

Oxfordshire CCG strategy and plan **2014/15-2018/19**

Introduction

This document is the strategy and plan for Oxfordshire CCG for the period 2014/15-2018/19.

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.

Our most significant improvement intervention is therefore focussed on integrating services around the patient – wherever possible pulling services closer to the patient's home. This programme will deliver improvements in the integration of health and social care and the integration of people's physical and mental health care. It will deliver 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.

The remaining improvement interventions will result in a significant improvement in our performance against the key pledges in the NHS constitution. This will give people much improved 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.

This plan is a draft, and we will not be finalising it until April subsequent to seeking the backing for our proposals from the Oxfordshire Health and Wellbeing Board and then our own Governing Body.

We look forward to receiving the comments and views of our provider and commissioner partners, and of NHS England, before we finalise and adopt this plan.

Dr Joe McManners

Chair, OCCG

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Chapter 1: 5yr ambition & vision

1.1 Our Vision for the Oxfordshire Health and Social care system in 2018/19

- a. The Oxfordshire health and social care system's vision for the system in five years' time is that it 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

- b. We will deliver our vision through a programme of 6 Improvement Interventions, which are designed to ensure Oxfordshire further develops the characteristics of a high quality and sustainable system. These are:
 - i. Achieving Integration
 - ii. Improving emergency and urgent care services
 - iii. Improving the efficiency and effectiveness of planned care
 - iv. Improving the efficiency and effectiveness of prescribing
 - v. Improving the management of Long Term Conditions
 - vi. Delivering a new approach to contracting and procurement

1.2 The Oxfordshire context - Population health

- a. The May 2013 Director of Public Health Annual Report for Oxfordshire identifies six main challenges to the long term health and wellbeing of the local population¹. These are:
 - i. **An ageing population – the “demographic challenge”**. This strategic plan focusses heavily on joining 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. This is the primary focus of our achieving integration programme, which recognises the need for locality based solutions that reflect the differing characteristics of populations across the County.

 - ii. **Breaking the cycle of disadvantage**. This plan proposes a much closer partnership programme between OCC, district councils, the third sector, NHS England and Oxfordshire CCG to deliver targeted prevention and health improvement interventions with our most vulnerable rural and urban communities. The programme recognises the substantial changes to the ethnic minority structure of the county (In Oxford nearly half of births (47%) in 2010 were to non UK-born mothers, compared to a national and County average of 26%). It will focus on uptake of prevention and early

¹ http://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/publichealth/PH_AR_2013-14.pdf

intervention measures in targeted communities (determined in partnership with the DPH); neighbourhood based partnership work to address the determinants of poor health; measures to tackle loneliness in the older population and ensuring GPs are active partners in the local Thriving Families initiative.

- iii. **Mental health and wellbeing: avoiding a Cinderella service.** This plan focusses on ensuring parity of esteem by continuing the good work to develop outcomes based contracts for mental health services, and on the increasing integration of physical and mental health services in primary, community and secondary care settings.
- iv. **The rising tide of obesity.** Oxfordshire is doing better than the national average on childhood and adult obesity, but 1 in 4 adults in the County (and rising) are obese. Our public health partners in OCC continue to be heavily focussed on improving access to exercise and weight loss services.
- v. **Excessive alcohol consumption .** Whilst alcohol related hospital admissions in Oxfordshire are lower than the national average they are climbing in line with it, with the average age of those admitted being between 55 and 64. The CCG remains an active partner on the Safer Communities Partnership Board and will be developing plans during year 1 of this strategy to provide better access to services for the most vulnerable adults identified in conjunction with the police and voluntary sector agencies, as well as supporting GPs to offer brief intervention advice during the course of NHS Healthchecks.
- vi. **Fighting killer infections .** Oxfordshire has well established mechanisms for managing CDIFF and MRSA and these are explored fully in chapter 14. Local increases in TB are small, and are a result of much improved detection rates. The detection and management of TB will remain an area for close scrutiny in the light of known demographic changes, particularly in Oxford City. Our health inequalities and access programme (see chapter 4) will focus on uptake of screening and immunisations in our most vulnerable communities.

1.3 Our local health economy

- a. The Oxfordshire health and social care system is under significant financial pressure, with the CCG forecasting a year-end deficit of £6.1m for 13/14 and is proposing a deficit budget for 14/15. Whilst rates of growth have slowed over the last 12 months, key performance pressures continue to be:
 - i. Increase in A&E attendances and emergency admissions , with the share of patients with multiple attendances and admissions growing fastest
 - ii. Unacceptably high numbers of patients experiencing delayed transfers of care
 - iii. The failure to meet referral to treatment time targets and increased outpatient referrals
 - iv. The failure of the CCG QIPP programmes to deliver anticipated cost savings.
- b. Improving performance in these four areas is an aspect of this plan. Performance will be improved through the delivery of a suite of improvement interventions, underpinned by robust business cases developed with support from our external consultants Deloitte and enshrined in contracts.

- c. These are intended to :
 - i. Reductions in appropriate use of A&E by offering more effective diversion to primary or community based services
 - ii. A primary care service able to drive effective integration of services around the individual patient
 - iii. Integrated health and social care community teams that can prevent admission and support early discharge
 - iv. A primary care led multi-morbidity model of care for patients with long term conditions, focused on those patients who form the top 2% of health service users
 - v. Rapid access to multi-disciplinary assessment services designed to reduce the likelihood of admission by offering same day assessment supported by same day home based treatment and care services to vulnerable older people, patients with complex co-morbidities and those at end of life.
 - vi. Contracts that incentivise our principle community and secondary care providers to work together to deliver improved outcomes for patients on the urgent care pathway.
 - vii. Community based health and social care support services that enable people to return home from hospital in a timely manner and then to regain their independence
 - viii. Improved end of life care through increased registration on palliative care registers, enhanced use of Advanced Care Planning and improved integration of end of life service providers
 - ix. A reduction in emergency admissions from care homes.
 - x. A reduction in outpatient referrals through GP led peer review and improved access to information on thresholds and guidelines, supported by improved elective care pathways.

- d. The current state of readiness of the local system to deliver this change is well placed:
 - i. The CCG and Oxfordshire County Council (OCC) 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 our plans.
 - ii. The CCG and OCC are building on these existing arrangements to work closely together to develop and deliver a Better Care Fund Integration plan
 - iii. Oxford Health Foundation Trust and Oxford University Hospitals Trust are continuing to work with the CCG and OCC to achieve integrated, outcomes based components in the standard contracts for 14/15.
 - 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 months.
 - v. The CCGs internal capacity and capability building programme has delivered a highly capable interim leadership team, who are now progressing work to secure the formation of a new permanent leadership team for the organisation.
 - vi. Work to develop an outcomes based approach to commissioning 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.

1.4 Key messages from our JSNA

- a. Further to analysis of the JSNA, the Oxfordshire Health and Wellbeing strategy 2012-2016 identifies a number of priorities where change is required to improve health:
 - i. The need to shift services towards the prevention of ill health.
 - ii. The need to reduce inequalities, break the cycle of deprivation and protect the vulnerable.

- iii. The need to give children a better start in life.
- iv. The need to reduce unnecessary demand for services.
- v. To help people and communities help themselves.
- vi. The need to make the patient's journey through all services smoother and more efficient.
- vii. The need to improve the quality and safety of services.
- viii. The need to streamline financial systems, especially those pooled between organisations, and to align all budgets more closely.

1.5 Delivering transformational change

- a. The specific material transformation initiatives through which OCCG will deliver the change required are our 6 Improvement Interventions:
 - i. Achieving Integration
 - ii. Improving emergency and urgent care services
 - iii. Improving the efficiency and effectiveness of planned care
 - iv. Improving the efficiency and effectiveness of prescribing
 - v. Improving the management of Long Term Conditions
 - vi. Delivering a new approach to contracting and procurement
- b. These have been developed through a robust process of :
 - i. Patient and public engagement
 - ii. Locality planning workshops
 - iii. Data and performance analysis
 - iv. Outline business case development and review – at which point a number of schemes were rejected
 - v. Development of full business cases
 - vi. Review of full business cases by our external support team
 - vii. Further development of business cases
 - viii. Programme sign off by the Executive Team of the CCG
- c. The projects which make up each Improvement Intervention are summarised below. The aggregated impact we expect that they will have on national outcome measures can be found in chapter 2 and the financial impact expected from this suite of programmes is summarised in chapter 15.
- d. In addition to these 6 Improvement Interventions we will maintain focus on tackling health inequalities (see chapter 4), delivering parity of esteem (see chapter 5) and maintaining the highest standards of patient engagement, quality and safety (see chapter 6 and 14).

1.6 The role of our localities in shaping this plan

- 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 locality 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:

| Identified priority | Action incorporated in plan |
|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Developing primary care to enable it to drive a shift of care from hospital into the community | Primary care development programme scoped and already underway (see chapter 7) |
| Improving the range and accessibility of community based services to support admission avoidance and to speed discharge | Achieving Integration Improvement Intervention , supported by Better Care Fund Plan , designed to deliver this (see chapter 8) |
| Tackling health inequalities by offering targeted support to address lifestyle behaviours and choices | Partnership plan to tackle health inequalities agreed with PH teams in OCC and NHS England (see chapter 4) |
| Improving the quality of care provided by care homes | Incorporated into Achieving Integration Improvement Intervention. (See Appendix 1 and 1.7.1 d below) |
| Developing a multimorbidity model to support patients with long term conditions | Improving the effectiveness and efficiency of care for patients with LTCs is one of our 6 major transformational programmes. See appendix 1 and 1.7.5 below |
| Reducing inappropriate use of A&E by providing greater access to primary skills | Agreement to identify the best way of achieving this is incorporated into the q1 milestones of our urgent and emergency care improvement intervention (see chapter 9) |
| Improving EOL care | Incorporated into Achieving Integration Improvement Intervention into See Appendix 1 and 1.7.1 f below |
| Reducing first outpatient activity | Incorporated into our Planned Care Improvement Intervention (see chapter 10) |
| Improving access too and quality of diagnostic services | Incorporated into our Planned Care Improvement Intervention (see chapter 10) |
| Improving access to and quality of mental health services, particularly for people with addictions | Incorporated into our ongoing work to tackle health inequalities (see chapter 4) and to deliver parity of esteem (see chapter 5) |
| Improving the interface between primary and secondary care | Revisions to LCD roles and responsibilities will clarify clinical leadership for key programme areas, and those individuals will lead work on their programme areas with colleagues in secondary care (see chapter 17) |
| Improving patient education about how to navigate the service | The CCG will work with CSCSU to define and agree a communications programme aimed at improving appropriate use of NHS services |

1.7 Improvement Interventions (see Appendix 1 for more detail on each Intervention)

1.7.1 Improvement Intervention 1: Achieving Integration

- a. *Agree and deliver Better Care Fund Plan.* TBC but proposals include:
- i. Deliver front line integrated health and social care teams underpinned by a single assessment process, integrated care plans and care under single lead professionals
 - ii. Build reablement into all home care rather than in a separate service
 - iii. 7 day working in social care

- iv. Implement individual service funds for home support
- v. Increase investment in carers and the ALERT service
- vi. Deliver agreed End Of Life strategy, focussing on working with informal carers
- vii. Enhance online information services
- viii. Commission one stop health and social care shops for crisis, rapid response and home support
- ix. Consider integration of infrastructure with partner commissioners.

b. *Contract for outcomes*

- i. Building on the Gateway review of Outcomes Based Commissioning and the inclusion of OBC in the 14/15 Operating Framework, identify an appropriate mechanism to deliver improved outcomes for older people

c. *Primary care development*

- i. Appraise options for developing structure of primary care to meet changing expectations re: access and GP led integration of care around the patient
- ii. Agree a vision and strategy for primary care development
- iii. Develop and deliver an implementation plan for this strategy
- iv. Support the development of clinical leaders of primary care so they have the capacity to act as strategic partners in provider discussions
- v. Support improvement of the quality of care provided in general practice
- vi. Increase the capacity of primary care to innovate and change at the practice level

d. *Quality in care homes*

- i. Review and rationalise current care home support services countywide
- ii. Enhance primary medical services provisions to residents(SE only)
- iii. Increase quality of care to residents, in part through contract review countywide
- iv. Increase medicines management support to staff and provide targeted medicines optimisation work in care homes (SE only)

| | Option A South East Pilot | | Option B Top 20 Outliers | | Option C Oxfordshire-wide | |
|------------|------------------------------|-----------|-----------------------------|-----------|------------------------------|-----------------|
| | 2014/15 | 2015/16 | 2014/15 | 2015/16 | 2014/15 | 2015/16 |
| Finance | | | | | | |
| Saving | £23,884 | £25,712 | £53,444 | £69,070 | £184,203 | £248,805 |
| Investment | £199,450 | £199,450 | £199,450 | £199,450 | £1,359,500 | £1,359,500 |
| Net Saving | -£175,566 | -£173,738 | -£146,006 | -£130,380 | - £1,175,297 | - £1,110,695 |

e. *Improve integration of Psychological Services*

- i. Pilot anxiety and depression interventions for COPD and cardiac patients
- ii. Provide access to community psychological medicine services for people with complex LTC and MUS

- iii. Improve identification and management of people presenting with Mental health problems in ED and as inpatients
- iv. Develop a service modelled on the Birmingham RAID service to improve rapid access to psychological services in the acute hospital setting

| Finance | 2014/15 | 2015/16 |
|------------|---------|---------|
| Saving | TBC | TBC |
| Investment | TBC | TBC |
| Net Saving | TBC | TBC |

f. *End Of Life Care (EOL)*

- i. Improve EOL care in the community through greater use of community palliative care and hospice services

| Finance | 2014/15 | 2015/16 |
|------------|---------|---------|
| Saving | £81,225 | TBC |
| Investment | £0 | TBC |
| Net Saving | £81,225 | TBC |

g. *Integrated health hubs*

- i. Pilot development of an integrated community health hub model offering health and social care services in Rose Hill – if preferred option of relocating primary care practice onto the estate cannot be achieved.

1.7.2 Improvement Intervention 2: Improving emergency and urgent care services

- a. Deliver an improved model for urgent and sub acute care through one or a combination of: Service redesign, contractual mechanisms to reward innovation, and integration across the patient pathway between community and acute providers.
- b. The service redesign proposal will be the subject of a joint provider/commissioner options appraisal to be completed in q1 of 2014/15, and comprises of:
 - i. referral of patients presenting at ED whose need is not urgent and could be safely signposted to community based or primary care services
 - ii. Review of MIU provision
 - iii. Development of urgent ambulatory care pathways in the acute
 - iv. Roll out of Emergency Medical Units (EMUs) or equivalent pathways

c. *Retender the PTS contract to:*

- i. Deliver current services plus urgent transport to GP and EMUS
- ii. Additional discharge journeys
- iii. Reduction in aborted journeys
- iv. Reduction in 999 initiated ambulance conveyances
- v. Procure ambulance transfer of patients to GP practices for acute assessment where that assessment has the potential to prevent admission or allow early EMU assessment with the potential for subsequent community management

| Finance | 2014/15 | 2015/16 |
|------------|----------|----------|
| Saving | £984,106 | -£70,568 |
| Investment | £ 23,000 | £0 |
| Net Saving | £961,106 | -£70,568 |

d. Retender 111 and OOH to deliver improved and integrated service with enhanced clinical input

| Finance | 2014/15 | 2015/16 |
|------------|----------|----------|
| Saving | £237,355 | £237,355 |
| Investment | £0 | £0 |
| Net Saving | £237,355 | £237,355 |

1.7.3 **Improvement Intervention 3: Improving the efficiency and effectiveness of planned care**

a. *Enable primary care to reduce first outpatient referrals by 7,000 over next two years*

| Finance | 2014/15 | 2015/16 |
|------------|----------|---------|
| Saving | £972,444 | |
| Investment | £722,500 | |
| Net Saving | £249,944 | |

b. *Review trauma and orthopaedics pathways in order to:*

- i. Improve referral quality and maximise conversion rates
- ii. Optimise efficiency of care pathways following referral (including review of MSK hub)
- iii. Maximise opportunities to deliver care in alternative settings
- iv. Optimise GP use of pathology and radiology and improve quality and cost effectiveness of those services

- v. Create a model for improvement of other top cost specialities in subsequent years of the plan
- c. Explore potential over 5 years to *expand use of private sector providers* .
- d. Continue to work with OUHT to *improve the efficiency of outpatient clinics*
- e. Continue GP led audit of *adherence to thresholds and referral guidelines*, supported by rollout of the DXS system
- f. Ensure that all *contractual levers* (for example outpatient/daycase agreements) are consistently applied

| Finance | 2014/15 | 2015/16 |
|------------|------------|------------|
| Saving | £1,254,318 | £2,234,284 |
| Investment | £0 | £0 |
| Net Saving | £1,254,318 | £2,234,284 |

- g. Continue existing programme to improve *efficiency and effectiveness of diagnostic services* by:
 - i. Improving the quality of radiology performance, access and turnaround times to meet national and local standards by March 2016
 - ii. Optimising GP usage of pathology and radiology imaging services by September 2014
 - iii. Increasing community provision of radiology

| Finance | 2014/15 | 2015/16 |
|------------|----------|---------|
| Saving | £292,485 | TBC |
| Investment | £0 | TBC |
| Net Saving | £292,485 | TBC |

- h. Improve *dementia diagnosis and treatment* by:
 - i. Expanding SW dementia pilot to deliver increased dementia diagnosis in primary care countywide
 - ii. Streamline the memory assessment service pathway across OUHT and OHFT, enabling it to meet projected increase in demand within current spend
 - iii. Improving carer support and post diagnosis care through enhanced investment in carers grants and additional dementia advisors
 - iv. Continuing to develop dementia champions across the county to build dementia friendly communities.

| Finance | 2014/15 | 2015/16 |
|------------|-----------|----------|
| Saving | -£10,913 | £234,633 |
| Investment | £209,032 | £32,505 |
| Net Saving | -£219,945 | £202,139 |

1.7.4 **Improvement Intervention 4: Improving the efficiency and effectiveness of prescribing**

a. *Improve primary care prescribing by:*

- i. Focussing on medicines optimisation for: antimicrobials, vitamin D, diabetes and COPD.
- ii. Working closely with primary care to improve medicines optimisation in care homes and medicines optimisation in HF patients

| Finance | 2014/15 | 2015/16 |
|------------|------------|---------|
| Saving | £2,400,000 | TBC |
| Investment | £0 | TBC |
| Net Saving | £2,400,000 | TBC |

iii. Reducing waste by:

- reviewing “when necessary” and “not dispensed” items
- Pilot “costs on bags” project
- Pilot “not dispensed” project
- Review of repeat prescribing and dispensing
- Synchronisation of meds

| Finance | 2014/15 | 2015/16 |
|------------|---------|---------|
| Saving | £42,453 | £65,768 |
| Investment | £2,781 | £4,250 |
| Net Saving | £39,672 | £61,518 |

- b. Ensuring most *cost effective prescribing in secondary care* for diabetic macular oedema; retinal vein occlusion and age related macular degeneration.

| Finance | 2014/15 | 2015/16 |
|------------|----------|---------|
| Saving | £664,336 | TBC |
| Investment | £0 | TBC |
| Net Saving | £664,336 | TBC |

- c. *Retendering* supply of wound care dressings to rationalise wound care costs.

| Finance | 2014/15 | 2015/16 |
|------------|---------|---------|
| Saving | £25,000 | £0 |
| Investment | £0 | £0 |
| Net Saving | £25,000 | £0 |

1.7.5 Improvement Intervention 5: Improving the management of Long Term Conditions

- a. Develop a *reconfigured LTC service model* to improve the quality of care for people with LTC, reducing unnecessary emergency hospital admissions. This will be achieved through:
- i. Preventing people with LTC presenting at hospital by better managing people with LTC in the community through integrated local multidisciplinary teams
 - ii. Development of a pro-active, primary care led, multi morbidity service focussed on those patients who are the top 2% of service users.
- b. *Heart Failure:*
- i. Review diagnostic referral pathway
 - ii. Prescribing review and meds optimisation (ensuring close joint working with prescribing intervention)
 - iii. Develop integrated care team (MH/PH/rehab)
 - iv. Deliver education on self care
- c. *Diabetes:*
- i. Develop new integrated pathway based on OBC model to be delivered from April 15
 - ii. Implement new pre-diabetes prevention approach from April 2014 (and then integrate into new pathway)
 - iii. Develop secondary care CQUIN to improve responsiveness to inpatients with diabetes
 - iv. Evaluate value of multimorbidity integrated pathway

| Finance | 2014/15 | 2015/16 |
|------------|----------|------------|
| Saving | £738,707 | £1,470,000 |
| Investment | £0 | £tbc |
| Net Saving | £738,707 | £1,470,000 |

1.7.6 Improvement Intervention 6: Delivering a new approach to contracting and procurement

- i. Improve the use of formal contract affordability envelopes and clear negotiation strategies
- ii. Contract for delivery of improvement interventions, using all the levers available in the national standard contract and national business rules
- iii. Integrate the learning from our investment in Outcomes Based Commissioning into all our contracting practice, with particular emphasis on using contracts to pursue integration to benefit our whole health system and contribute to its sustainability .
- iv. Explore potential over 5 years to expand the use of alternative providers (including new primary care organisations where these emerge),in the context of a clear commercial strategy.
- v. Establish improved business disciplines within the CCG including Programme Management Office, Business Intelligence and contracting and procurement expertise .

1.8 The role of our localities in delivering this plan

- a. OCCGs member practices will play a key role in ensuring the successful delivery of this plan. In particular practices will need to:
 - i. Engage in the primary care development programme
 - ii. Deliver prescribing savings
 - iii. Continue to reduce first outpatient referrals
 - iv. Deliver a shared care model for dementia, and build on the SW 12/13 pilot to increase capacity for dementia diagnosis and management in primary care
 - v. Increase rates of IAPT referral
 - vi. Refer patients with COPD and HF to CBT services
 - vii. Use the newly available community psychological medicine liaison service
 - viii. Help shape the development of integrated community teams and sub acute community based urgent care services, and then make active use of those new services
 - ix. Increase the identification of patients who are palliative and improve use of Advanced care Plans
 - x. Participate in a pilot programme to develop better ways of providing medical support to care homes (not all practices) and to improve the quality of care homes provide
 - xi. Deliver the new GMS provisions for risk stratification and case management, and build on these to deliver a multi-morbidity model of care for patients with long term conditions
 - xii. Support delivery of the partnership work with public health partners to tackle health inequalities (not all practices)
 - xiii. Continue to develop PPGs so that the patient voice is informed, representative and empowered in the commissioning process and encourage them to enhance their relationships with practices by focusing on preparation for CQC inspection as well as addressing other practice specific concerns.
 - xiv. Provide effective signposting to interventions and opportunities to support self-care, develop healthy lifestyles and make informed choices around healthcare options.

1.9 The 6 characteristics of a high quality and sustainable system

This performance improvement programme will help move Oxfordshire towards being a system that has the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance.

1.9.1 *Characteristic 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*

- a. Our 6 objectives have been developed in response to a widespread public engagement exercise.
- b. Delivery of all our improvement interventions will be underpinned by:
 - i. The structured inclusion of patients, carers and voluntary organisations in our service redesign work.
 - ii. The ongoing development of pro-active and inclusive Patient Participation Groups (PPGs) in all of our practices, led by the lay chairs of our 6 locality patient forums who in turn have a direct relationship with our Non Executive lead for public involvement. Support for PPG development will be focussed on practices with populations experiencing health inequalities.
 - iii. Ensuring that our service redesign proposals empower people to look after themselves. For example Our Better Care Fund plan will ensure that home care is re-contracted so that successful re-ablement is specified as an outcome of home care, rather than being commissioned as a separate stand alone service, and our Long Term Conditions Improvement Intervention will incorporate structured support to patients to self care.
 - iv. Delivery of an ongoing programme of public consultation and engagement through Talking Health, public meetings, meetings in public, media campaigns and joint work with our local authority partners.

1.9.2 *Characteristics 2 and 3 : Wider primary care, provided at scale and a modern model of integrated care*

- a. The most significant improvement intervention in our plan is our programme to achieve integration of services led by primary care. In year one of this programme we will therefore undertake an options appraisal for the future development of primary care, agree a vision and strategy for primary care in Oxfordshire and develop an implementation plan for delivering that change.
- b. In order to ensure we have full engagement in, and support for, the outcomes of this work, we do not anticipate implementation getting underway until early in year 2. Our Locality Clinical Directors, and through them our wider primary care membership, have however already agreed that the objectives of this programme are:
 - i. To produce an agreed vision and five year strategy for the development of primary care in Oxfordshire which addresses the role of practices in:
 - ii. Providing more proactive coordination of care, particularly for people with long term conditions including dementia
 - iii. Providing more holistic, integrated care in the community

- iv. Ensuring fast, responsive access to urgent care needs
 - v. Preventing ill health, including more timely diagnosis and early identification of people at greatest risk of becoming unwell
 - vi. Involving patients and carers more fully in their self care
 - vii. Ensuring high quality care, in particular the patient experience
- c. To produce and support the delivery of a plan for federated working in Oxfordshire which articulates the preferred function and form of federated working in the county so that primary care is in a position to:
- i. Meet changing expectations re: access and GP led integration of care around the patient
 - ii. Enter the market as a provider of services operating at scale across the county
 - iii. Develop more innovative and integrated primary and community services which deliver improved access and increased continuity of care
 - iv. Support effective urgent and emergency care pathways
 - v. Address health inequalities more effectively in areas of both urban and rural deprivation
- d. To develop the leadership capacity of primary care so that leaders are identified and supported to act as strategic partners in provider discussions around changes in service delivery.
- e. To support improvement of the quality of general practice, working closely with the Local Area Team, to ensure that core GMS/PMS services as well as enhanced services improve and to address adverse performance variation.
- f. To develop change management capacity within general practice, through a programme of organisational development and incentives to ensure that changes are made at the practice level which will transform out-of-hospital care and improve access to services.
- g. Our Integration Improvement Intervention also incorporates programmes that will deliver a modern model of integrated care. These are:
- i. Our Better Care Fund Plan which will result in creation of single, locality based teams delivering front line social work, occupational therapy and community health services (including District Nursing). Patient care will be informed by a single assessment process and delivered via a joint care plan, owned by an accountable lead professional. Delivery will be underpinned by integrated IT systems and jointly owned performance metrics. These teams will need to incorporate (or at least access) primary, community , secondary care and social care expertise, and :
 - To deliver joined up health and social care to the frail elderly, patients with multimorbidities (particularly the top 2% of cost risk), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register

- Have named social and community healthcare link workers assigned to each general practice
 - Have clearly defined roles and responsibilities within urgent and emergency care pathways
- ii. Our plan to integrate psychological services in primary and secondary care. This will ensure that patients who have both a long term condition (or multiple conditions) and anxiety or depression are treated holistically in the community, at ED and as inpatients.
 - iii. Our Quality in Care homes programme which will ensure that the residents of our nursing and residential care homes benefit as much from the development of modern integrated services as people still living in their own home.
- h. Our integration intervention is heavily dependent on our contracting improvement intervention. It is our intent to negotiate an element of the OHFT contract jointly with the OUHT contract, in order to start implementation of Outcomes Based Commissioning for Older People. Discussions are underway with Oxfordshire County Council to see if any of their commissioned services could be included. Such a contracting intervention would seek delivery of services through a visibly integrated pathway which links the pathway through primary, community and acute services. This would be through a holistic approach meeting the person's physical health, mental health and social care needs.

1.9.3 *Characteristic 4: Access to the highest quality urgent and emergency care*

- a. There has recently been increased commitment to multi-agency engagement, to identify and deliver improvements in the urgent care flow. This will continue as part of the Urgent care Working Group, ensuring short, medium and long term interventions are focused on improving bottlenecks in the pathway.
- b. An improved model for urgent and sub acute care may be delivered as a combination of the contract improvement intervention, using contractual mechanisms to reward innovation, and service redesign. The service redesign proposal will commence with a joint provider/commissioner options appraisal to be completed in q1 of 2014/15 and will cover:
 - i. referral of patients presenting at ED whose need is not urgent and could be safely signposted to community based or primary care services ()
 - ii. Review of MIU provision
 - iii. Development of urgent ambulatory care pathways in the acute provider
 - iv. Roll out of Emergency Medical Units, or equivalent pathways that can provide same day geriatrician led, multidisciplinary health and social care assessment and treatment services that enable patients to avoid admission.(this will also contribute to our integration ambitions).
- c. Greater integration between our OOH provider and the 111 service – ensuring right place first time is achieved more consistently.

- d. Greater integration between our PTS and ambulance services – ensuring it is easier for people to access the right emergency care, in the right place first time, and supporting more effective discharge to improve flow.
- e. Procure ambulance transfer of patients to GP practices for acute assessment where that assessment has the potential to prevent admission or allow early EMU assessment with the potential for subsequent community management.
- f. Whole system ownership of the Urgent Care Improvement Plan, covering service improvements across the entire patient flow, overseen by the Urgent Care Working Group
- g. Identification and assertive case management of the small number of children who make up the majority of non-elective admissions, ensuring children are managed closer to home and inappropriate admission is avoided.

1.9.4 Characteristic 5: A step change in the productivity of elective care

- a. Our Planned Care Improvement Intervention will take approx. 4million out of the planned care activity budget from 2014 to 2016. This will be achieved through:
 - i. Reducing variation in outpatient first appointments in General Practice through delivery of the following 9 projects:
 - Demand management by peer review of 1st out-patients referrals within practices – Identification of out-patient referrals where there is no benefit from a secondary care referral, lessons learned fed back at Locality meeting alternatives sought and education sessions developed
 - Demand management through reduction of those consultant to consultant referrals
 - Expansion of e-mail advice
 - Practice Level specialist enhanced review – where specialist knowledge exists within a practice
 - Locality based specialist review
 - Supportive referral review within secondary care for urology and Gastro
 - Dermatology project
 - Ophthalmology extension of IOP scheme to reduce referrals based upon false positives; setting up community triage and treatment pathways.
 - Review of the MSK triage – to assess value for money / quality
 - ii. A focus initially on the Trauma and Orthopaedics pathway, to deliver a combination of:
 - Improvements in efficiency of outpatient clinics *
 - Robust application of treatment thresholds
 - Movement of day case to outpatient procedures
 - Improved patient pathways and shared decision making

*OUH plan to save 2.7 million over three years over several specialities **

- iii. Better value diagnostic services
- iv. Improved dementia diagnosis and care

- b. The CCG is also planning to expand its use of the wider healthcare market in the next five years. Given pressures on the main acute provider in terms of capacity and demand, making better use of the private provider facilities in the county makes sound sense.
- c. There is recognition that prices may not be lower in the independent sector but that there is more will to discuss and agree total price patient pathways across specialties. This would make it easier to project spend across the financial year.

1.9.5 Characteristic 6: Specialised services concentrated in centres of excellence (as relevant to the locality)

We are still working with colleagues in Wessex to agree the detail of how this characteristic will be met.

1.10 Sustainability, outcomes and inequalities

1.10.1 Delivering a sustainable NHS for future generations in Oxfordshire

- a. The Oxfordshire health and social care system is challenged financially, and this plan sets out to achieve run rate balance by 2015/16, and then a sustained financial balance thereafter.
- b. Our improvement interventions have been designed to deliver the transformational change required to reach a sustainable position – and we are very clear that delivery of the Better Care Fund, primary care, planned care and urgent care interventions are particularly critical to the long term sustainability of the system, but that they will take time to bear fruit in terms of delivering shifts in activity.
- c. Taking this more transparent and realistic approach to our planning gives us confidence that we can deliver sustainability, particularly as our planned interventions are underpinned by two other significant changes:
 - i. Committing to an improvement intervention solely focused on contracting and procurement, through which we will:
 - Appraise the options for achieving our goals through contracting or procurement (in addition to system leadership) improving the disciplines of formal contract affordability envelopes and clear strategies
 - Contract for delivery of improvement interventions, using all the levers available in the national standard contract and national business rules
 - ii. Ensure that we integrate the learning from our recent investment in Outcomes Based Commissioning into all our contracting practice, in line with Everyone Counts , with particular emphasis on using contracts to pursue integration in way which benefits our whole health system and contributes to its sustainability
- d. Improving our business disciplines to ensure that we deliver our Plan and our improvement interventions by establishing a PMO in the CCG, embedding contracting and procurement capability into our appraisal of options to achieve improvement interventions and ensuring we have robust , industry standard , approaches in place to manage and monitor delivery of the 6 improvement interventions we have identified and applying those disciplines to business as usual.

1.10.2 How our plan will improve health outcomes in alignment with the seven NHS outcome ambitions

- a. *Ambition 1: Securing additional years of life for the people of England with treatable mental and physical health conditions*
 - i. Our Integration intervention includes a specific initiative to deliver improved psychiatric liaison in primary, community, emergency and secondary care inpatient settings – with priority given to improving care for patients with COPD, HF, multimorbidity and/or medically unexplained symptoms.
 - ii. Our Long Term Conditions Intervention will deliver an enhanced, multimorbidity based, care model for patients with LTCs that comprises risk stratification, integrated care planning, care under a single named lead professional and support to self care.
 - iii. We will build on the excellent work done to develop outcomes based commissioning for people with mental health problems in our contract negotiation with OHFT. Our aspiration is to contract with the main provider and our principle

voluntary sector partners to deliver care that results in improved quality of life (as defined by service users) in order to aid sustained recovery.

- iv. Learning from the good practice in iii) above we will explore using the outcome based approach for Child and Adolescent Mental Health Services.

Potential Years of Life Lost from conditions considered amenable to healthcare – 5 year ambition

| E.A.1 | PYLL (Rate per 100,000 population) |
|-----------------|------------------------------------|
| Baseline | 1779.7 |
| 2014/15 | 1807.0 |
| 2015/16 | 1804.0 |
| 2016/17 | 1789.0 |
| 2017/18 | 1763.0 |
| 2018/19 | 1722.7 |

- b. *Ambition 2: Improving the health related quality of life of the 15 million + people with one or more long term condition, including mental health conditions*

- i. Our integration and LTC interventions will result in the care of patients with LTCs being co-ordinated by GPs but delivered by our new integrated health and social care community teams. The Locality Commissioning teams will continue to support case finding by these new multidisciplinary teams using the ACG tool. GP led integrated teams will then deliver single assessments, and develop integrated care plans under the leadership of single named professionals. The new MDT teams will break down silos between specialist LTC teams and between health and social care, and will ensure treatment of the whole person and not the conditions that the person may have. A full suite of self-care interventions designed to motivate and empower patients will be available, and the planned integration of psychiatric liaison support in primary, community and secondary care – with a clear focus on patients with LTCs - will ensure parity of esteem.

Health related Quality of life for people with long term conditions – 5 year ambition (Percentage of people responding yes definitely or yes to some extent to q32 of GP patient survey)

| E.A.2 | Average EQ-5D score for people reporting having one or more long-term condition |
|-----------------|---------------------------------------------------------------------------------|
| Baseline | 76.90 |
| 2014/15 | 76.90 |
| 2015/16 | 77.00 |
| 2016/17 | 77.00 |
| 2017/18 | 77.10 |
| 2018/19 | 77.20 |

c. *Ambition 3: Reducing the amount of time spent avoidable in hospital through better and more integrated care in the community, outside of hospital*

A number of our planned improvement interventions will contribute to delivery of this ambition.

- i. Our integration and LTC Improvement Interventions will deliver integrated health and social care close to home for the elderly and those with LTCs and integrated physical and mental health care in year 1 of the plan.
- ii. Our primary care development programme will ensure we can deliver the evolution required in primary care to ensure general practice is contributing fully to this priority from the beginning of year 2.
- iii. Our urgent and emergency care improvement intervention will remodel our emergency and sub-acute pathway so that it delivers :
 - referral of patients presenting at ED whose need is not urgent and could be safely signposted to community based or primary care services
 - A dedicated Clinical Decision Unit for Paediatrics, co-located with the Emergency Department at the JR
 - Enhanced MIU provision
 - Access to urgent ambulatory care pathways in the acute
 - Roll out of Emergency multidisciplinary units to provide 1 stop shop alternatives to A&E for those needing a speedy assessment and same day package of community health and social care in order to remain at home.
- iv. As part of the Urgent Care Working Group, OCCG will continue to deliver activities from the Urgent Care Improvement Plan, and lead the engagement across the system, to identify short and medium term interventions to improve flow. These include a range of service improvements taken by providers, of which there is on-going focus to embed at operational level.

Combined 5 year ambition for measures assessing unplanned hospitalisation for : chronic ACS conditions; asthma, diabetes and epilepsy in u19s,; acute conditions not normally requiring hospitalisation and emergency admission for children with respiratory tract infections (Admissions per 100,000 of the population)

| E.A.4 | Emergency admissions composite indicator |
|-----------------|-------------------------------------------------|
| Baseline | 1471.7 |
| 2014/15 | 1414.1 |
| 2015/16 | 1329.1 |
| 2016/17 | 1240.7 |
| 2017/18 | 1148.7 |
| 2018/19 | 1056.4 |

- d. *Ambition 4: Increasing the proportion of older people living independently at home following discharge from hospital*
- i. Our Achieving Integration improvement intervention will deliver a developed primary care market that is leading delivery of community based integrated care for older people , with access to:
 - front line integrated health and social care teams who can provide multidisciplinary physical health, mental health and social care to older people, managed by a single lead professional and designed to keep people at home
 - home care support services with built in re-ablement
 - enhanced ALERT services
 - ii. This will be underpinned by:
 - an outcomes based component of our core contract for services for older people with OUHT and OHFT that requires them to deliver the Better Care Fund outcomes
 - enhanced investment in carers
 - development of lay and/or clinical dementia champions across the County who will lead development of dementia friendly communities.
 - iii. Our Urgent and Emergency Care Improvement Intervention will deliver improved emergency and sub acute care for older people which minimises admissions and lengths of stay, so enhancing the likelihood of people remaining independent at home.

| Metrics | | Current Baseline (as at....) | Performance underpinning April 2015 payment | Performance underpinning October 2015 payment |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------------------------|---------------------------------------------------|-----------------------------------------------------|
| <i>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</i> | Metric Value | 71.70% | N/A | 80% |
| | Numerator | 345 | | 400 |
| | Denominator | 480 | | 500 |
| | | | (April 2012 - March 2013) | (April 2014 - March 2015) |

- e. *Ambition 5: Increasing the number of people having a positive experience of hospital care*
- i. Our Planned and Urgent and Emergency Care Improvement Interventions will deliver improvements to:
 - the management of OP and OPFU
 - diagnostic waits
 - choice available to patients
 - urgent care pathways
 - urgent care for people with ACS conditions
 - friends and family test scores
 - ii. Our Achieving Integration Intervention will deliver improved care for older people and people with complex co-morbidities across the pathway (including inpatient care). This will particularly impact those patients identified through risk stratification as being in the top 2% of service users.
 - iii. Our work on maternity commissioning will deliver improved experience for women using the CQC survey (2010, 2013) as baselines. The aim is to improve continuity of care and to reduce the number of women who deliver in an obstetric led unit by maximising capacity at the Freestanding Midwifery Led Units.

5 year ambition for keeping the numbers of people reporting poor inpatient care low (Total number of poor responses divided by total no of respondents, expressed as average no of negative responses to multiple questions per 100 patients.)

| E.A.5 | The proportion of people reporting poor patient experience of inpatient care |
|-----------------|-------------------------------------------------------------------------------------|
| Baseline | 149.7 |
| 2014/15 | 149.6 |
| 2015/16 | 149.5 |
| 2016/17 | 149.4 |
| 2017/18 | 149.3 |
| 2018/19 | 149.2 |

- f. *Ambition 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*
- i. Our Achieving Integration Improvement Intervention will deliver:
- a development of psychiatric liaison services in primary, community, emergency and inpatient settings
 - increased access to psychological therapies for patients with ACS conditions –particularly cardiac and COPD
 - multidisciplinary community teams that incorporate older adult mental health workers.

5 year ambition for keeping the numbers of people reporting poor GP and OOH care low (Average no of negative responses per 100 patients)

| E.A.7 | The proportion of people reporting poor experience of General Practice and Out-of-Ours Services |
|-----------------|--------------------------------------------------------------------------------------------------------|
| Baseline | 4.80 |
| 2014/15 | 4.81 |
| 2015/16 | 4.82 |
| 2016/17 | 4.83 |
| 2017/18 | 4.84 |
| 2018/19 | 4.85 |

- g. *Ambition 7: Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care*

- i. Oxfordshire does not have a significant problem with avoidable deaths. It is already business as usual for the CCG and its provider partners 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.

1.10.3 How our plan will reduce health inequalities

- a. OCCG has developed and agreed a partnership approach to reducing health inequalities with the Public Health teams at OCC and NHS England.
- b. Data will be pooled (within Information Governance and data protection regulations) by the 3 partners to identify those primary care practices where:
 - i. we have populations that have been agreed as priorities for this work in the Health and Wellbeing Strategy, based on data in the JSNA. Ie: Children in poverty; Ethnic minorities; Carers; Lonely old people; High number of mental health service users; People with physical and learning disabilities
 - ii. and there is :
 - Low uptake of core PH interventions (smoking cessation, breastfeeding, weight loss, screening, immunisations , healthchecks)
 - Populations with potential to benefit from improved blood pressure, cholesterol, anti-coagulation and blood sugar control.
 - Low carer registration
- c. OCCG locality support pharmacists will then provide hands on support to those identified target practices to identify individuals, groups or communities that might benefit from targeted outreach work by Locality Equality and access teams.
- d. OCCG will work with clinicians to ensure priority is given to delivery of interventions to improve blood pressure, cholesterol, anti-coagulation and blood sugar control.
- e. OCC and NHS England will ensure that service providers target their resources to provide services to these priority practices.
- f. OCC and OCCG will work together to ensure that families identified via the national Troubled Families initiative can be identified in primary care and that their case workers are fully aware.
- g. In addition OCCG Equality and Access teams will continue to support neighbourhood based strategic partnership work in areas of deprivation; will work closely with Age UK and will continue to support military and veteran communities.
- h. OCC and OCCG will deliver joined up services to prevent, detect and intervene early where children are being exploited or at risk of being exploited.
- i. OCC and OCCG will make 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 CAMHS) when required.

1.11 Partner sign up to this plan

- a. This plan has been developed in response to established local Health and Wellbeing Board priorities and the Call to Action Consultation.
- b. The core content has been developed with input from the 6 locality Clinical Directors, who have approved the content as set out in this draft for sharing with NHS England.
- c. A draft Plan on a Page summary has been shared with our key stakeholders in the NHS, local government, the academic community and the voluntary sector, and we are awaiting feedback.
- d. Draft content has been shared at the Health and Wellbeing Board Steering Group, and the full suite of plan documents will be taken for formal approval by that body in March.

1.12 Alignment between our Better Care Fund plan and 5 year strategic vision

- a. Our Better Care Fund plan is designed to further the aims and objectives of Oxfordshire's Joint Health and Wellbeing strategy (2012-2016) and the OCC/OCCG Joint Older People's Commissioning Strategy (2013-2016) – both of which were fully informed by the JSNA and user engagement.
- b. The Better Care Fund will be used to deliver our joint ambition for integration, in that it will be used to:
 - i. Deliver joined up health and social care to the frail elderly, patients with multi-morbidities (particularly the top 2% of cost risk), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register through the creation of integrated, locality based, health and social care teams.
 - ii. Deliver anticipatory care plans and care co-ordination when unstable for those patients.
 - iii. Develop locality based 'hubs' that are community facing and offer rapid access, multi-disciplinary health and social care team assessment for diagnosis and care planning.
 - iv. Move to acute hospital stays that are as brief as needed, so the patient moves to the most appropriate place as soon as possible without delay
 - v. Help primary care develop to work better together and improve joint working with community, social care and secondary care.
 - vi. Develop the primary care provider community so that GP services can contribute and potentially lead integrated care services
 - vii. Have named social and community healthcare link workers assigned to each general practice and embedded within locality based integrated health and social care teams
 - viii. Have clearly defined roles and responsibilities within urgent and emergency care pathways
 - ix. Deliver a new jointly commissioned service model that delivers shared outcomes for patients across the system
 - x. Provide 7 day working in health and social care

- c. Moving resources, via the Better Care Fund, to support :
 - i. More personalised home support which removes short visits
 - ii. Dementia support
 - iii. Family carer support
 - iv. Equipment and assistive technology
 - v. Information and advice
 - vi. Discharge to assess care service
 - vii. Increased spend on reablement and rehabilitation
 - viii. Increased investment in carers breaks
 - ix. Investment to support people to die at their usual place of residence
 - x. Sharing of data
 - xi. Data co-ordination (dementia and co-morbidities)
 - xii. 7 day working
 - xiii. Increased demand for funded nursing care and continuing healthcare
 - xiv. Integrated support for hospital admission avoidance

1.13 The key themes which arose from the Call to Action engagement programme that have been used to shape the vision

- a. Our public Call to Action consultation on our draft 5 year strategy identified that the issues of major concern to the public are that:
 - i. We be open and transparent about the financial challenge we face – this plan is realistic about the scale of the financial challenge facing the organisation
 - ii. If we have to cut services to make savings , we are up front about that – this plan does not propose cutting any services, but does set out ambitious plans for service transformation that will make us more efficient
 - iii. Whilst there is support for the patient outcomes in our outcomes based commissioning plans, we shouldn't rush into this new form of contracting – we are undertaking a rigorous review of this work and that will inform our next steps in relation to commissioning for outcomes. We are committed to ensuring that the good work we have done with our partners to date to understand our joint responsibility for delivering better outcomes for patients in a more efficient way is reflected in our use of the standard contracts for 14/15.
 - iv. Care closer to home is supported, but not to the detriment of the quality of care – our plans for development of integrated community teams and EMUs will deliver enhanced quality of care and enhanced outcomes to patients.
 - v. We need to change the attitude of the public from “fix me now” to individuals taking joint responsibility for their health with their GP – this is a longer term goal, and we will strive to deliver this via the work of our equality and access teams in each locality, through our PPGs and through the self management components of our Better Care Fund and Long Term Condition programmes.
 - vi. We need a comprehensive all ages education programme about how to use the NHS – our Equality and Access teams are beginning to address this with some early work to raise awareness in those communities least familiar with the NHS, in partnership with key general practice partners in areas of high immigration and deprivation.

- vii. We should maximise the potential of technology to free up GPs time to deliver face to face care – our Better Care Fund plan will see increased investment in the County Council’s Alert service, and our LTC programme proposes that we look again at how we can work with our partners in the AHSN to exploit the potential of new, and potentially more effective telehealth solutions. Our locality teams are actively supporting development of patient access to record, on line appointment booking, text message appointment reminders etc .
- viii. We should reduce duplication and waste – our achieving integration improvement intervention is designed to reduce hand offs between organisations and so to eliminate bureaucracy and waste - both for the system and for individual patients and service users.

1.14 Our clear ‘you said, we did’ framework to show those that engaged how their perspective and feedback has been included

- a. Oxfordshire has a well established “you said, we did” framework. The report on our Call to Action programme will be uploaded on our website and actively promoted via Talking Health.
- b. When our Governing Body receives and adopts this strategic plan in March the covering paper will formally note how this plan addresses the feedback from the public - and this information will then be widely in the public domain.
- c. Our newly defined PMO will require all programmes to demonstrate how they have engaged patients and service users in service re-design, and how they have provided feedback to those who took the trouble to engage with us.
- d. We will continue to use our patient engagement structures (Lead NED working with 6 lay chairs of locality fora, who represent PPGs in their locality, who in turn represent patients) to cascade information from the CCG to patients and to ensure patient views inform decision making.
- e. The CCG will continue to work with Healthwatch Oxfordshire to identify and address areas of patient and public concern about healthcare.

Chapter 2: Outcomes

2.1 Our current position on outcomes as set out in the NHS Outcomes Framework

- a. The CCG routinely monitors its performance against the Outcomes Indicator set and the Constitution standards, as well as a broad range of quality, activity and financial outcomes. Current performance against the Constitution standards is summarised in chapter 13.
- b. To inform this plan the CCG has also reviewed its position on national benchmarks and trends to date as released in the NHS Atlas of Ambition.
- c. In addition to known areas of concern as set out in the opening chapter (see section 1.3) specific areas for improvement have been identified as:
 - i. Patients reporting very bad care in hospital (in the bottom end of the 3rd quintile)
 - ii. Emergency admissions (in the top quintile but the aggregated measures hides some trends that need to be addressed)
 - iii. Patients experience of GP and Out of Hours services (in the bottom end of the top quintile)

2.2 The actions we need to take to improve outcomes

Please See section 1.10 above for the mapping of our Improvement Interventions to the national outcome ambitions.

2.3 How community and clinician views have been considered in developing plans and quantifying ambitions

- a. Our plan has its roots in early consultation with member practices and our Call to Action consultation (see section 1.13).
- b. As the plan has developed each business case that has been developed to inform the sub components of each improvement intervention has had a clinical owner.
- c. Our Locality Clinical Directors have met to discuss and agree the plan at each stage of its iteration, including:
 - i. All Locality Directors meeting in December 2013
 - ii. Governing Body workshop in January 2014
 - iii. Locality Clinical Directors planning workshop in January 14
 - iv. All locality Clinical Directors meeting in February 2014

2.4 Data , intelligence and local analysis explored to inform planning decisions

- a. Performance against Outcome Measures has been cross referenced with NHS Constitution indicators performance. This clearly indicates that pressures are building within the planned care system for our main provider. There are issues with cancer waiting times, issues with RTT targets, diagnostics wait and cancelled operations.
- b. There are also pressures within the urgent care system. In spite of apparent lower volumes of activity this autumn and early winter compared to the previous year, the 4 hour wait performance target is not met and ambulance handover performance remains an issue.
- c. Both planned care and urgent care will have an impact on patients reporting bad care in hospital. Addressing these issues is fundamental to improving the outcome measure.

- d. The emergency admission composite measure has been disaggregated and associated trends examined so that the individual components can be addressed. The likely demographic impact has been examined and has highlighted particular pressures for the under 19s in Oxford.

2.5 Alignment to JSNA and Health and Wellbeing Strategy

- a. Please see para 1.4 for more information on priorities identified in the JSNA.
- b. Our plan is also fully aligned to the Joint Health and Wellbeing Strategy for Oxfordshire which can be seen at:
<http://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf>
- c. The Health and Wellbeing strategy is based on analysis of the data captured in the JSNA and current priority areas agreed in the Joint Health and Wellbeing Strategy are:

1. Children and Young People

Priority 1: All children have a healthy start in life and stay healthy into adulthood

Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups

Priority 3: Keeping all children and young people safe

Priority 4: Raising achievement for all children and young people

2. Adult Health and Social Care

Priority 5: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support

Priority 7: Working together to improve quality and value for money in the Health and Social Care System

3. Health Improvement

Priority 8: Preventing early death and improving quality of life in later years

Priority 9: Preventing chronic disease through tackling obesity

Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness

Priority 11: Preventing infectious disease through immunisation

- d. Actions being taken by OCCG to meet these agreed system priorities are woven through our 6 improvement interventions and our key areas of business as usual described in the quality, parity of esteem and health inequality chapters of this plan.

2.6 Involvement of HWB in agreeing outcome-

- a. OCCG has shared the content of the draft plan at the Health and Wellbeing Board Steering Group and will be taking it for formal approval by that body in March.

2.7 Anticipated impact on providers

| | % impact of Improvement Interventions 14/15 | | % impact of Improvement Interventions 15/16 | |
|----------------------------------|---------------------------------------------|---------|---------------------------------------------|---------|
| | Activity | Finance | Activity | Finance |
| Accident and Emergency | 0.13% | 0.10% | 5% | 5% |
| Day Cases | 1.69% | 3.14% | 0% | 0% |
| Elective | 5.04% | 0.44% | 5% | 8% |
| Excess bed days EL | 17.07% | 18.19% | 0% | 0% |
| Excess bed days Non- Elective | tbc | tbc | tbc | tbc |
| Non- Elective | 5.43% | 1.25% | 2% | 0% |
| Outpatient First Attendance | 5.31% | 5.51% | 0% | 0% |
| Outpatient Follow-Up | 0.00% | 0.00% | 0% | 0% |
| | | | | |

FOR SPLIT BY PROVIDER PLEASE SEE SEPARATE OPERATIONAL PLAN TEMPLATE

2.8 Aggregation of whole systems plans and how they contribute to 5 year vision

- a. The CCG is working with all partners to progress the improvement interventions. These interventions build upon ongoing clinical and service dialogue between the organisations and will be contractualised in accordance with the national timetable. In determining the finance and activity consequences of the interventions, due cognisance has been taken of Provider impact by point of delivery and where applicable HRG.
- b. By cross referencing the interventions to specific providers, the risk of duplication or cost pushing is minimised. This will be further tested within the final plans which are post contract agreement.
- c. The service impacts of the BCF have also been considered in terms of finance, activity and outcome impacts across all organisations.

2.9 Our 5 year ambition for the 7 NHS Outcome ambitions

BENCHMARK COLUMN TO BE ADDED FOR FINAL SUBMISSION

| NHS National Outcome ambition | Measure | Baseline | 2018/19 | Calculated by |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Securing additional years of life for the people of England with treatable mental and physical health conditions | Potential years of life lost from conditions considered amenable to healthcare (no of amenable deaths divided by population) | 1779.7 | 1722.7 | Rate per 100,000 of population |
| Improving the health related quality of life for the 15m+ people with 1 or more LTC, including MH conditions | Health related quality of life for people with LTCs (measured using the EQ5D tool in the GP patient survey) | 76.9 | 77.20 | Percentage of people responding yes definitely or yes to some extent to q32 of GP patient survey |
| Reducing the amount of time spent avoidably in hospital through better integrated care in the community, outside of hospital. | Composite rate: - Unplanned hospitalisation for chronic ACS conditions and for u19s with asthma, diabetes or epilepsy - Emergency admissions for children with lower respiratory tract infections and adults with acute conditions not usually requiring admissions | 1471.7 | 1056.4 | Admissions per 100,000 of population |
| Increasing the proportion of older people living independently at home following discharge from hospital | See BCF table below | | | |
| Increasing the number of people having a positive experience of hospital care | Patient experience of inpatient care (friends and family test) | 149.7 | 149.2 | Total number of poor responses divided by total no of respondents, expressed as average no of negative responses to multiple questions per 100 patients. |
| Increasing the no. of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community | Composite indicator comprised of GP and GP OOH services | 4.80 | 4.85 | Average number of negative responses per 100 patients |
| Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care | Indicator in development nationally | | | |

2.10 Our 1 & 2yr plan to support the long-term ambition

| NHS National Outcome ambition | Measure | Baseline | 2014/15 | 2015/16 | Calculated by |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Securing additional years of life for the people of England with treatable mental and physical health conditions | Potential years of life lost from conditions considered amenable to healthcare (no of amenable deaths divided by population) | 1779.7 | 1807 | 1804 | Rate per 100,000 of population |
| Improving the health related quality of life for the 15m+ people with 1 or more LTC, including MH conditions | Health related quality of life for people with LTCs (measured using the EQ5D tool in the GP patient survey) | 76.9 | 76.9 | 77 | Percentage of people responding yes definitely or yes to some extent to q32 of GP patient survey |
| Reducing the amount of time spent avoidably in hospital through better integrated care in the community, outside of hospital. | Composite rate: - Unplanned hospitalisation for chronic ACS conditions and for u19s with asthma, diabetes or epilepsy - Emergency admissions for children with lower respiratory tract infections and adults with acute conditions not usually requiring admissions | 1471.7 | 1414.1 | 1329.1 | Admissions per 100,000 of population |
| Increasing the proportion of older people living independently at home following discharge from hospital | See BCF table below | | | | |
| Increasing the number of people having a positive experience of hospital care | Patient experience of inpatient care (friends and family test) | 149.7 | 149.6 | 149.5 | Total number of poor responses divided by total no of respondents, expressed as average no of negative responses to multiple questions per 100 patients. |

| NHS National Outcome ambition | Measure | Baseline | 2014/15 | 2015/16 | Calculated by |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------|---------|---------|-------------------------------------------------------|
| Increasing the no. of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community | Composite indicator comprised of GP and GP OOH services | 4.80 | 4.81 | 4.82 | Average number of negative responses per 100 patients |
| Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care | Indicator in development nationally | | | | |

2.11 Our outcomes ambitions for the additional Better Care Fund Indicators

| Metrics | | Current Baseline (as at...) | Performance underpinning April 2015 payment | Performance underpinning October 2015 payment |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------|---------------------------------------------|-----------------------------------------------|
| <i>Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population</i> | <i>Metric Value</i> | 534 | N/A | 473 |
| | <i>Numerator</i> | 582 | | 546 |
| | <i>Denominator</i> | 109000 | | 115000 |
| | | (April 2012 - March 2013) | | (April 2014 - March 2015) |
| <i>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</i> | <i>Metric Value</i> | 71.70% | N/A | 80% |
| | <i>Numerator</i> | 345 | | 400 |
| | <i>Denominator</i> | 480 | | 500 |
| | | (April 2012 - March 2013) | | (April 2014 - March 2015) |
| <i>Delayed transfers of care from hospital per 100,000 population (average per month)</i> | <i>Metric Value</i> | 26.9 | 21.8 | 17.0 |
| | <i>Numerator</i> | 140 | 115 | 90 |
| | <i>Denominator</i> | 521000 | 528000 | 528000 |
| | | (April 2012 - March 2013) | (April - December 2014) | (January - June 2015) |
| <i>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]</i> | | | N/A | |
| <i>Achieve above the national average of people very satisfied with the care and support they receive from adult social care</i> | <i>Metric Value</i> | 62.7% | N/A | 64.1% |
| | <i>Numerator</i> | 4236.8 | | n/a |
| | <i>Denominator</i> | 6760.6 | | n/a |
| <i>Increase the proportion of older people (aged 65 and over) with an ongoing care package supported to live at home</i> <i>Numerator: Number of people receiving home care or an on-going direct payment from an older person's budget</i> <i>Denominator + people funded in a permanent care home place from a council budget</i> | <i>Metric Value</i> | 60.0% | N/A | TBC |
| | <i>Numerator</i> | 2122 | | TBC |
| | <i>Denominator</i> | 3537 | | TBC |
| | | Mar-13 | (insert time period) | Mar-15 |
| <i>increase the proportion of older people (aged 65 and over) with an on-going care package supported to live at home</i> | <i>Metric Value</i> | | | |
| | <i>Numerator</i> | | | |
| | <i>Denominator</i> | | | |
| | | (TBC) | | |

Chapter 3 : Values and principles

3.1 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

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

3.3 This is a brief summary of how these principles are embedded within our improvement interventions:

- a. *Clinicians and Patients working together to redesign how we deliver care*
 - Each of our improvement interventions has been informed by consultation with clinicians and patients through our Call to Action consultation, our Locality Planning Workshops , our work to develop PPGs and discussion at existing programme boards. Ongoing involvement will be delivered via the same mechanisms.
- b. *Reducing health inequalities by tackling the causes of poor health*
 - Please see chapter 4
- c. *Commissioning Patient Centred High Quality Care*
 - Please see chapters 6 and 14 for a brief description of our embedded mechanisms for managing and maintaining quality in all our services
- d. *Promoting integrated care through joint working and more care delivered locally*
 - Our Achieving Integration Improvement Intervention is focussed on realising this – please see chapter 8
- e. *Supporting individuals to manage their own health*
 - Our LTC Improvement Intervention will deliver improved self care over the later years of this plan .

Chapter 4: Improving health and reducing health inequalities

- 4.1 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 support 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>
- 4.2 The agreed approach can be summarised as follows:
- a. Each OCCG locality will identify a small number of practices where there are populations that have been agreed as priorities for this work in the Health and Wellbeing Strategy, based on data in the JSNA. These are:
 - 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 interventions (smoking cessation, breastfeeding, weight loss, screening, immunisations , healthchecks)
 - ii. Populations with potential to benefit from improved blood pressure, cholesterol, anti-coagulation and blood sugar control. (NAO 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 providers and locality teams .
 - d. Local PPG fora will be asked to endorse the proposed selection of target practices
 - e. Then OCC, NHS England provider and locality teams will work together in joint teams as below:
 - 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 (taking burden off Practice Managers)
 - 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 following clinical interventions in locality work plans for the year:
 - 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
- 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, etc 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 on behalf of joint OCC/NHSE/CCG so practices not bombarded
 - ix. CCG locality teams will focus PPG development work on same priority practices
- f. In addition to the above, CCG Equality & Access teams will only focus on neighbourhood based strategic partnership programme work, work with carers and work with military and veteran communities .
- g. For children and families OCC and OCCG will deliver:
- i. Joined up services to prevent, detect and intervene early where children are being exploited or at risk of being exploited.
 - ii. 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 CAMHS) when required.
 - iii. Targeted action in areas where breastfeeding initiation rates are low (e.g. Banbury) and where continuation rates have declined in order to target support and evidence based interventions in very local areas.
 - iv. Work with primary care in Oxford City to develop and implement a 'flag' system in practices so that families who are part of the Council's 'Thriving Families Programme' are identified in practices and clear routes of referral back to family case workers are identified. This will support delivery of the Troubled Families programme to turn around lives of the most vulnerable families.
 - v. Exploring the potential for co-commissioning with NHS England to meet the primary and community care needs of our homeless population
- h. The outcomes we expect to realise across the system from this approach within 2 years are as set out in chapter 2.

4.3 Implementing EDS2

- a. EDS2 is a useful tool that supports OCCG Statutory Duties under Equality and Human Rights legislation (Equality Act 2010, Human Rights Act 1998) and the Health and Social Care Act (2012)
- b. It requires us to embed equality & diversity within the organisations mainstream processes to support :
 - i. Better health outcomes;
 - ii. Improved patient access and experience
 - iii. A representative & supported workforce
 - iv. Inclusive leadership.
- c. Proposals to carry forward EDS2 IN OCCG will go through the appropriate governance processes.
- d. Meanwhile an Equality Impact Assessment will be conducted on this plan before submission to the OCCG Governing Body in March.

Chapter 5: Parity of esteem

5.1 5yr year ambition: OCCG is committed to achieving parity of esteem for mental health services and the people who use them in Oxfordshire by 2019. We will achieve that through 3 key initiatives:

- i. Outcomes Based Commissioning for adult mental health services
- ii. Improved integration of mental health and physical health services to improve patient and system outcomes around co-morbidities
- iii. Improved identification and support for children and young people with mental health problems

5.2 Outcomes Based Commissioning 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.

| 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 |

- b. These outcomes will be delivered via outcomes based contracting that is resourced from an s75 NHS Act 2006 Pooled Commissioning Budget. The budget for these services in 2013-14 is £38m of health and social care money.

5.3 Improved integration of mental health and physical health services to improve patient and system outcomes around co-morbidities

- a. OCCG will improve outcomes for people with physical health and other co-morbid conditions by commissioning the following psychological interventions:
 - i. CBT for people with Heart Failure, COPD and other long-term conditions which supports self-management and reduces readmission
 - ii. A revised and extended emergency department psychological medicine service that supports clinicians in the urgent care pathway and avoids admission and readmission by diverting/referring people into those outcomes-based services set out above in (1)

- iii. A community psychological medicine service that supports the management of people with complex long-term conditions and medically unexplained symptoms to increase capacity and capability in primary care and reduce unplanned admissions and unnecessary planned care including diagnostics
- iv. An improved response to the needs of complex people such as those with acquired brain injury, co-morbid autistic spectrum disorders and/or learning disability which will reduce use of the urgent care system (particularly in relation to Mental Health Act) and mitigate potential costs of rehabilitation and social care

The current budget for psychological interventions is £3.7m

5.4 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 the County Council

| Ambition | What will we do to achieve this? |
|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Improve transitions from children's to adult mental health services | <ul style="list-style-type: none"> • Evaluate new service model by April 2014. • Continue review of gaps in provision for young people aged 16-24 years resulting from eligibility thresholds and transition from CAMHS to adult services, particularly young people with ADHD, ASD or with conduct disorders |
| Better outcomes for children with Autism | <p>Co-ordinate the review the ASD diagnostic pathway for 5-18 year olds across all relevant providers including schools.</p> <ul style="list-style-type: none"> • Prioritise actions in the Oxfordshire Autism Strategy • Implement Improving Access to Psychological Therapies (IAPT) for children and young people. |
| Ensure support is available to children and young people with mental health issues | <ul style="list-style-type: none"> • Develop mental health support in community settings such as schools, clubs, hubs (Youth counselling and joint working with Public Health) • Implement IAPT for children and young people. |
| Improve existing mental health services for children and young people | <ul style="list-style-type: none"> • 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) |
| Improve targeted support for children and young people at particular risk of developing mental health problems | <ul style="list-style-type: none"> • Commission effective support for young carers. |

5.5 Our 1 & 2yr plan to support the long-term ambition (by organisation and to be finalised by 4th April)

| Parity of Esteem initiative | 2 year implementation plan |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Improved outcomes for people living with severe mental illness | <ul style="list-style-type: none"> • Agreement on outcomes and measures (OCCG) by April 14 • Negotiation into OH contract and CQUIN and/or implementation plan April 14 • Design/procurement solutions June 14 (OCCG) • New OBC services in place April 15 • Evidence of impact from April 15 |
| Improved mental health of people living with physical health problems | <ul style="list-style-type: none"> • Evaluation of current IAPT/LTC projects (OCCG and OH) April 14 • Pilot community psychological medicine service (OCCG and OH) to Sep 14; evaluation by Dec 14 (OCCG) • Implementation of revised urgent psychological medicine service from April 14 (OH) • Design and implementation of evaluated services by April 15 |
| Identification and support for young people with MH problems | <ul style="list-style-type: none"> • 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) |

Chapter 6: Patient services

6.1 Patient Services

- 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. 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.
- b. 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.
- c. 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. Meetings are held at different locations around Oxfordshire. Questions are invited in advance of the meeting and answered during the meeting. The questions and written answers are published on the CCG website.
- d. In addition to this ongoing approach, 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, it is hoped, will begin to be built into the commissioning 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 will inform the five year plan.
- e. The CCG works in close partnership with healthcare providers and Oxfordshire County Council and a number of engagement exercises are run jointly.

6.2 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 discussions 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.

6.3 **Our 5yr year ambition**

- a. Our 5 year ambition is to build on this work improving citizen engagement and widening participation to realise the goal of people being partners in healthcare.

6.4 **1 & 2yr plan to support the long-term ambition (by organisation and to be finalised by 4th April)**

- a. The CCG plan 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.

Chapter 7: Wider primary care provided at scale

7.1 OCCGs aim is to provide as much care as possible to where patients live and work. Developing primary care so that general practice is at the heart of integrated and wider out-of-hospital services is fundamental to achieving this aim.

7.2 **Our 5 year ambition is** to develop primary care across Oxfordshire which is high quality, cost effective, sustainable, and capable of playing a strong role at the heart of more integrated out-of-hospital services.

7.3 Our desired outcomes are:

- a. Primary care which can deliver better health outcomes, including more personalised care which addresses the increasing complex needs of people with multi-morbidity
- b. General practice which provides high quality care, including excellent patient experience
- c. Efficient use of resources within primary care
- d. Increased integration of primary, community, and intermediate care, and with out-of-hours services
- e. Primary care which has the capacity to be an effective player in the market, bidding for a range of contracts to deliver a wider range of out-of-hospital care at scale across the county

As a result, people will:

- f. Receive more care at home or in community settings, rather than in hospital
- g. Know who is co-ordinating their care and will be involved in planning their care
- h. Feel well supported to manage their long-term condition
- i. Have wider and more flexible access to appointments with GPs and practice staff through extended opening hours and increased use of email, Skype and phone consultations
- j. Experience high quality primary care

7.4 The objectives of our 1 and 2 year plan are:

- a. To produce an agreed vision and five year strategy for the development of primary care in Oxfordshire which addresses the role of practices in:
 - i. Providing more proactive coordination of care, particularly for people with long term conditions including dementia
 - ii. Providing more holistic, integrated care in the community
 - iii. Ensuring fast, responsive access to urgent care needs
 - iv. Preventing ill health, including more timely diagnosis and early identification of people at greatest risk of becoming unwell
 - v. Involving patients and carers more fully in their self care
 - vi. Ensuring high quality care, in particular the patient experience
- b. To produce and support the delivery of a plan for federated working in Oxfordshire which articulates the preferred function and form of federated working in the county so that primary care is in a position to:
 - i. Enter the market as a provider of services operating at scale across the county
 - ii. Develop more innovative and integrated primary and community services which deliver improved access and increased continuity of care
 - iii. Support effective urgent and emergency care pathways
 - iv. Address health inequalities more effectively in areas of both urban and rural deprivation
- c. To develop the leadership capacity of primary care so that leaders are identified and supported to act as strategic partners in provider discussions around changes in service delivery. This will ensure that primary care views are clearly voiced and considered in any

system level change, particularly in the development of models of integrated care provided out-of-hospital.

- d. To support improvement of the quality of general practice, working closely with the Local Area Team, to ensure that core GMS/PMS services as well as enhanced services improve and to address adverse performance variation.
- e. To develop change management capacity within general practice, through a programme of organisational development and incentives to ensure that changes are made at the practice level which will transform out-of-hospital care and improve access to services.
- f. These objectives will be achieved through:
 - i. A county wide project team with GP and practice manager representatives from each locality to develop the vision and strategy for the development of primary care in consultation with partners and the public
 - ii. Locality based engagement events with practices to discuss the need to develop primary care and to consider the options for how they might work together at scale to offer a wider range of services
 - iii. Provision of seed-corn funding to support federated working in the county
 - iv. Working with health and social care commissioners to identify contractual opportunities for primary care to bid to provide more integrated out-of-hospital care
 - v. Local investment schemes which support practices to provide more co-ordinated care, particularly for those people with multi-morbidity

Chapter 8: A modern model of integrated care

8.1 Our 5 year ambition for integration is to :

- a. Deliver joined up health and social care to the frail elderly, patients with multi-morbidities (particularly the top 2% of cost risk), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register through the creation of integrated, locality based, health and social care teams.
- b. Deliver anticipatory care plans and care co-ordination when unstable for those patients.
- c. Develop locality based 'hubs' that are community facing and offer rapid access, multi-disciplinary health and social care team assessment for diagnosis and care planning.
- d. Move to acute hospital stays that are as brief as needed, so the patient moves to the most appropriate place as soon as possible without delay
- e. Help primary care develop to work better together and improve joint working with community, social care and secondary care.
- f. Develop the primary care provider community so that GP services can contribute and potentially lead integrated care services
- g. Have named social and community healthcare link workers assigned to each general practice and embedded within locality based integrated health and social care teams
- h. Have clearly defined roles and responsibilities within urgent and emergency care pathways
- i. Deliver a new jointly commissioned service model that delivers shared outcomes for patients across the system
- j. Provide 7 day working in health and social care
- k. Improve the integration of physical and mental health care
- l. Integrate prevention work commissioned and undertaken by OCC, NHS England and OCCG

8.2 The actions we are taking to progress delivery of this vision over the next two years are:

- a. Supporting a comprehensive primary care development programme (see chapter 7)
- b. Contracting for outcomes for the frail elderly, those with complex LTCs and MH patients within the framework of the standard NHS contract across our provider community, to ensure integrated delivery by our community and acute providers
- c. Developing and contracting for a sub acute pathway designed to support admission avoidance and early discharge
- d. Specifying the functions, outcomes and characteristics we require of integrated health and social care community teams within our contract with OHFT and our Better Care Fund agreement with OCC
- e. Moving resources, via the Better Care Fund to support :
 - i. More personalised home support which removes short visits
 - ii. Dementia support
 - iii. Family carer support
 - iv. Equipment and assistive technology
 - v. Information and advice
 - vi. Discharge to assess care service
 - vii. Increased spend on reablement and rehabilitation
 - viii. Increased investment in carers breaks
 - ix. Investment to support people to die at their usual place of residence
 - x. Sharing of data
 - xi. Data co-ordination (dementia and co-morbidities)
 - xii. day working
 - xiii. Increased demand for funded nursing care and continuing healthcare
 - xiv. Integrated support for hospital admission avoidance
- f. Strengthening the availability of psychiatric liaison in primary, community and secondary care settings to ensure integration of physical and mental health care teams; embedding older adult mental health care within integrated health and social care community teams;

supporting the local MH triage pilot in partnership with Thames Valley Police; working with Oxfordshire Safer Communities Partnership to improve rapid access to physical and mental healthcare for vulnerable adults.

- g. Developing and delivering an integrated approach to prevention and early intervention with OCC, NHS England and our third sector partners.

8.3 Measuring progress

- a. Please see chapter 2 for the Outcomes we want to achieve from delivery of a modern model of integrated care.

Chapter 9: Access to the highest quality urgent and emergency care

9.1 Alignment of our vision with Professor Keogh's report

Our vision aligns with the Keogh report in that we are:

- a. Scoping the provision of Ambulatory Care Pathways (ACPs) to support the management of patients with urgent care needs without recourse to admission for diagnosis or treatment. The development of ACPs will coincide with the further expansion of Emergency Multidisciplinary Units (EMUs) and EMU pathways, which offer community based management of frail elderly adults. These services will support the rapid care of patients and return to their home, reducing the number of patients with a length of stay of less than 24 hours.
- b. Analysing the need for a model to refer patients presenting at ED whose need is not urgent and could be safely signposted to community based or primary care services, which will enable patients suitable for management within the community to be assessed, treated if appropriate or signposted to services, avoiding inappropriate attendance and queuing in A&E. This work will be supported by the continuation of Choose Well and other patient education campaigns, to support patients in accessing the right care, first time.
- c. Reviewing the provision of Minor Injury and First Aid Units across Oxfordshire to ensure that patients can optimise their access to care outside of A&E. A planned needs assessment will determine how best to deliver care within the county and in particular within Oxford and inform whether a MIU should be developed for patients within the city.
- d. Supporting OUH in its role as a regional stroke and trauma centre, consolidating expertise and services to manage patients with more serious or life threatening emergency needs. OCCG will work with partner organisations to consider how to most effectively provide such care across the county and the delivery of urgent care across two acute sites- the John Radcliffe and the Horton.
- e. Developing patient transport services to further support effective discharge of patients, following the provision of Winter monies to enable additional evening journeys.
- f. Exploring the potential to provide transportation to GP practices for patients requiring rapid assessment in the community. This may enable earlier referral to hospital for patients requiring such care, reducing the 'bunching' of admissions in the afternoon and increasing the likelihood that patients can be discharged on the same day, improving the patient experience.
- g. Increasing the number of patients receiving appropriate care and management by telephone through 111 and Out of Hours consultations, reducing the number of patients required to travel to a primary care base, particularly during evenings and weekends, for care.

9.2 Developing the footprint for our urgent and emergency care network

- a. OCCG will work with partners across a variety of fora to determine the footprint of the urgent and emergency care network
- b. Principally this will be led by the Urgent Care Working Group, which comprises senior representation from organisations across health and social care in Oxfordshire, who ensure the delivery of the system wide improvement plan. This covers programmes across all stages of patient flow including caring for patients closer to home, admission avoidance and facilitation of discharge.
- c. These groups will link with the Health and Wellbeing Board to determine the most pressing needs for the population identified within the Joint Strategic Needs Assessment. Whole system programme boards will use evidence based analysis and recommendations, as well as local needs assessments to determine and deliver commissioning intentions. The Urgent

Care Working Group will oversee the flow of patients in the community, into ED and through to discharge to ensure that the development of services are aligned across all organisations.

9.3 Beginning the process of designation for all facilities within our network

- a. The Urgent Care Working Group will co-ordinate the development work to designate all facilities within the urgent and emergency care network during 2014/15. A programme of provider and patient engagement, furthering the work within the Joint Strategic Needs Assessment, will inform the shape of urgent and emergency services within the county.

9.4 5yr year ambition for urgent care

- a. The ambition is to develop an urgent and emergency care strategy for Oxfordshire based on the full Urgent and Emergency Care review (including unpublished phases). This will include a full analysis of relevant health and social care services across the county and the refining of such services in line with Prof Keogh's vision of specialised centres to manage emergency cases.

9.5 1 & 2yr plan to support the long-term ambition

- a. Support appropriate management of patients in the community via the development of:
 - i. Primary care triage at ED
 - ii. Ambulatory care pathways
 - iii. Minor Injury and First Aid Units
 - iv. Emergency Multidisciplinary Units and pathways
 - v. Patient Transport services
 - vi. 111 and Out of Hours services

Chapter 10: A step-change in the productivity of elective care

- 10.1 There is a two year plan to take approx. £4million out of the local spend on elective activity. Given the current national trend for referrals into elective services to be increasing nationally there are limits to the reductions that can be achieved locally. It is recognised that the tensions between better patient care, less resource and increasing demand given local demographics makes it harder to reduce spend.

| | 2 year net savings |
|----------------|--------------------|
| Diagnostics | 292485 |
| Pathway review | 3488602 |
| 1st Outpatient | 249944 |
| Dementia | -17806 |
| Total | 4013225 |

- 10.2 The reduction will be achieved through a combination of the following actions:

- a. The CCG will invest in primary care capacity to continue thorough peer review of first outpatient referrals, in order to drive down variation.
- b. The OUH have a project running until Sept 14 to completely redesign all their outpatient clinic templates. This will increase the efficiency of clinics and create additional capacity in specialties with the greatest flows in.
- c. The CCG planned care team has a number of GP leads across key specialties who are able to audit adherence to thresholds and referral guidelines both in primary and secondary care. Specialities with GP leads are:
 - i. T/O
 - ii. Gynae
 - iii. Urology
 - iv. Gastro
 - v. Dermatology and Plastics
 - vi. Cancer
 - vii. Diagnostics – pathology and imaging
 - viii. Ophthalmology
 - ix. ENT
- d. In 2010 the then PCT worked with OUH on ensuring that those procedures that could be carried out as outpatient procedures but were being done as day case were charged to the commissioner at the lower outpatient tariff. These business rules will now be reapplied.
- e. It is key to ensuring efficiency that patient pathways are clear and lead to the patient being treated at the right time, in the right place and in the right way. The CCG is using its planned care GP leads to refresh existing patient pathways and develop new ones. Clear patient pathways help go against the default position that referral to a surgeon will result in a surgical procedure in all cases.
- f. The introduction of DXS will make it much easier for GP's to access these on practice systems alongside patient decision aids

- g. The CCG is also planning to expand its use of the wider healthcare market in the next five years. Given pressures on the main acute provider in terms of capacity and demand, making better use of the private provider facilities in the county makes sound sense. There is recognition that prices may not be lower in the independent sector but that there is more will to discuss and agree total price patient pathways across specialties. This would make it easier to project spend across the financial year. Specific elective pressure points sit within the following specialities:
- i. Trauma and orthopaedics
 - ii. Ophthalmology
 - iii. ENT
 - iv. Gynaecology
 - v. Dermatology
 - vi. Plastics
 - vii. Gastroenterology
- h. Two of the independent sector providers that the CCG contracts with have expressed an interest in expanding the services they offer via Choose and Book. Recent guidance from Monitor allows CCG's to effectively accept qualification to provide services through contracts held by other CCG's (but only if local site is qualified through CQC for that speciality)
- i. The CCG is aware of both the opportunities that the expansion of the independent sector brings but also the challenges. Cost pressures created in podiatry and audiology provision under Any Qualified Provider have been challenging.

10.3 5yr year ambition

| 5 year endpoint | 2 year implementation plan |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| Reduction in follow up model applied to all seven high volume specialities to reduce follow up | 2014/15 Reduction in follow ups in T/O |
| | 2015/16 Reduction in follow ups in ophthalmology |
| Move from 0.06% elective spend within private providers to 5% in 2019 | 2014/15 Expansion of services offered by private providers |
| All specialities have access to consultant led e mail advice services by 2019 | 2014/15 Expansion of email services to expanded range of specialities |

10.4 1 & 2yr plan to support the long-term ambition

- a. In 13/14 projected £112 million full year spend projected 13/14 across elective points of delivery.
- b. Plan from 2014 to 2016 to reduce by £3 million (2.75% reduction)
- c. Plan from 2016 to 2019 to reduce by £2 million
- d. Total reduction 2014 – 2019 from 112 to 106 million

Chapter 11: Specialised services concentrated in centres of excellence

The CCG is working closely with NHS England to ensure appropriate alignment of assumptions and improvement interventions within specialist services. The significant level of tertiary services present within Oxfordshire presents a real opportunity and risk for the system as a whole.

Chapter 12: Access

12.1 Convenient access for everyone

- a. Oxfordshire CCG is committed to improving access for patients to the right service, first time 24 hours a day 7 days a week. More services will be accessed outside of acute hospitals in a closer to home community setting.
- b. Patients will have improved access to a full range of providers in an emergency, urgent or planned care episode. They will have greater support in making these decisions should they need it through an improved 111 service and access to locality based information on finding the right service first time through a variety of sources including posters, local media and social media type solutions.
- c. Patients may initially access health care through primary care (in and out of hours), ambulance and A&E for the first step in their patient journey. However all too often the next steps have been too complex and difficult for patients to navigate.
- d. In the community settings the Single point of access to community care will expedite the next steps to ensure rapid 0 to 2 hour response times.
- e. Mental health services and community services will have extended opening times and will be available 7 days a week.
- f. Patient's from minority groups will have better information and will be actively supported to access services, such as screening programmes. Patients with mental health needs often find it difficult to access services and as such their physical and mental health may suffer, we will work closely with voluntary sector organisations and providers to change this.

12.2 Primary Care

- a. **5 year Ambition:** As part of our ambition to develop more innovative and integrated primary and community services, we will develop primary care across the county so that it has the capacity to deliver improved access to patients. This will include:
 - i. Increased access to appointments with GPs and practice staff through extended opening hours
 - ii. Increased use of on-line booking of appointments
 - iii. More flexible access to treatment and advice through increased use of email, Skype and phone consultations
 - iv. Increased support to people experiencing poverty and socio-economic disadvantage and recent immigrants who may need particular help in accessing health services effectively
- b. **1 & 2yr plan for primary care to support the long-term ambition**
 - i. Supporting practices to work together at scale to provide increased access to care, using seed-corn funding to promote federated working.
 - ii. Sharing the learning from practices that secure Challenge Funding to test new models of providing access to primary care.
 - iii. Using Local Investment Schemes to enable practices to review and if appropriate restructure how they use their clinical resources so that GPs are able to offer a wider range of appointments
 - iv. Working with voluntary services and local authority partners to provide information and advice to those in greatest need of support to access health services appropriately

- v. Supporting the development of PPGs , so that they have the capacity and capability to help practice improve access

12.3 Community Care

a. 5 year *Ambition*

- i. We will be completing the multidisciplinary transformation programme to support admission avoidance pathways with a specific focus on people with multimorbid long term conditions who are of older age.
- ii. For the more rural areas this will be through GPs and other healthcare services (e.g. Outpatients, Out Of Hours) referring to specific units (Abingdon and Witney).
- iii. For people living in or close to Banbury and Oxford we will be working with the current providers of emergency services to make optimal use of the ambulatory care pathway. This will ensure adaptation of the current services in line with the needs of people with multimorbid long term conditions who are of older age and ensure the avoidance of unnecessary admissions

b. 1 & 2yr plan to support the long-term ambition

- i. We will commission community services that are accessible on a seven day a week basis with a two hour response time for the people in need of urgent care.
- ii. There will be a single point of access for the whole county and in addition there will be an access point in each locality.
- iii. The Single point of contact will provide a responsive service through a multidisciplinary service, (specifically this means all health and social care) which will complete a whole person assessment, inclusive of mental and physical health needs.
- iv. There will be timely access to an appropriate care package co-ordinated and monitored by a named lead clinician as required.

12.4 Mental Health

a. **5yr year ambition:** People will have 7 day a week, 24 hour responsive mental health services that are viewed as an integral part of the whole health care system. Patients with mental health needs will have greater support to ensure they have full access to all of the mainstream services such as NHS health checks and screening programmes.

b. 1 & 2yr plan to support the long-term ambition

- i. There will be improved information and advice about mental health through a
- ii. Mental Health Information Service that is available on-line 24/7 (<http://www.oxmindguide.org.uk/>) and during office hours by telephone.
- iii. Psychological Therapies - Oxfordshire's IAPT service is accessible by GP and self-referral. Appointments are offered within 28 days of referral. Services are available during office hours which are extended to 8.30-7.30 Tues/Weds/Thurs.
- iv. Community Mental Health Services- Services are accessible by self, third party and GP referral. From April 2014 services will be accessible from 0700-2100 7 days a week. Services are accessible by phone and at a network of local hubs.
- v. OCCG commissions a Well Being service from Oxfordshire Mind that offers advice, information and practical support from a wide range of locations across the county which act as an additional front door located in local communities for people with mental health problems.

- vi. Acute Mental Health Services GPs needing a psychiatric opinion will be contacted within 15 minutes of their call. Oxfordshire is piloting a joint DH/Home Office pilot to embed mental health nursing staff alongside police to support responsiveness to people in crisis. People in crisis will be assessed by the assessment teams between 0700 and 2100 and by the emergency duty team outside of these hours. Patients will be able to access crisis day services as an alternative to admission.
- vii. Psychiatric liaison will be provided from 0800 to 0800 in the Emergency Department of our local general hospitals, with extended hours on Sundays and Mondays to reflect the patient flow through the ED department.

12.5 Access for minority and vulnerable groups

a. 5yr year ambition

Our ambition is to:

- i. Reduce health inequalities, to ensure that the most vulnerable in society get better access to health improvement initiatives and care, better quality of services, and improvement in their health outcomes.
- ii. Ensure all of our commissioned services will continue to be performance managed in line with the Equality Act 2010 to ensure that barriers to access are overcome eg alternative communication, physical and attitudinal barriers.
- iii. Develop outcomes based commissioning for people with mental health problems that will deliver personalised care planning that delivers outcomes through a focus on the individual's practical, emotional and cultural needs.
- iv. Continue to provide dedicated community mental health services based in homelessness hostels and to work with our providers to identify and support military veterans with mental health problems in the community.
- v. Continue to deliver specific programmes around the needs of children and young people transitioning into adult services, carers, people with co-morbid drug and alcohol and mental health problems and groups such as the local Chinese and Polish communities.
- vi. Ensure that our Equality and Access Teams support targeted health improvement initiatives with minority communities and vulnerable group – for example by leading on health partnerships in five Regeneration Partnerships in Oxford City; targeted campaigns with minority communities eg dementia awareness, Choose Well, Public health campaigns, implementation of the Oxfordshire Carers Strategy and delivering targeted approaches to improve uptake of screening and immunisations and life-style services.

12.6 Access to Urgent Care

a. 5yr year ambition: Oxfordshire CCG will continue to work with its partners across health and social care to provide the right care, first time and support the effective management of patients seeking urgent care services

b. 1 & 2yr plan to support the long-term ambition:

- i. Following the successful introduction of 111 locally in September 2012 and a national review of the 111 service by NHS England due in 2014, OCCG will tender for a revised 111 service during 2014-15 to begin during 2015-16. 111 supports patients to access the most appropriate care based on their need and location
- ii. OCCG will make greater use of the data 111 provides about service access to inform future commissioning decisions, ensuring that urgent care services are available at times and in places that are convenient to patients
- iii. OCCG will continue to work with South Central Ambulance Service (SCAS), the provider of 111 across Oxfordshire, Buckinghamshire, Berkshire, Hampshire,

- Southampton and Portsmouth and the relevant CCGs to manage the service in a cohesive and streamlined way.
- iv. Ambulance demand continues to increase year on year; the volume of total Ambulance Service activity is up 8.3% year to date compared with the same period last year (April to November).
 - v. OCCG will continue to incentivise SCAS to increase the number of patients managed without an ambulance arriving on scene- 'hear and treat' or managed within the community- 'see and treat' while reducing inappropriate conveyances to hospital.
 - vi. OCCG will support SCAS to implement NHS Pathways as the triage tool within the 999 service, which will enable ambulance staff to use their resources more effectively to meet the needs of patients by determining the type of response required prior to arrival on scene.
 - vii. OCCG will work with its commissioning partners across South Central to ensure SCAS are managed in a co-ordinated manner. Focus continues on ensuring patients arriving at hospital are transferred to the care of hospital staff in a timely manner, providing optimal patient care and ensuring that ambulances are able to respond to the next call as quickly as possible.
 - viii. OCCG will continue to offer patients alternatives to A&E for their urgent care needs. The national review of A&E services by Professor Bruce Keogh will inform the provision of Minor Injury and First Aid Units across the county, to ensure that patients are able to access services that will care for them rapidly and in convenient locations.
 - ix. OCCG will review the need for a Minor Injury Unit within the city of Oxford, where patients currently have to travel outside of the ring road if they wish to access such services. This work will be supported by the continuation of the Choose Well campaign, which empowers patients to identify which service would best meet their needs, such as accessing a pharmacy for medication advice.
 - x. The CCG will work with Oxford University Hospitals (OUH) to scope and further develop ambulatory care pathways, which enable patients to be treated with access to necessary diagnostic tests without being required to be admitted to a bed. Ambulatory care not only improves the patient experience, as they are supported to return home as quickly as possible, but also supports hospitals in managing demand for beds. This work will integrate with the further development of Emergency Multidisciplinary Units (EMUs). These measures will support OUH to achieve the four-hour standard and ensure that patients are assessed in a timely manner when seeking urgent care.

12.7 Planned Care Access

- a. The CCG will work closely with localities to ensure that elective activity services are accessible to all sections of the Oxfordshire population. It will ensure that services meet the required equality legislative standards and be appropriate for the diverse population the CCG serves.
- b. Whilst recognising that not every market town can have access to every elective procedure the CCG supports the use of peripheral clinic sites where appropriate.
- c. When procuring new elective services or agreeing to clinic or service site moves access is a key criteria for the CCG and this includes access for those reliant on public transport.
- d. The main provider Trust operates an access policy for its elective services setting out its commitment to meet NHS Constitution requirements. Where this fails, the CCG will invoke the measures outlined in the NHS Constitution Standards section including the use of contract levers and fines.
- e. The CCG is aware of the barriers to services that can be in place for disadvantaged and minority groups and makes active use of advocacy services.

Chapter 13: Meeting the NHS Constitution standards

13.1 Baseline position

| Measure | Definition | Standard | Lower Threshold | Reporting period | Month Actual | 13/14 YTD Actual | Indicator RAG |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------------|------------------|--------------|------------------|---------------|
| RTT waiting time for non-urgent consultant-led treatment | RTT - admitted % within 18 weeks | 90% | 85% | Dec-13 | 88.86% | 91.35% | |
| | RTT - non-admitted % within 18 weeks | 95% | 90% | Dec-13 | 96.80% | 96.99% | |
| | RTT - Incomplete % within 18 weeks | 92% | 87% | Dec-13 | 90.77% | | |
| | Number of patients waiting more than 52 weeks | 0 | 10 | Dec-13 | 1 | | |
| | RTT - admitted pathways greater than 52 weeks. | 0 | | Dec-13 | 2 | | |
| | RTT - non-admitted pathways greater than 52 weeks. | 0 | | Dec-13 | 0 | | |
| | RTT - Incomplete pathways greater than 52 weeks. | 0 | | Dec-13 | 1 | | |
| Diagnostic Wxns | % waiting 6 weeks or less | 99% | 94% | Dec-13 | 98.17% | | |
| A&E - OUHT | % of patients who spent 4 hours or less in A&E - OUHT | 95% | 90% | Jan-14 | 87.13% | 93.41% | |
| | Patients who have waited over 12 hours in A&E from decision to admit to admission | 0 | | Dec-13 | 0 | 0 | |
| A&E - RBFT | % of patients who spent 4 hours or less in A&E - RBFT | 95% | 90% | Jan-14 | 88.13% | 93.51% | |
| Cancer 2 week waits | Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer | 93% | 88% | Dec-13 | 94.90% | 94.85% | |
| | Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected | 93% | 88% | Dec-13 | 98.48% | 94.85% | |
| Cancer 31 day waits | Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis | 96% | 91% | Dec-13 | 97.44% | 97.74% | |
| | Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is Surgery | 94% | 89% | Dec-13 | 90.00% | 97.18% | |
| | Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is an Anti-Cancer Drug Regime | 98% | 93% | Dec-13 | 100.00% | 99.46% | |
| | Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course | 94% | 89% | Dec-13 | 80.72% | 91.30% | |
| Cancer 62 day waits | Percentage of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer | 85% | 80% | Dec-13 | 80.29% | 83.21% | |
| | Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service | 90% | 80% | Dec-13 | 96.46% | 94.71% | |
| | Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status. | No Targets | | Nov-13 | | 100.00% | No Targets |
| Category A ambulance calls | Cat A response within 19 mins | 95% | 90% | Dec-13 | 94.80% | 95.43% | |
| | Cat A response within 8 mins - Red 1 | 75% | 70% | Dec-13 | 81.40% | 78.89% | |
| | Cat A response within 8 mins - Red 2 | 75% | 70% | Dec-13 | 71.94% | 74.77% | |
| MSA Breaches | Mixed Sex Accommodation | 0 | 10 | Dec-13 | 0 | 5 | |
| Cancelled operations | All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another booking date within 28 days, or the patients' treatments to be funded at the time and hospital of the patient choice | 0 | 0 | Sep-13 | 2.63% | 10.90% | |
| | Urgent operations cancelled for a second time | 0 | 0 | Dec-13 | 0 | 0 | |
| Mental Health | Care Programme Approach (CPA) The proportion of people under Adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period | 95% | 90% | Sep-13 | 97.70% | 96.74% | |
| Local Priorities | Increase flu immunisations for at risk under 65's (excl. pregnant women and carers) | 55% | | Dec-13 | 51.93% | 51.93% | |
| | Increase the % of radiology requests made via the ICE system as a proportion of the total number of requests made by GPs to the OUH radiology service | 80% | | Jan-14 | 85.75% | 68.41% | |
| | Reduction of average length of delay for those OUHT patients classed as DTCC: baseline 15 days | 13.5 | | Apr-13 to Dec-13 | N/A | 16.6 | |
| Ambulance Handover Time (JRH) | Percentage of Ambulance handovers within 15 mins | 85% | | Jan-14 | 73.11% | 68.86% | |
| Ambulance Handover Time (HGH) | Percentage of Ambulance handovers within 15 mins | 85% | | Jan-14 | 92.40% | 81.81% | |

The table above summarises the baseline position in terms of performance against constitution standards in Oxfordshire at the end of January 2014. Our ambition is to be meeting all standards by the end of year 2, and to be sustainably compliant by the completion of this plan.

13.2 RTT

- a. The main provider Trust is struggling to meet RTT consistently across the following specialities:
- b. ENT, Ophthalmology, Neurology, Plastics, Gynae
- c. The predicted clearance time is running at 12 weeks across the Trust with over 10.000 patients on the outpatient waiting list.
- d. The CCG intends to take action to offer to move patients from the main Trust if there is no assurance that patients will be treated within the standards set out in the constitution.

13.3 DIAGNOSTIC TEST WAITING TIMES

- a. The CCG monitors the 6 week diagnostic target as part of the 18 week referral to treatment pathway.
- b. The CCG has worked closely with providers in 13/14 to ensure accurate timely information is available to ensure this target is monitored and consistently met. In 14/15 the CCG will meet regularly with the OUH diagnostic teams to ensure early action is taken to remedy poor performance.
- c. In 2014/15 the CCG will jointly implement an improvement intervention plan with the OUH to improve diagnostic imaging capacity in localities, reduce unnecessary imaging and improve turnaround times. The CCG will work with the laboratories and GPs to ensure clinicians request the most appropriate investigations for patients and it is hoped that this will reduce demand in other clinical areas.
- d. Diagnostic tests are continually changing and improving and over the next 5 years the CCG will continue to work with its providers to ensure patients receive appropriate investigations in a timely manner.

13.4 A&E 4 hour WAITS

- a. OCCG works closely with partners across health and social care to manage patients appropriately in the community and avoid unnecessary attendances at A&E. The focus for the system is to create flow and capacity within A&E for those patients whose acuity requires care in an acute setting by providing community based alternatives to patients with lower needs in locations closer to home. Such services lead to reduced 4 hour waits for patients by reducing the volume of patients attending A&E.
- b. The Urgent Care Working Group leads the development of services to ensure that patients access the right care, first time. The Working Group comprises senior representation from organisations across health and social care in Oxfordshire, who ensure the delivery of the system wide improvement plan. This covers programmes across all stages of patient flow including caring for patients closer to home, admission avoidance and facilitation of discharge. The Urgent Care Working Group co-ordinates actions to increase flow and capacity and prioritises development according to the greatest benefit such work will bring to the system.
- c. Organisations across the health and social care system actively work to maintain patients in the community, providing services to support independence, such as the Single Point of Access, which provides health and social care through one referral point. Patients with chronic conditions, or those experiencing an acute episode of illness, can be assessed, managed and maintained in their home or a community setting without requiring admission to an acute bed, through the provision of social care equipment, domiciliary or nursing care. During 2013/14, Emergency Multidisciplinary Units (EMUs), and pathways which provide rapid care for the frail elderly by specialist medical staff such as gerontologists, were expanded to four locations across the county, further supporting the management of patients in the community.

- d. The availability of Minor Injury and First Aid Units across the county support patients to access care without attending ED. The further development of such services will be reviewed as part of OCCG's response to the Urgent and Emergency Care Review Phase One Report. The flow of patients to alternatives to A&E is further supported by the development of 111, which was successfully implemented in Oxfordshire in September 2012. 111, supported by a comprehensive Directory of Services, enables patients to be directed to the most appropriate, local service to meet their needs. OCCG will make greater use of the data 111 provides about service access to inform future commissioning decisions, ensuring that urgent care services are available at times and in places that are convenient to patients. This work will be supported by the continuation of the Choose Well campaign, which empowers patients to identify which service would best meet their needs, such as accessing a pharmacy for medication advice.
- e. OCCG will continue to benchmark performance against similar health and social care systems and learn from best national practice. OUH invited the Emergency Care Intensive Support Team (ECIST) to review its practice and identify where further benefits for patients could be achieved. The learning from such best practice has been included in the system wide improvement plan.
- f. Health and social care organisations worked jointly prior to Winter to identify where additional resources could most effectively support flow during periods of increased pressure. A robust programme management approach was taken to assure performance each week. Senior decision makers across the system regularly reviewed the allocation of resources and were empowered to move capacity to where it would have the greatest effect.

13.5 CANCER WAITS

- a. There are targets being missed by the main provider trust relating to cancer waits. The CCG will continue to work closely with the Trust to ensure patients are being treated within the standards of the constitution.
- b. It will continue to use the levers within the contract to ensure performance is recovered to meet these targets. Plans for 2014 include strengthening of the MDT with all tumour sites covered.
- c. The roles of the patient tracker team are being revised and an overseeing audit and validation post is being recruited to ensure the standards they work to.
- d. Additional radiotherapy sessions are being run at weekends.

13.6 CAT A AMBULANCE CALLS

- a. OCCG commissions emergency ambulance services in partnership with other CCGs across South Central (Milton Keynes, Buckinghamshire, Berkshire, Hampshire, Southampton and Portsmouth from South Central Ambulance Service NHS Foundation Trust (SCAS). OCCG ensures that the rights and pledges within the NHS Constitution are met through robust contract management and quality monitoring with monthly meetings to monitor and address both aspects of performance.
- b. Year to date, SCAS have met the key performance indicators for ambulance calls, which require an ambulance vehicle to arrive on scene within 8 minutes in 75% of cases and for an ambulance capable of conveying the patient to hospital to arrive on scene within 19 minutes in 75% of cases. SCAS are contracted to meet these targets across Oxfordshire and Buckinghamshire.
- c. OCCG works closely with SCAS to support performance at district council level (e.g. Vale of the White Horse), where due to the low number of emergency calls and the rural nature of the road network, performance can be more challenging. SCAS are increasing the number of Community First Responders, who are equipped with defibrillators, in rural areas to ensure patient safety. In addition, commissioners are incentivising 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, treat and convey'. This will support the availability of ambulance vehicles to attend patients with life threatening conditions and patient flow through the urgent care system.

- d. During the next year, SCAS will implement NHS Pathways, the triage tool used within the 111 telephony service, within 999. This change will allow SCAS to determine the type of response that the patient requires, the most appropriate service to meet their needs and if an ambulance is required, the type of vehicle to attend on scene. This will allow them to make more efficient use of their resources, further supporting achievement of the ambulance call standards.

13.7 MIXED SEX BREACHES

- a. OCCG recognises that eliminating mixed sex accommodation has a key role to play in supporting patients privacy and dignity. Providers report breaches to delivering single sex accommodation to the CCG on a monthly basis as part of contractual arrangements. This includes an explanation as to whether these breaches are clinically justified or not.
- b. Where non clinically justified breaches occur the CCG will enforce contractual penalties and escalate through the contract performance clauses where required
- c. Where clinically justified breaches occur the CCG will work with providers to review demand and capacity. In 2014/15 we will jointly review capacity on Stroke Units to assess if improvements can be made.
- d. Our plan over 5 years would be eliminating clinically justifiable breaches as well as sustaining improvements in non-justifiable breaches.

13.8 MENTAL HEALTH

- a. We will continue to manage within our contract with Oxford Health NHS Foundation Trust's Oxfordshire's performance against the proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%

13.9 A&E WAITS FOR ADMISSION

- a. OCCG continues to support partners across health and social care to manage patient flow and support the safe, effective and timely discharge of patients from bedded care to ensure that those attending A&E requiring admission are cared for within the national standards.
- b. Providing holistic care for the frail elderly within Emergency Multidisciplinary Units (EMUs), where patients have rapid access to specialist medics, social workers and community nursing to arrange care within their home, enables patients at risk of admission to be cared for within the community. During 2013-14 OCCG expanded the number of EMUs from one, in Abingdon, to four, at Witney, Oxford and Banbury. These units will be supported to continue treating patients in the community.
- c. Where possible, OCCG will encourage OUH to manage appropriate patients along an ambulatory care pathway, where patients have rapid access to diagnostic assessment and care without recourse to admission within the acute setting. Such ambulatory care pathways allow patients to be triaged, treated and returned home without staying overnight.

13.10 CANCELLED OPERATIONS

- a. There has been an issue with the Trust providing validated data on cancelled operations. Ensuring that the CCG is commissioning using accurate data and intelligence is key.

- b. If the main trust cannot provide assurance that it can treat patients within the standards set within the constitution for listing and then treating patients then the CCG will look to move cohorts of patients to alternative providers.

13.11 AMBULANCE HANDOVERS

- a. OCCG continues to support SCAS and OUH to achieve ambulance handover targets. During 2013/14 this included:
 - i. The introduction of dual verification to improve the accuracy of recording when ambulances arrive and transfer a patient to the care of hospital staff
 - ii. The provision of Hospital Ambulance Liaison Officers (HALO) over Winter to support ED staff receiving ambulance patients and efficient transfer of care
 - iii. The reconfiguration of receiving bays within the Emergency Department, to increase the capacity and responsiveness of ED staff to take incoming patients.
 - iv. The provision of additional nursing and medical staff during Winter and other periods of high demand to increase capacity.
- b. The delivery of Ambulance services is part of the wider plan to increase patient flow through the urgent care system. The strategies to decrease inappropriate attendance at ED, through the use of community alternatives such as Minor Injury Units or Ambulatory Care Pathways, will reduce overall demand for ED services. Indirectly, such strategies support the achievement of ambulance handover, by increasing the capacity of ED staff to receive incoming ambulances. Specific focus on the handover process will continue over the next two years, such as a review of the benefit of HALO staff.

13.12 5yr year ambition

- a. The ambition is to ensure we are sustainably compliant with all constitution standards by year 5.

13.13 1 & 2yr plan to support the long-term ambition

- a. Deliver the planned and urgent care improvement interventions described in this strategic plan, in order to ensure full compliance within 2 years.

Chapter 14 : Quality

14.1 Quality of Healthcare

- a. The centrality of quality to NHS commissioners has been eloquently and amply set out, most recently in the reviews of Berwick, Keogh and Francis. 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. OCCG aims to:
 - i. develop a focus on quality that transcends organisational boundaries and covers all aspects of care, from birth to death;
 - ii. ensure quality is integral to all healthcare services across Oxfordshire
 - iii. ensure quality is everybody's business: public, patients, NHS staff, family and carers;
 - iv. support all stakeholders to raise concerns and/or lead improvement;
 - v. use measurement for quality where possible while acknowledging that not everything which is important can be measured;
 - vi. strive for continuous quality improvement.
- e. These aims have been agreed by the governing body and are detailed in our Quality Statement approved in November 2013.
- f. The CCG operate a "Clinical Assurance Framework, approved January 2104. 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."
- g. We will continue to develop this framework and where possible in 14/15 publish all quality and performance reports and related documents on the CCG web site.

14.2 Patient safety

- a. The CCG review 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 RCAs 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. Reduce the number of medication errors by working with key providers;
 - 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.

14.3 Clinical Effectiveness

- a. The CCG review a wide range of clinical audits and NICE guidance and it would be impractical to detail all initiatives; key areas of improvement for 2014/15 is detailed below:
 - i. Continue to reduce mortality rates in the acute sector by enhancing mortality review meeting 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;
 - iv. Improving care for inpatients suffering from pneumonia by redesigning the patient pathway.

14.4 Patient experience

- a. The CCG review a wide range of information relating to patient experience and it would be impractical to detail all initiatives; key areas of improvement for 2014/15 is 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 to address areas for improvement
 - iii. Use patient experience data as a lever to drive up quality
 - 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 reprofiling outpatient capacity to match demand.
 - vi. Enhancing the discharge process for patients

14.5 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 score.
- b. There are active discussions with senior leaders in nursing to develop a culture of partnership with patients and carers 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, 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 DoN & MD NHS England supporting this approach.
- c. 5 Year ambition for this work is to have this embedded across all staff groups achieving an outcome of where communication, care, communication and competence are sighted less frequently in patient feedback and complaints.

14.6 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. 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 surveys alongside patient surveys in conjunction with other quality metrics to evaluate the quality of services being provided.

14.7 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 (Accident and Emergency, community and acute hospitals, and Emergency Medical Units). We have also incentivised social care providers to pick up clients within 72 hours, including Fridays and over the weekend. The Emergency Duty Teams also ensure there is support available 24 hours a day, 7 days a week.
- b. This will be developed further with OCC through our Better Care Fund plan and is being progressed by the CCG through contract development and negotiation with providers.

14.8 Safeguarding

- c. The mandate from the government is that we are expected 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. To achieve this we are required to prevent and reduce the risk of abuse or neglect through continuing to improve safeguarding practice.
- d. It is the aim of OCCG that we will ensure consistent, safe, effective and respectful care is provided to every patient. All staff will be able to accurately 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 local quality health 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
- e. 1 & 2yr plan to support the long-term ambition (by organisation and to be finalised by 4th April)
 - 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 in the functioning and development of the OSCB, OSAB of all health commissioners and providers.
 - iii. Ensure that representation and involvement in the work of the Health and Well-Being Board is integrated into safeguarding.
 - iv. 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.
 - v. Review and develop assurance frameworks that demonstrate all providers have effective safeguarding arrangements.
 - vi. Review and develop assurance frameworks that demonstrate all providers are using the Mental Capacity Act appropriately and whenever it is required.
 - vii. To ensure all providers are complaint with the Prevent Agenda.
 - viii. Work with partners and colleagues to develop a learning and development framework that enables lessons to be learnt and shared across the locality

14.9 Innovation

- 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 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 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 documents has been developed by the Thames Valley Lead Pharmacists and links to local plans around 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 an expensive and disabling 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. As well as collaborating in undertaking applied health research, the CCG is committed to rapid implementation of best practice - for instance in rolling out and evaluating the local implementation of patient self-management of their blood pressure, shown to be more effective than usual care. We have started using text messaging to facilitate patient engagement. This is being piloted in the city locality then planned to roll out countywide.
- f. **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.
- g. 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 AHSN and the Oxford NIHR Biomedical Research Centre.
- h. 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 homes, and those with chronic enduring illnesses and comorbidities, the highest users of NHS services.
- i. 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.

- j. Oxfordshire 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 IH&W. OCCG will make full use of other NICE guidance in accordance with the NICE Policy including identified disinvestment opportunities. New interventions and technologies recommended with NICE will be assessed for local implementation as they are published. OCCG will be proactive in the use of the IH&W CoLab Portal.

- k. 5yr year ambition (Unit of Planning): Oxfordshire CCG's aspiration, in line with that of NHS England. is for a 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 idea, products, services and clinical practices.

- l. 1 & 2yr plan to support the long-term ambition (by organisation and to be finalised by 4th April)
 - i. Use the Area Prescribing Committee (APCO) to embed automatic incorporation of NICE TAG 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

Chapter 15: Delivering Value and sustainability

- 15.1 This is the first submission of the plan to NHSE following early draft submission to the Area Team on 24th January.
- 15.2 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 under-lying, recurrent baseline for 14/15 is a deficit position of £18.5m.
 - b) Changes to the CCG's allocations.
 - i. The CCG has received a significant increase in 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 expected to receive an increase in its running costs allocation. Due to the national methodology adopted this has not been the case and the running cost allocation is below the 2013-14 allocation (£0.1m)
 - c) 13/14 Deficit Recovery
 - i. Any deficit the CCG makes in 13/14 will be repayable in 14/15 as a non-recurrent adjustment to our allocation. The current forecast outturn deficit is £6.1m.
 - 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 £7.6m with a contingency held of 1%. The plan for 2015-16 is for breakeven with a contingency held of 0.5% and 1% NR 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 £6.1m forecast outturn deficit for 2013-14 to the underlying deficit of £18.5m and then to the £7.6m forecast deficit for 2014-15 is shown below:

Financial Position

Revenue Resource Limit

| £ 000 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Recurrent | 614,023 | 633,762 | 660,693 | 662,130 | 673,386 | 684,833 |
| Non-Recurrent | 15,781 | (6,161) | (7,575) | (0) | 7,244 | 8,749 |
| Total | 629,804 | 627,601 | 653,118 | 662,130 | 680,630 | 693,582 |

Income and Expenditure

| | | | | | | |
|------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Acute | 345,001 | 348,648 | 339,685 | 336,299 | 333,149 | 328,850 |
| Mental Health | 63,588 | 62,111 | 59,954 | 59,250 | 58,178 | 56,912 |
| Community | 63,836 | 62,678 | 59,480 | 58,059 | 61,048 | 64,349 |
| Continuing Care | 33,722 | 35,506 | 64,759 | 68,515 | 77,009 | 84,705 |
| Primary Care | 88,121 | 89,268 | 96,879 | 100,076 | 106,179 | 112,607 |
| Other Programme | 26,238 | 14,637 | 14,577 | 14,606 | 14,489 | 14,358 |
| Total Programme Costs | 620,506 | 612,848 | 635,333 | 636,804 | 650,052 | 661,782 |

| | | | | | | |
|---------------|--------|--------|--------|--------|--------|--------|
| Running Costs | 15,393 | 16,159 | 14,510 | 14,539 | 14,557 | 14,623 |
|---------------|--------|--------|--------|--------|--------|--------|

| | | | | | | |
|-------------|---|-------|-------|-------|-------|-------|
| Contingency | - | 6,169 | 3,276 | 3,311 | 6,806 | 6,936 |
|-------------|---|-------|-------|-------|-------|-------|

| | | | | | | |
|--------------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Total Costs | 635,899 | 635,176 | 653,118 | 654,653 | 671,416 | 683,342 |
|--------------------|----------------|----------------|----------------|----------------|----------------|----------------|

| £ 000 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|------------------------------------|----------|---------|---------|---------|---------|---------|
| Surplus/(Deficit) In-Year Movement | (11,669) | (1,480) | 7,575 | 7,244 | 1,505 | 838 |
| Surplus/(Deficit) Cumulative | (6,095) | (7,575) | (0) | 7,244 | 8,749 | 9,586 |
| Surplus/(Deficit) % | -0.97% | -1.21% | -0.00% | 1.09% | 1.29% | 1.38% |
| Surplus (RAG) | RED | RED | RED | GREEN | GREEN | GREEN |

| | | | | | | |
|--------------------------------------------|--|----------|---------|---------|--------|--------|
| Net Risk/Headroom | | (3,001) | (4,691) | (4,458) | 1,782 | 2,359 |
| Risk Adjusted Surplus/(Deficit) Cumulative | | (10,576) | (4,691) | 2,786 | 10,531 | 11,946 |
| Risk Adjusted Surplus/(Deficit) % | | -1.69% | -0.72% | 0.42% | 1.55% | 1.72% |
| Risk Adjusted Surplus/(Deficit) (RAG) | | RED | RED | AMBER | GREEN | GREEN |

Chapter 16 – IM&T

16.1 IM&T Strategy

- a. OCCG is developing a full IM&T strategy, which is available in draft form on request. The following tables relate the CCG's IM&T plans, as set out in its IM&T Strategy, to the CCG's overall strategy and plans.
- b. In support of ALL topics listed below, IM&T plans include:
 - i. improvements to data quality, analytical tools and support services - to better monitor and forecast activity, costs, outcomes;
 - ii. becoming smarter in the use of information and knowledge (the evidence-base) to inform decision-making;
 - iii. ensuring IM&T requirements and opportunities are routinely considered as an integral part of any proposed improvement plans.
- c. To avoid repetition, these generic enablers are not mentioned again in the table below, although specific aspects are, where relevant.
- d. Further explanation of the approach to integration / interoperability is provided below this table.

16.2 How the strategy supports delivery of Improvement Interventions

| Improvement Intervention | Further Relevant Detail | IM&T Enablers |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| New approach to contracting | Outcome based commissioning | Linking records along care pathway |
| Efficiency & effectiveness of prescribing | Improve primary care prescribing | <i>Nothing specific</i> |
| Efficiency & effectiveness of planned care | Optimise referrals, care pathways | Clinical decision support tools |
| Improving emergency & urgent care | 111 and OOH to deliver improved and integrated service with enhanced clinical input | Records sharing / access between 111, OOH, GPs, Emergency Depts Urgent Care Dashboard – to help reduce avoidable A&E visits and non-elective admissions for high-risk patients |
| Achieving integration | GP led integration of care around the patient Integrated community health hub - health and social care services | Interoperability, Oxfordshire Care Summary, Cross-organisational initiatives – see Integration, below |
| Managing long-term conditions | Reducing unnecessary emergency hospital admissions Integrated local multidisciplinary teams Self care | ACG risk stratification; support integrated local teams - see Integration, below Telehealth – to support greater self care |

| Strategic Objectives | IM&T Enablers |
|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Clinicians and patients working together to plan and deliver better patient care | Patient / carer access to their own records Telehealth Further use of e-technology (websites, apps, social media, ...) to empower citizens / patients |
| Reducing health inequalities by tackling the causes of poor health | <i>Nothing specific</i> |
| Outcomes based commissioning | Linking records along care pathway |
| Commissioning patient centred high quality care | Full adoption of Commissioning Intelligence Model |
| Promoting integrated care through joint working | See Integration, below |
| Supporting people to manage their own health | Patient / carer access to their own records Telehealth Further use of e-technology (websites, apps, social media, ...) to empower citizens / patients |
| More care delivered locally | Telehealth |

16.3 Integration

- a. Integrated working between organisations / teams is highly dependent upon sharing patient / client information – hence OCCG's IM&T strategy emphasises the importance of interoperability. The cross-organisational Oxfordshire Care Summary has been live for over a year, and it is being further developed. It is intended to establish a cross-organisational steering group (which will include social services representation), to guide and oversee the further development of interoperability solutions

Chapter 17: Organisational development

17.1 Developing Our Approach to the New World of Clinical Commissioning

- a. As a very young organisation, OCCG 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. It has also already adjusted its 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.
- b. In January 2014, following three months' operation of the 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. It had 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
- c. It 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 Acute Contracting and Procurement
 - A new post of Head of Programme management Office
- d. A further review of organisational structure was initiated in February 2014 and key objectives have been identified as follows:
 - i. Ensuring proportionality between the size and scale of programmes of delivery for this plan and the clinical and managerial resources identified to deliver them
 - ii. 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
 - iii. 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
 - iv. Ensuring that the workforce – managerial and clinical – has the skills and expertise to commission to the very highest standards
 - v. Establishing fit for purpose arrangements with our co-commissioners, notably Oxfordshire County Council

17.2 Our Organisational Development Priorities

- a. In October 2013, OCCG established its organisational development priorities and in the ensuing months began to execute them. Whilst they have been revised slightly to take into account emerging priorities and new leadership structures, they remain our key priorities :
 - i. **Executive Team** development: a six month plan was put in place in late October 2013
 - ii. **Clinical Leadership** : two away days have taken place on October 22nd and on 4th February 2014 and organisational development interventions have now been agreed; these include coaching and mentoring for Locality Clinical Directors, coaching and

mentoring for succession plan candidates for the LCD and key clinical commissioner roles; and LCD group organisation

- iii. **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
 - iv. **Intermediate Tier:** following the decision to restructure the CCG, an organisational development programme will be put in place to embed the new structure and it is anticipated that agreement of the programme and starting its implementation will take place in the first quarter of 2014/15
- b. Because organisational structures in the NHS are revised on a frequent basis, especially in the commissioning of healthcare and given that system levers and incentives are also subject to frequent changes along with regulatory systems, the CCG is aware that organisational shelf life is too short to accommodate long term organisational development plans and is committed to their frequent revision.
 - c. We aspire to be an adaptive organisation with a workforce capable of rapid adaptation, the acquisition of new skills and a culture that supports high aspiration for our communities and for the professionals who work with us.

17.3 System Leadership and Organisational Development

- a. The Oxfordshire health and social care system is facing significant financial and performance pressures in recent years and in particular has been overtrading in acute care for many years. The goal of a sustainable Oxfordshire – living within its allocation and performing highly is shared by the leadership of the CCG, OCC, OUHT and OHFT and the CCG is committed to playing a leading role in facilitating processes which will enable this goal to be achieved – for example through new ways of organising care and incentivising creativity and better care, through initiatives such as Outcomes Based Commissioning.
- b. In order for this commitment to be enacted, the consent and shared positive commitment of our much valued providers and co-commissioners is essential and we plan to invest in the development of our shared leadership community, with this goal in mind.

Chapter 18: Governance Overview

- a. The CCG has established a Financial Challenge Board, reporting to its Finance and Investment Committee, to govern some of the key programmes of delivery in 2014/15. One of these programmes is the development and agreement of this plan.. The Senior Responsible Owner, the Interim Chief Operating Officer and the Clinical Responsible Owner, the Locality Clinical Director (Oxford City) with the support of a Programme Manager (the Interim Associate Chief Finance Officer) and supporting managers, were charged with the establishment of the a sub- programme to develop this plan. The Financial Challenge Board receives reports on the sub-programme's :
 - Project milestone achievement against target date
 - RAG status for the current period and previous period
 - Work completed in the previous period
 - Expected achievements in the forthcoming period, and
 - A report on the key risk and issues facing the sub programme and how they will be managed
- b. Because of the importance of the plan to the achievement of financial balance, its development has been considered at Governing Body level both in informal workshops and in public meetings.
- c. The CCG has agreed governance arrangements with its partner commissioner Oxfordshire County Council, to ensure the endorsement of the plan by the Health and Wellbeing Board; and specific arrangements to ensure that the Better Care Fund is shaped and agreed at Joint Management Group and Health and Wellbeing Board levels.
- d. It is a key corporate objective of the CCG that the plan is delivered and achieves its intended impacts. The organisational development implications of this goal are considered elsewhere in this plan. The governance of delivery has also been considered. In the first quarter of 2014/15 it is intended that the Financial Challenge Board's existence will be reviewed in the light of progress towards financial balance and the establishment of a new senior clinical and managerial leadership group - the Clinical Executive or CE. The CE will replace the former Senior Management Team and will report directly to the Governing Body and account to it, and to partners, for the delivery of the plan.
- e. An organisational restructure commencing in February 2014, will establish accountabilities for the major programmes of work in the plan – both improvement initiatives and enabling initiatives such as improved contracting and procurement- , and align managerial job roles and clinical roles to them. The establishment of reporting lines within the management structures and resourcing and leadership within clinical ranks along with the flow of business intelligence, will ensure that the CE remains sighted and in control of delivery at all times. As part of the organisational restructure, delivery, accountability and reporting lines to our partner commissioner in Oxfordshire County Council will also be established.
- f. Commentators have turned their attention in recent years to the contrast in command and control as opposed to co-cooperative governance models in the industrial and commercial setting. In the wake of the Mid Staffordshire Inquiries, there has also been a rightful focus on the behaviours that characterise a system delivering care which commands the confidence of patients, the public and professionals. The move from the governance model of PCTs and their forebears to the distinct membership model of CCGs has also attracted much thought and attention. The CCG has reflected on the means by which it secures good governance given its particular make up and geography and its previous performance in delivery.
- g. The CCG is dependent on concordance by its member practices with the key levers which will deliver best care at best value. Thus the demand management, pathway leaning, contractual controls and evidence based practice measures established in the plan, are subject to the consent of clinical professionals. Each of the six localities established in Oxfordshire, operates autonomously in organising its precise means of governance and holding to account

of practices. As part of delivering this plan, agreement on a consistent, assured and good enough data flow has been identified as one of the critical objectives of the CCG and Locality Clinical Directors with the support of the Business Intelligence function and locality teams will address this as a matter of priority. By ensuring proactive dissemination and transparency of data demonstrating concordance, variation (both warranted and unwarranted) and practice level performance, the CCG will engage with and serve its member practices and this will give the CCG a powerful adjunct to its improved business capability as intelligence is the equal of controls in achieving good governance.

Chapter 19: Conclusion

This draft plan is the culmination of much work within the CCG, supported by colleagues in the CSU and external consultants. The organisation has grasped the magnitude of challenge that it is facing in terms of service and financial pressures. Significant progress has been made in identifying appropriate opportunities to meet the challenge but there is further work to be done. The focus between the submission of this plan and subsequent submissions will be on current levels of ambition, partner engagement and system leadership. It will also be crucial to align all challenges and opportunities across the system such that resources are maximised for the benefit of Oxfordshire and there is no risk of pressure shunt or double count/ommission of opportunity.

Appendix 1 – improvement intervention summaries

Please see separately submitted document