tr>
<tr><td>1</td><td>-1.37%</td><td>3.20%</td></tr>
<tr><td>2</td><td>0.13%</td><td>0.39%</td></tr>
<tr><td>3</td><td>33%</td><td>31%</td></tr>
<tr><td>4</td><td>9%</td><td>tbc</td></tr>
<tr><td>5</td><td>4.8%</td><td>9.8%</td></tr>
<tr><td>6</td><td>2.08%</td><td>5.2%</td></tr>
<tr><td>7</td><td>Indicator in development</td><td></td></tr>
</table>
</td>
<td>Please see financial plan submissions and the following sections of the overall plan:

Sustainable NHS

Health outcomes in alignment with 7 ambitions

Inequalities</td>
</tr>
</table>

Segment	Key Line of Enquiry	Organisation response	Supported by:
	Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	The strategic vision has been shared with our public, our providers and our Health and Wellbeing Board, which has formally approved it and our Better Care Fund plan and has asked to be kept regularly updated on the plan's implementation. Our partners in OUHT have asked to form a joint steering group to manage the implementation of business cases which impact on the hospitals' work and this has been formally agreed. There is active engagement with our key providers to deliver outcomes based contracting. The vision for primary care has been actively embraced by our Localities.	
	How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	Our 5 year strategic vision is absolutely dependent on achieving closer integration of services right along the care pathway. Our Better Care Fund Plan is a critical enabler of this change, as it will ensure delivery of: • Integrated health and social care in the patient's home and in the community • A joint OHFT/OUHT contract for an integrated older peoples acute pathway • A discharge to assess service • 7 day working in social care	Please see chapter 4,

Segment	Key Line of Enquiry	Organisation response		Supported by:
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	Be open and transparent about the financial challenge	We have set a deficit budget because we know we can't get back in the black in 1 year	Please see https://consult.oxfordshireccg.nhs.uk/consult.ti/5yrstrat/consultationHome for full feedback on Call to Action Consultation
		They like the idea of outcomes based commissioning, but we shouldn't rush into it wholesale	We are working steadily with our local providers to develop this approach for mental health and acute care for older people	
		They want care closer to home as long as that care is high quality care	We will ensure that community based: urgent care, integrated health and social care and planned care are all of the highest quality and that you get the right care in the right place – which will be hospital when you need it.	
		The NHS needs to change the public's attitude from "fix me now" to people accepting joint responsibility for their health	We have committed our locality teams to doing targeted outreach, education, patient participation group and other development work to help deliver this long term goal	
		We need a comprehensive all ages education programme about how to use the NHS	Our locality teams are working 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.	
		We should maximise the use of technology to free up GP time for face to face care	The Better Care Fund plan includes increased investment in the ALERT service; our LTC programme commits us to on-going work with the academic community on identifying telehealth solutions and our locality teams are working with local practices to support provision of patient access to records online; on line appointment and repeat prescription services and text message appointment reminders	
		We should reduce duplication and waste	We are improving integration of care around the patient –for example our Better Care Fund plan will deliver a single health and social care assessment and a single health and social care plan with 1 care co-ordinator managing its delivery.	

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr><td></td><td>Is there a clear ‘you said, we did’ framework in place to show those that engaged how their perspective and feedback has been included?</td><td>Yes</td><td></td></tr>
<tr><td rowspan="3">a) Current position</td><td>Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?</td><td>Yes</td><td>See chapter 2,</td></tr>
<tr><td>Do the objectives and interventions identified below take into consideration the current state?</td><td>Yes</td><td>See chapter 2 and 3,</td></tr>
<tr><td>Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?</td><td>Yes</td><td>See unify submissions</td></tr>
<tr><td rowspan="2">b) Improving quality and outcomes</td><td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td><td>
<table>
<tr><th>outcome</th><th>2 years</th><th>5 years</th></tr>
<tr><td>1</td><td>-1.37%</td><td>3.2%</td></tr>
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<tr><td>7</td><td colspan="2">Indicator in development</td></tr>
</table>
</td><td></td></tr>
<tr><td>How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?</td><td>Our plans have their basis in the early consultation work undertaken with our member practices to identify and agree local strategic and service change priorities; our Call to Action consultation with the local community; joint work with our provider and commissioner partners, for example our weekly summits to improve urgent care delivery across the whole system; and our work with patients and carers to define the right outcomes for mental health and older people’s urgent care.</td><td></td></tr>
</table>

Segment	Key Line of Enquiry	Organisation response	Supported by:
	What data, intelligence and local analysis were explored to support the development of plans for improving outcomes and quantifiable ambitions?	• The data and analysis set out in our JSNA, the joint priorities we have agreed with the Health and Wellbeing Board and the issues identified in the Director of Public Health Annual Report. • An analysis of the current strengths and weaknesses in the local health and social care economy including: NHS Constitution measures, national outcomes measures for the five domains of the outcomes framework, local Health and Wellbeing Board outcomes, activity levels and financial performance against contract; benchmarking • The views of our member practices. • The views of local people.	See chapter 2,
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	We have a growing population overall, and a rapidly growing older population with pockets of rural isolation and urban deprivation which impact particularly on health outcomes. Our strategy will deliver: • more integrated health and social care, close to where people live and driven by their GP • a targeted partnership programme to reduce health inequalities around practices in areas of high need • rapid access to same day assessment and care	See chapter 2,
	How have the Health and well-being boards been involved in setting the plans for improving outcomes?	The strategy has been approved by the Health and Wellbeing Board, and has been developed in close consultation with the Board's steering group.	See chapter 2,
c) Sustainability	Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	yes	See Unify submissions
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	yes	See Unify submissions and chapter 3.
	Can the plan on page elements be identified through examining the activity and financial projections covered in operational and financial templates?	yes	See Unify submissions

Segment	Key Line of Enquiry	Organisation response	Supported by:
d) Improvement interventions	Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline • Enablers required for example medicines optimisation • Barriers to success • Confidence levels of implementation The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.	**See Appendix 1 to this plan** **Intervention One** Overall description [CCG to comment] Expected Outcome [CCG to comment with particular emphasis on the impact on the outcome ambitions or the six characteristics] Investment costs • Financial costs [CCG to comment] • Non-Financial costs [CCG to comment] Implementation timeline [CCG to comment] Enablers required [CCG to comment] Barriers to success [CCG to comment] Confidence levels of implementation [CCG to comment]	See separate tables at front of this appendix, and chapters 3 and 4,

Segment	Key Line of Enquiry	Organisation response	Supported by:
e) Governance overview	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	Future Plans will continue to developed in collaboration with key stakeholders through • Contract performance management review and variation • Collaborative outcomes based contracting with key providers • Health and Wellbeing Board • Health Liaison Committee • Oxford Strategic Partnership Board • Oxfordshire Safer Communities Partnership Boards • Joint Management Groups for older people, mental health and learning disabilities • Whole system governance arrangements on individual change programmes • Joint Quality, Innovation and Productivity Group with OUHT • Public involvement in programme boards • Work by localities to involve each of the 6 local stakeholder forums in evaluation and future planning	

Segment	Key Line of Enquiry	Organisation response		Supported by:
f) Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	Clinicians and Patients working together to redesign how we deliver care	Each major change programme has a GP Clinical Lead, who works closely with his/her counterparts in other parts of the system to develop the detailed business case and to drive its implementation	
		Reducing health inequalities by tackling the causes of poor health	We have a discrete programme to address this, and all our major interventions incorporate measures to improve access, particularly for people experiencing health inequalities	
		Commissioning Patient Centred High Quality Care	Please see our Quality Impact Assessment	
		Promoting integrated care through joint working	Many of our interventions are underpinned by specific objectives of improving integration along the pathway from prevention to palliative care ; and this is a fundamental unifying driver across interventions	
		Supporting individuals to manage their own health	This is fundamental to our Better Care fund plan and Long Term Conditions project	
		More care delivered locally	All our major interventions incorporate measures to provide more care close to home with significant reductions in levels of acute activity.	

Appendix 3: Outline OD Plan

OXFORDSHIRE CLINICAL COMMISSIONING GROUP (OCCG)

IMPLEMENTATION OF THE ORGANISATIONAL DEVELOPMENT (OD) PLAN

A. **1. WHERE WE ARE NOW**

Journeyman Support and Development Ltd. worked with OCCG throughout March and April 2014 through a series of 23 1:1, non-attributable interviews on a diagnostic that led to the development of the CCG's Organisational Development (OD) Plan, fleshing out the existing OD strategic framework that had been set towards the end of 2013/14. The work was completed satisfactorily and comprised two elements: -

- the OD chapter for OCCG's 5 year plan

- advice for the incoming CCG Chief Officer covering the twin aspects of internal OD/fitness for purpose and county-wide, whole system leadership shaping and OD. The purpose of the OD Plan is to support both internal and wider system development to create a professional, skilled professional organisation in the context of a county where system-wide strategy must be swiftly translated into clear and joint delivery plan, led and owned by a community of peer senior leaders who are aligned on trust and risk sharing.

The OD Plan aims to create the capacity needed to face the key challenges facing the system as follows:-

A. Maximising safety, efficiency and affordability now whilst transforming the strategic model of service delivery

B. Having one vision, strategy and delivery plan for the county as a whole whilst ensuring that it is shaped, owned and delivered in your localities

C. Driving better performance in our providers whilst building a common vision and service strategy through a virtual team of leaders across Oxfordshire as we take up your role as system leaders – this includes both aligning our 5 year plan with provider strategic and delivery plans and risk sharing around the implementation of our Better care Fund proposals. It needs to create capacity, financial and workforce aligned plans.

D. Being more agile and decisive now whilst building sustainable clinical and community engagement and effective collaborative commissioning with the County Council, NHS England, Commissioning Support Unit (CSU) and wider CCG partners

E. Making much needed changes to the CCG's structure now whilst supporting staff to grow and develop to meet the challenge

The OD journey we are on is in three stages:-

Stage 1- Achieved	Stage 2- Achieved	Stage 3- The present
Create OD Strategic Framework	Develop OD Plan	Implement the OD Plan

This implementation plan now covers **Stage 3** – making the business case for the investment needed to implement the OD Plan and secure the first priority interventions required, by **the end of July 2014.**

The OD Plan comprises 5 components:-

THEME	**FOCUS**
1. Sustainable Strategy and Delivery Plan for Oxfordshire 2014/15-2018/19	Aligned system-wide vision, strategy, implementation and peer top leaders
2. CCG Shape and Systems – Core Restructure	Needs-based design and transparent implementation of the CCG's restructuring
3. CCG Core Governance	Practical review of constitution and delegation arrangements
4. Learning, Development and Talent Management Plan	A professional, skilled, sustainable commissioning organisation with a clear operating model
5. Connected Commissioning	Effective joint, collaborative and co-commissioning with partners

12. DELIVERING THE WORK IN PRACTICE

The new CCG Chief Executive starts in June, with consultation on the CCG's new structure currently underway. He has signalled his intent that the OD strategy will be led personally by him and the OCCG Chair because of the importance of the CCG's rebuilding and the need for new consensus between top leaders across the county.

Implementation is likely to sit with two directors, with the clinical quality lead director leading on training whilst the lead director for strategy and

transformation will be leading on system wide OD and leadership development. The latter's team includes a Head of OD post, supported by an OD delivery post. This Stage 3 project will enable the CCG to start early, before the new structure is fully implemented. Early engagement with the Clinical Chair, new Chief Executive, lead Directors and County Top Leaders will be undertaken to ensure that ownership is tested and achieved. The work plan is set out below.

A. Briefly **stock take progress** to date against the OD Implementation Plan, including existing training programmes

PRODUCT: BRIEF SUMMARY OF EXISTING TRAINING AND GAPS

B. Review current funding arrangements for training, workforce development and OD, especially subscription or top-sliced related funding e.g. Wessex Leadership Academy, Heath Education England and Commissioning Support Unit to ensure maximum leverage for existing investment. In particular it will be important to secure HEE support for facilitation of workforce alignment strategies across the Oxfordshire system.

PRODUCT: SUMMARY OF FUNDING ARRANGEMENTS THAT CAN BE BROUGHT TO BEAR TO SUPPORT THE OD PLAN AND A PROPOSAL For JOINT WORK WITH HEE TO ALIGN COUNTY-WIDE WORKFORCE PLANS

C. Create the business case necessary to establish/fund the county-wide OD Programme and the internal development programme to deliver themes 1 and 4 above

PRODUCT:TWO PART BUSINESS CASE; 2 COMPONENTS – INTERNAL CCG DEVELOPMENT AND COUNTY WIDE PROGRAMME

D. Work with the Locality Clinical Directors lead **to shape, prioritise, cost and timetable the clinical leadership and localities element of theme 4**

PRODUCT: COSTED PROPOSAL TESTED WITH CLINICAL CHAIR AND LOCALITY CLINICAL DIRECTORS

E. Commence engagement with top leaders across the County **to determine the will, model, joint funding and commissioning arrangements for the County-wide programme.**

PRODUCT: OUTLINE PROPOSAL TO INFORM FUTURE PROCUREMENT FOLLOWING ENGAGEMENT WITH COUNTY TOP LEADERS TO SECURE OWNSERSHIP

Appendix 4 – IM&T Strategy

To insert into Oxon CCG 5-year Strategic Plan

Appendix 4– IM&T Strategy

The CCG will take advantage of the efficiency and effectiveness of information and information technology to achieve its objectives. To that end, OCCG has developed its draft IM&T strategy (available on request), which currently is being updated to better reflect the key themes in the 5-year Plan. The table below identifies IM&T dependencies or opportunities relating to these themes, and makes reference to specific IM&T components – many of which are covered in the current draft IM&T strategy.

Certain IM&T requirements are common dependencies for many of the 5-year Plan themes, including:

- Improvements to data quality, analytical tools and informatics support services - to better monitor performance and outcomes and to forecast activity and costs;
- Becoming smarter in the use of information and knowledge (the evidence-base) to inform decision-making;
- Sharing of records or access to records across organisational boundaries along the patient's care pathway, i.e. interoperability[3];
- Robust infrastructure – re technology, governance, information governance and effective mechanisms to deliver end-user awareness, training and support;
- Ensuring future IM&T requirements and opportunities are routinely considered as an integral part of any proposed improvement / service transformation plans.

Several of the IM&T components identified in the table below currently exist or are developments which are underway. Nonetheless, the breadth scale of the issues to be addressed means there is a considerable gap yet to be bridged. Bridging the gap over the coming years will require various challenges to be managed in terms of resources and effort, and also in terms of professional and organisational cultures.

[3] OCCG's draft IM&T strategy emphasises the importance of interoperability. The cross-organisational Oxfordshire Care Summary (OCS), which has been live for two years, and is being further developed, is a key component of OCCG's interoperability strategy. OCCG will continue to invest in the development and implementation of the OCS to enable the timely provision of integrated clinical information at the point of care.

Themes	IM&T Requirements / Opportunities	Key components of IM&T plans
Joined up patient-centred care; Seamless integration of services around the patient along the care pathway; Locality based integrated health and social care community teams	Access to shared records, care plans, assessments – amongst primary care, community teams, social care, acute care; Shared care plans especially for patients with complex needs / EOL care	Interoperability between systems; OCS; Summary Care Record (SCR); Mobile technologies; Tools to support single assessments and shared care plans; Shared Special Patient Notes for complex / EOL care
Primary care at scale, broader range of services, efficiencies	Use of technology to: enable more flexible working within and across practices; free up GP time; work more closely with other care services	Shared system access amongst general practices, and between practices and community teams (replacement community system planned); Mobile technologies for GPs and community staff; Online access by patients for booking, repeat prescriptions, viewing records; GP – specialist e-comms for advice; Extend e-requesting for all tests; Text messaging to patients
Streamline urgent care pathways, fewer emergency admissions	Information sharing between 111, OoH, ambulance service, GP, A&E; Identify patients at high-risk of avoidable A&E visits and urgent admissions	Care Pathways triage tool; Shared records via OCS and/or SCR, further interoperability developments; Urgent Care Dashboard
Avoid hospital attendance / admission; Care closer to home	Information / decision support tool to identify patients most at risk of hospital admission; Information sharing amongst urgent care partners (see above); Assistive technology to support patients at home	ACG risk stratification tool; Urgent care e-communications – see above; Telehealth
Engagement with public re appropriate use of NHS-funded services, resources and public health campaigns	Public communications programme to exploit e-communications wherever appropriate	Maintain and enhance CCG and practice websites; Greater use of social media and apps
Self-management; Help people and communities to help themselves	Exploit assistive technology and e-communications for education and support, wherever appropriate	Telehealth; Advice and support via websites, social media, apps, SMS, email, Skype, … Use of "Talking Health" online engagement and consultation tool
Reduce delayed transfers of care, allowing people to return home from hospital in a timely manner	Timely, efficient communications amongst those involved in a patients care before and after discharge	Shared assessments, care plans, e-communications, alerts, workflow - amongst hospital, community and social care teams
Improvement in performance re NHS Constitution pledges, outcomes, quality, national and local targets; Tracking progress on QIPP; Informed decision-making	Monitoring key indicators, including outcomes framework, patient experience feedback, quality indicators; Financial reporting; Identify warranted and unwarranted variations in performance	Consistent, assured quality of data; Health intelligence tools and reports, dashboards, benchmarking; Dr Foster data to identify ineffective procedures, potentially avoidable deaths, etc.; Analyst support services
Outcome based contracts	Analysis and monitoring of performance and outcomes along the whole care pathway	Linking records across episodes of care within and between organisations
Streamline planned care pathways, fewer outpatient referrals	Decision support tools to ensure referrals comply with best practice and guidance	DXS referrals / pathways guidance tool, integrated with GP systems; National e-referrals system; Pre-referral email advice from specialists