

Notice of Meeting Public Document Pack



Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 25 April 2013 at 10.00 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - District Councillor Rose Stratford

Councillors: Jenny Hannaby Anthony Gearing Keith Strangwood
Jim Couchman Gillian Sanders Lawrie Stratford

District Councillors: Martin Barrett Susanna Pressel
Christopher Hood Alison Thomson

Co-optees: Dr Harry Dickinson Dr Keith Ruddle Mrs A. Wilkinson

Notes:

Date of next meeting: 13 June 2013

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman - Councillor Dr Peter Skolar
E.Mail: peter.skolar@oxfordshire.gov.uk
Committee Officer - Claire Phillips, Tel: (01865) 323967
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Peter G. Clark
County Solicitor

April 2013

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About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking ‘outwards’ and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 6 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

- 1. Apologies for Absence and Temporary Appointments**
- 2. Declarations of Interest - see guidance note on the back page**
- 3. Minutes (Pages 1 - 8)**

To approve the minutes of the meeting held on the 22 February 2013 and to note for information any matters arising from them.

- 4. Speaking to or Petitioning the Committee**
- 5. Public Health Update**

10.15

Jonathan McWilliam, The Director of Public Health will provide the committee with his regular report on matters of relevance and interest to the committee including an update on the Health and Wellbeing Board.

- 6. Emergency Planning arrangements for the NHS (Pages 9 - 12)**

10.30

Jonathan McWilliam, The Director of Public Health and Angela Baker, Consultant in Public Health will provide the committee with an update on the changes to the structure for emergency planning in the NHS.

- 7. Review of the midwifery led unit in Chipping Norton (Pages 13 - 22)**

10.50

Andrew Stevens and Jane Hervé from the Oxford University Hospitals Trust will present a report on the outcome of the review into births at the midwifery led unit in Chipping Norton and plans for reopening of the Unit.

8. Clinical Commissioning Group update

11.20

Dr Mary Keenan, Medical Director and Gareth Kenworthy, Finance Director, Oxfordshire Clinical Commissioning Group will give a verbal report on matters of interest and relevance to the committee including an update on the current financial situation.

9. Commissioning intentions for 2013/14 (Pages 23 - 76)

11.35

Dr Mary Keenan, Medical Director and Gareth Kenworthy, Finance Director, Oxfordshire Clinical Commissioning Group will present the commissioning intentions for the year ahead.

10. Healthwatch

11.55

Alison Partridge, Public Engagement Manager and Lisa Gregory, Engagement Manager, Oxfordshire County Council will give an update on the plans for Healthwatch and the progress of the new Public Information Network (PIN).

11. Chairman's Report

12.05

The Chairman will give a verbal update on meetings attended since the last formal meeting of the Health Scrutiny Committee in February.

The Committee will also be updated on the implications of new governance arrangements for HOSC.

12. Close of Meeting

12.15

Declarations of Interest

The duty to declare.....

Under the Localism Act 2011 it is a criminal offence to

- (a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
- (b) provide false or misleading information on registration, or
- (c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?

The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?

The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *“You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself”* or *“You must not place yourself in situations where your honesty and integrity may be questioned.....”*.

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:

Employment (includes *“any employment, office, trade, profession or vocation carried on for profit or gain”*.), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members’ conduct guidelines. <http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/> or contact Rachel Dunn on (01865) 815279 or Rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

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Agenda Item 3

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 21 February 2013 commencing at 10.00 am and finishing at 13.25

Present:

Voting Members: District Councillor Rose Stratford – in the Chair

Councillor Jenny Hannaby
Councillor Jim Couchman
Councillor Gill Sanders
Councillor Lawrie Stratford
District Councillor Martin Barrett
District Councillor Dr Christopher Hood
Councillor Susanna Pressel
District Councillor Alison Thomson

Co-opted Members: Dr Harry Dickenson
Dr Keith Ruddle
Mrs Anne Wilkinson

Other Members in Attendance: Councillor Tim Hallchurch (Substituting for Councillor Dr Peter Skolar)
Councillor Hillary Hibbert Biles (for Agenda Item 8)

Officers:

Whole of meeting Claire Phillips

Part of meeting Angela Baker

Agenda Item	Officer Attending
6	Dr Mary Keenan, OCCG
7	Riana Relihan, Oxfordshire PCT
8	Andrew Stevens, OUHT Jane Herve, OUHT Paul Brennan, OUHT Tony McDonald, OUHT
10	Adrian Chant, LINK Sue Butterworth, LINK Patricia Wells, LINK Linda Watson LINK

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.

76/13 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillor Skolar (Councillor Hallchurch substituting), Councillor Strangwood.

77/13 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Cllr Rose Stratford and Cllr Lawrie Stratford declared they are both members of the League of Friends for Bicester Community Hospital.

78/13 MINUTES

(Agenda No. 3)

The minutes were approved with the following amendment:

The first sentence of the eight paragraph of item 73/12 should read: "Patricia Wells" rather than Shelia from LINK.

Matters arising:

71/12 Cllr Pressel confirmed that she had been misinterpreted and the main point she would like to communicate is that the OCCG should be considering the timescales for bids as GPs can't complete with larger conglomerates with the current short timescales in place.

67/12 A&E waiting times

The committee asked OUHT for updates on A&E waiting times and delayed transfers of care.

72/11 Cllr Hannaby confirmed to Cllr Pressel that a provider's previous service history cannot be taken into consideration when assessing tenders.

73/12 District Nursing

Cllr Presell requested a report on District Nursing (Oxford Health) at a future meeting.

79/13 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

Cllr Hibbert-Biles and five public speakers asked to address the committee on the Cotswold maternity unit item. Cllr Rose Stratford asked the speakers to address the committee during item 8.

80/13 HEALTHWATCH UPDATE

(Agenda No. 5)

The Chairman confirmed this item had been removed from the agenda.

81/13 CLINICAL COMMISSIONING UPDATE

(Agenda No. 6)

Dr Mary Keenan addressed the committee. She confirmed that the five conditions for authorisation are being addressed between now and the end of March 2013.

The first draft of the Oxfordshire Clinical Commissioning Group (OCCG) Operating Plan was submitted to the NHS Commissioning Board Area Team in January 2013 for feedback. The plan highlights the large financial challenge for the OCCG.

The plan has been structured around the NHS outcomes domains:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

OCCG will be moving towards outcome-based commissioning focused on outcomes that matter to patients and clinicians in the following three areas:

- Frail elderly
- Maternity
- Mental health

Oxfordshire is at the forefront of the national process.

OCCG are looking to pool budgets with OCC to help deliver long-term financial health. The main focus of the work is the Older People's pooled budget which, when in place, will be the main underpinning arrangement to implement the Older People's Joint Commissioning Budget 2013/16.

The committee raised concerns about the potential for GPs to have a conflict of interest with the new arrangements. OCCG confirmed that it has robust procedures in place to identify GPs medical interests.

Dr Mary Keenan emphasised the scale of the financial challenge facing the OCCG. Opportunities for savings around areas such as more consistency around follow up appointments are being explored. The committee requested an update report an information on the financial challenge for the next meeting.

82/13 COMMUNITY HOSPITAL UPDATE

(Agenda No. 7)

Riana Relihan, Estates Project Manager at Oxfordshire PCT gave an update on the status of the two community hospital developments in Oxfordshire. The changing structure of the NHS has led to delays for the Bicester and Townlands community hospitals.

The Townlands delay has been a result of the project funder Aviva needing new assurances as the premises will now belong to NHS property Services Limited. Progress has been made between Aviva and the Department of Health which is leading towards the financial close of the project.

Bicester is two to three weeks away from signing a contract. The financial close of Townlands is more complex and is due mid April 2013. The PCT are currently assessing what impact this could have on project costs and sign-off by Property Services Ltd.

The committee said the Bicester hold up is frustrating and more transparency is needed with members of the public.

83/13 CHIPPING NORTON MATERNITY REVIEW

(Agenda No. 8)

Public addresses were made by:

Cllr Hibbert-Biles – Local County Councillor

Jennifer Lanham - Maternity Services Liaison Committee Chair

Kim Murray - Cotswold Maternity Unit supporters group

Kate Barlow - A mother from the local community

Heather Bower - A representative from the local community

Sarah Boyd - Chipping Norton & District branch National Childbirth Trust

All public speakers expressed their desire for the Cotswold Maternity Unit to reopen as soon as possible. Other concerns raised included:

- Limited transparency of the internal review
- Opinions being gauged from current staff only
- Methods of data gathering
- Reduction of student places

A paper circulated by the Cotswold Maternity Group to some members of the committee is to shared with the OUHT.

Cllr Hibbert-Biles addressed the committee and raised concerns that the consultation had closed in January but there hasn't been any recommendations published or reopening date set. Cllr Hibbert-Biles expressed the need for the OUHT to consult the public on what is happening and increase transparency.

Oxford University Hospitals Trust were represented by:

Paul Brennan, Director of Clinical services at Oxford University Hospitals

Jane Hervé, Head of the OUHT midwifery service,

Andrew Stevens, Director of Planning,

Tony McDonald, General Manager, Children's and Women's Division

The OUHT confirmed that the decision to close the unit was taken after patients and staff raised concerns about the high transfer rate. There were a range of complex issues at the Unit and the OUHT felt the best course of action was to close it temporarily and launch a review. The OUHT stated their intention is to reopen the unit once any recommendations highlighted through the review have been implemented.

Jane Hervé confirmed that more detail would be provided when the report is published and thanked the local community for all of their support. A summary of data collection methods was given and Jane Hervé confirmed that all staff were happy to meet with her. The OUHT will work closely with GPs and local groups to implement any changes

At this stage the review has identified the following emerging themes:

- The local community want the Cotswold Maternity Unit to be available for a full range of services
- Recent transfers have been appropriate
- An effective discharge policy needs to be agreed
- Midwives and local GP's need to collaborate
- Staffing ratios and a skills mix need to be agreed
- Cultural challenges
- A review of working arrangements is needed
- The service needs to be promoted in the community

The committee expressed concern about the amount of time the unit has already been closed. Andrew Stevens reiterated the point that a range of issues combined led to the OUHT taking the decision to close the Unit. The OUHT confirmed the report would be going to the board meeting on the 13th of March 2013 and the papers would be available on the website a week before.

In response to a question the OUHT confirmed that there was no evidence of adverse clinical outcomes in the Unit.

The committee was sympathetic to local concerns about the review and emphasised to the OUHT that it should reflect the candour of the Francis report; be independent; and be timely.

The committee agreed that OUHT will discuss the best way to consult the HOSC on recommendations with the Chairman and that the priority is to reopen the Unit as soon as possible.

OUHT updated the committee on the recent decision to temporarily suspend emergency abdominal surgery at the Horton hospital in Banbury due to staffing issues. The Trust is planning to consult formally on the future of services at the Horton this year.

84/13 PUBLIC HEALTH (Agenda No. 9)

Angela Baker presented the public health update in the absence of Jonathan McWilliam.

Transition plans for Public Health are going well and 8 members of staff are to move to County Hall on the 2nd April 2013.

The Health and Wellbeing board becomes a statutory requirement from April 1st 2013. An update on progress of the board will be covered in the Public Health update at the next HOSC meeting. The committee requested the dates of future Health and Wellbeing boards and an update on the Public Information Network (PIN) at the next meeting.

The Joint Strategic Needs Assessment is in progress and will be published by the end of March 2013. The results of the assessment will influence the Strategy for the Health and Wellbeing board.

The Planning for Patients 2013/14 paper builds on the information presented by OCCG. It lists the five domains that all organisations will be measured against. The plans will be signed off locally 31st March 2013.

The Everyone Counts - planning for patients 2013/14 paper sets out how the CCG and NHS Commissioning group will be monitored, what improvements they are expected to make and how money should be spent. There are five headlines:

- The importance of the NHS constitution
- The NHS Offer
- Delivering against the NHS Outcomes Framework
- Three local priorities
- Other National Priorities to be rolled out

The Public Health Outcomes Framework sets out the desired outcomes for Public Health and details on how these will be measured. The two main outcomes identified are:

- increased healthy life expectancy
- reduced difference in life expectancy and health life expectancy between communities

The overall picture is good for Oxfordshire with only a few specific indicators needing more consideration:

- The figures for the number of people killed/seriously injured are much lower this year. In future the figures are also to be compared against the national average.
- The Drug Treatment figures are skewed by the fact the DAT team are now part of Public Health and all treatment had to stop and start with a new provider. A report on this area of work is to be brought to the committee at a future meeting.
- Work is planned for next year to encourage young people to get tested for Chlamydia
- Current data suggests that Oxfordshire has more falls than other populations. The committee requested a report on fall indicator for a future HOSC meeting.

Information on the indicators is updated on a regular basis. More information on specific indicators can be found on the internet at <http://www.phoutcomes.info/>

85/13 LINK - FINAL REPORTS

(Agenda No. 10)

Adrian Chant, Sue Butterworth, Mary Judge and Linda Watson presented the final reports from LINK. Linda Watson gave a summary of the LINK work over the years and highlighted the partnership working with local groups and engagement with the public.

The Maternity Services Review Report highlights two concerns:

- Conflicting information and limited support for breastfeeding
- Lack of consistency of support

Jane Hervé confirmed the OUHT have drafted a response which would be with LINK within the next week.

The findings from the review of information provided for NHS Dental Patients in Oxfordshire has been shared with the PCT/OCCG. This report was requested by the PCT and the recommendations relate to display signage, printed and on-line materials. Angela Baker confirmed that there are four oral health practitioners in Oxfordshire that are available to schools.

Adrian Chant updated the committee on the OMEGA report into ME services which had been discussed at the previous meeting. OMEGA has met with the OCCG and will be looking at care pathways in the future. The committee requested that the OCCG and Oxford Health responses to the report be shared when available.

The report from the Mental Health Hearsay event in December will be taken to the Better Health Programme Board on 28th Feb 2013. Issues identified included:

- GP and Medication Reviews
- Support Carers and Confidentiality
- Information isolation and the need for a range of communication channels
- Integration across Services
- Care pathways and care co-ordination
- Crisis response and staff attitudes

Linda Watson confirmed the LINK handover event will take place in March to agree the priority work to pass onto Local HealthWatch.

The committee thanked LINK for all their work especially the large number of volunteers.

86/13 CHAIRMAN'S REPORT

(Agenda No. 11)

Cllr Rose Stratford updated the committee on the meeting held with the OCCG in February.

Cllr Couchman updated the committee on a meeting held with the Care Quality Commission (CQC) in November. There were some concerns raised by members

about the CQCs ability to meet its new role and have sufficient resource to monitor quality of services. The committee requested an item on the CQC at a future meeting.

87/13 CLOSE OF MEETING

(Agenda No. 12)

The meeting finished at 13.25

..... in the Chair

Date of signing

Briefing for Health Overview and Scrutiny Committee The changing world of Emergency Planning

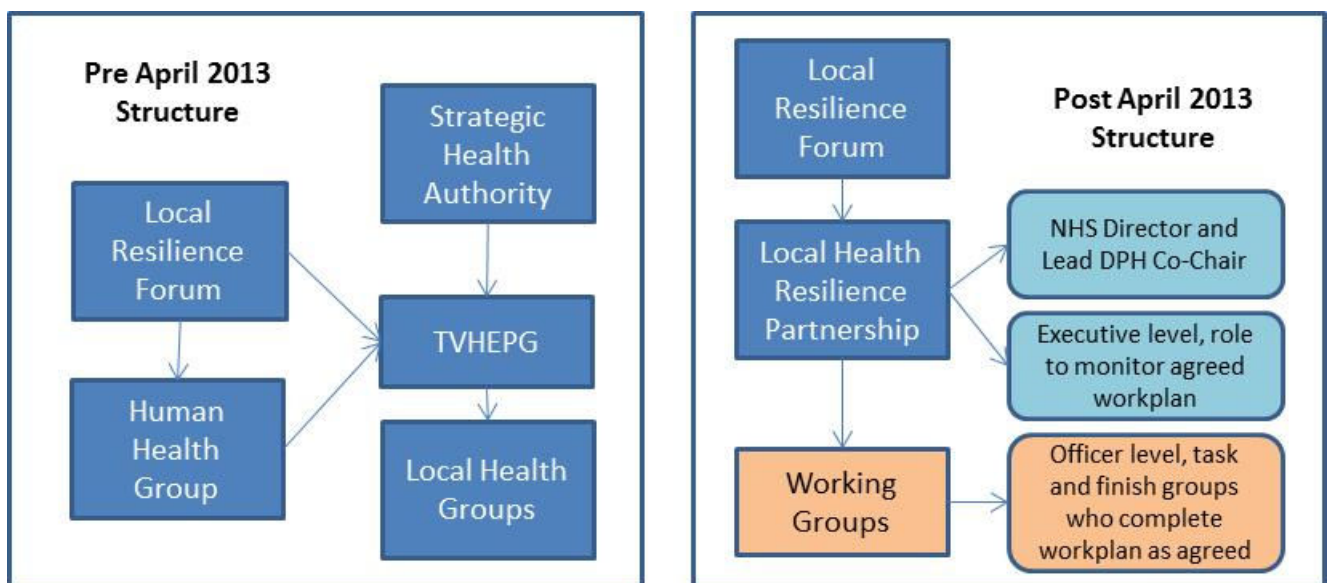
Background

There is now guidance for Emergency Planning Resilience and Response (EPRR) clearly stating the responsibilities for the three lead Directors (one from NHS England, one from Public Health England and a representative Director of Public Health).

<http://www.dh.gov.uk/health/2012/08/epr-arrangements/>

Moving from the old system to the new system

The changes to the Health system have meant that emergency planning across Health has changed in terms of structure, and, the who does what. The “what we do”, has however, remained the same. We have moved from the left hand structure to the right hand structure



(TVHEPG = Thames Valley Health Emergency Planning Group)

What each group does?

Local resilience forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. These agencies are front line Responders. All organisations within Local Resilience Forum have a responsibility to co-operate with each other, sharing relevant information. The geographical area the forums cover is based on police areas, in our case, Thames Valley Police Authority area.

Local Resilience Forums are also supported by other organisations, such as the Highways Agency and public utility companies. They work with other partners in the military and voluntary sectors who provide a valuable contribution to the emergency planning agenda.

The aim is to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

The Local Health Resilience Partnership

The Local Health Resilience Partnership replaced the Human Health Group, this has been in shadow from January 2013. It aims to:

- Bring together all health responders so that they can co-ordinate, plan and carry out specific joint work.
- The chairs will be the point of contact for Local Resilience Forum (LRF).
- Co-chaired by an NHS England Director and the Lead DPH (Oxfordshire), it will link the Local Resilience Forum, NHS England and Public Health England Centres. This will enable us to assess and provide assurance about specific incidents and emergencies.
- The Lead DPH will link back to the appropriate Local Authority and other DPH's.
- The core membership of the LHRP includes NHS England, Lead Director of Public Health (**co-chair**), Ambulance Service Lead, Public Health England Centre EPRR Lead.
- Other members may be agreed locally,
- The Local Health Resilience Partnership and Local Resilience Forum are coterminous; and will develop a three year strategy with an annual work plan. This is currently under development.

There is a legal requirement for all Health organisations to participate, this includes all Clinical Commissioning Groups.

The NHS side of the LHRP will

- Ensure the local roll-out of LHRPs, coordinating with PHE and local government partners.
- Ensure the NHS has integrated plans for emergencies in place across the local area.
- Develop joint emergency "health" plans with PHE and local authorities, through the LHRP.
- Ensure that plans for Emergency Planning are in place from April 2013
- Provide the NHS co-chair of the LHRP who will also represent the NHS on the LRF.
- Have the capability to lead the NHS response to an emergency at a local level.
- Ensure a 24/7 on-call roster for NHS emergency response in the local area, comprising staff with the appropriate competences and authority to coordinate the health sector response to an emergency.
- Determine, in the light of the impact on NHS resources and with advice from the Director of Public Health, at what point the lead role in response to an incident or emergency will transfer, if required, from police to the NHS.

The Lead Director of Public Health will

- Monitoring the NHS plans to ensure they are fit for purpose.
- Developing joint emergency "public health" plans (STAC) across all LA's, with PHE and NHS England, through the LHRP.
- Ensure the NHS organisations are resilient to manage emergencies that cause increase demand or disruption to patient services.
- Co-chair of the LHRP.
- Having the capability to support the NHS response to an emergency at a local level until the NHS LAT lead can take over
- Ensuring a 24/7 on-call roster for Public Health emergency response across all LA in the local area, comprising of staff with the appropriate competences and authority to coordinate the Public health response.
- A first point for dispute resolution between LHRP members should they arise;

The DPH's role in Local Authorities

- All DPH's will provide leadership for Public Health system within their local authority
- All DPH's will ensure that there are plans in place to protect their local population and escalate concerns as appropriate, this is in part the mandatory responsibility to have protection plans which protect their local population.

- Work with the Lead DPH to ensure effective communication between themselves, the Local Authority they represent and ultimately LHRF/LRF and PHE.
- Provide support to the development of LHRP Public Health plans (STAC Plans) and contribute to the 24/7 on call rota

Where are we now

- The Lead DPH has been agreed with all other Thames Valley Local Authorities
- The group has met several times in shadow form and has now agreed a slightly wider membership which includes a representative from Clinical Commissioning Groups and a representative from NHS provider trusts across Thames Valley.
- Terms of reference and Concepts of Operations have been agreed for the group
- A three year strategy is being developed
- An interim Public Health England Centre Director has been appointed

Whilst these are early days, the systems remain in place to deal with emergencies as and when they arise. The Local Health Resilience Forum will bring strength of high level commitment and leadership to the process.

Jonathan McWilliam
April 2013

Angela Baker

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REPORT ON THE FINDINGS OF A REVIEW OF THE MIDWIFERY LED UNITS IN CHIPPING NORTON

HOSC

25 April 2013

1. Introduction

At the HOSC meeting held on 21 February 2013, members of the Oxford University Hospitals NHS Trust were given the opportunity to explain the review, including details of the process and the emerging themes. As outlined previously the review was instigated as a result of a number of issues that had been identified through internal monitoring processes, staff and via the Maternity Services Liaison Committee.

The Trust reiterates its commitment to the reopening of Cotswold Maternity Unit to births and it is important to note that the Unit has continued to provide a full antenatal and postnatal service to the local community during this time.

2. Review process and themes

A) Process

In order to fully address the scope of the review, a robust structure of interviews, meetings, case reviews and questionnaires were completed. It was also important to ensure the review encompassed an appropriate timescale to determine practice, cultural issues and identify changes any that have been implemented in the CMU. In order to address these issues the decision was taken to focus on the last 4 years (2008 -2012).

B) Initial themes

- Local women and their families are supportive of the Cotswold Maternity unit and want it to be available for the full range of services.
- Women and staff believe that the option of staying for one night after the birth of their child should be offered to all women giving birth in the CMU.
- The need for midwives and local General Practitioners' to work closely together to support each other in the care of pregnant women and to collaborate in the ongoing development of the unit.
- The need to agree staffing ratios and the appropriate skill mix to provide the service at the CMU.
- Concerns raised by staff on the periphery of the units at Chipping Norton about working practices, isolation of the unit and lone working.
- To review the working arrangements to ensure continuity and provision of midwifery care.

3. Presentation of the findings

Paul Brennan, Director of Clinical Services presented the findings of the review to the Trust Board on 13 March 2013. After extensive discussion the findings and recommendations were accepted with a number of further actions. These included:

- The development of an action plan which must be presented at Trust Board in May and June 2013 to review progress with implementation of the actions.
- Leadership – to ensure a consistent approach and implementation of day to day monitoring in the unit with feedback to Trust Board.
- The need to address the cultural issues in the unit.
- Marketing the unit once there is assurance the unit is fully operational and safe to open for births.

There was agreement to fully open the unit by the 1 July 2013 or before if all actions in place. The action plan and progress against the plan will be considered at the June 2013 Trust Board meeting at which the final decision on the timing of the opening of the CMU will be determined.

4. Recommendations

The review identified 31 recommendations and these were detailed in the report in line with the purposes of the review (included in the paper presented to HOSC on 21 February 2013). The recommendations have been formatted into an action plan to ensure each recommendation is monitored, completed and evidence collected to show compliance.

5. Appropriate service model at the Cotswold Maternity Unit

The Cotswold Maternity unit is highly valued by the local community and is an important part of the OUHT strategy to deliver care as close to home as is appropriate. There is a need to review the staffing within the unit, their roles and responsibilities and the links to other community teams in order to ensure appropriate cover and service provision; this is underway. The plan is to fully reopen and provide antenatal, intrapartum and postnatal care to the population of Chipping Norton and surrounding areas.

The Trust is committed to maintaining safe maternity services throughout the county. In order to maintain safe and sustainable clinical viability the number of births at the CMU needs to grow substantially. A marketing campaign will be agreed to ensure the population of Chipping Norton and the surroundings areas are fully informed about the CMU and the services available. The outcomes will be closely monitored by the OUHT and commissioners.

6. Conclusion

This review has found that there were problems at Chipping Norton that contributed to the position in which the Trust needed to take the decision to suspend births at the unit. The action plan (accompanying this report) addresses these problems and there is now a need to move on in a positive way with a supportive structure in place to ensure a fulfilling working environment and a successful Cotswold Maternity Unit.

**Jane Hervé,
Head of Midwifery
April 2013**

REVIEW OF THE MIDWIFERY LED UNIT IN CHIPPING NORTON

2008-2012

ACTION PLAN

The Oxford University Hospital NHS Trust made the decision to conduct an extensive review into the Cotswold Maternity Unit following concerns raised through internal monitoring processes about clinical care. The problems related to working practices within the unit and were not confined to a single incident. These issues when considered together were concerning and informed the Trust’s decision to suspend births at the unit and undertake this review. The review identified a number of recommendations that need to be actioned before the unit opens for births by the 1st July 2013. This action plan outlines the recommendations, the individuals responsible, the timescale for completion and evidence to support implementation of the recommendation.

1. Clinical Governance arrangements

RECOMMENDATION	INDIVIDUAL RESPONSIBLE	TIMESCALE	EVIDENCE
It is essential that there is a consistent approach across all the midwife led units in Oxfordshire and that all practice in the midwife led units complies with the OUH and National guidelines.	Clinical Midwifery Manager	June 2013.	
Monitoring must occur in each MLU and monthly meetings should be held to review numbers of births, transfers and cases; senior midwifery staff should be involved in the meetings. These must feed into	Clinical Governance Manager	Start date April 2013. Monthly meetings.	Proforma developed. Meetings arranged for Wallingford, Wantage and the Spires starting April 2013

the Directorate and Divisional governance structures and this will ensure that any concerns are identified quickly and actions taken.			
Audits should be undertaken by Supervisors of Midwives to ensure compliance with local and national guidelines and the results presented at the Directorate Governance Committee.	Contact Supervisor of Midwives	Start date April 2013. Agree ongoing audit timescales.	
The MLU's in Oxfordshire should be benchmarked against other units across the UK to offer assurance about practice, guidelines, numbers of births, antenatal and postnatal services.	Clinical Midwifery Manager	April 2013.	
Regular meetings should be held between CMU staff and local GPs to improve communication and provide information about changes within the unit or local/national guidance.	Clinical Midwifery Manager	Meetings to be arranged from April 2013 and agree frequency. Action notes to be agreed and circulated after each meeting.	
The senior midwifery management team should provide regular support for all staff in the CMU.	Clinical Midwifery Manager/Head of Midwifery	Fortnightly visits/meetings to the CMU.	
There should be quarterly visits from the Divisional Executive team to meet staff.	Head of Midwifery/Divisional General Manager	Start date – April 2013.	First visit arranged for 23 April 2013
The HOM will work closely with the Oxfordshire Commissioning Group to agree reporting structures and provide assurance about the safety of the CMU.	Head of Midwifery/Lead Commissioner	Finalise May 2013.	Meeting being arranged
Links should be developed with local			

user groups to receive feedback about the services provided in the CMU.	Clinical Midwifery Manager	Start May 2013.	
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2. Clinical Practice

RECOMMENDATION	INDIVIDUAL RESPONSIBLE	TIMESCALE	EVIDENCE
Managers should ensure all staff are aware of and work within local and national guidelines and this should be monitored through audit and Supervision of Midwives.	Clinical Midwifery Manager	April 2013.	
Collaboration should be enhanced between OUHT and OBU to ensure excellence in the development of the midwives of the future. The senior midwifery management team should work closely with OBU to ensure OUHT receives regular feedback from the Midwifery Link Lecturers.	Head of Midwifery/Lead Midwife for Education	Finalise arrangements – April 2013.	Maternity Practice Education Forum arranged for 22 April 2013. To be held quarterly.
The HOM and Lead Midwife for Education should agree formal feedback mechanisms regarding pre and post registration midwifery training.	Head of Midwifery/Lead Midwife for Education	Finalise arrangements – April 2013	Monthly meetings agreed. First meeting took place 18 March 2013
There must be involvement and support from the Consultant Midwives in the provision of women's care, especially if women with known obstetric or medical risks request to birth in the CMU.	Consultant Midwives	Arrangements in place.	

3. Risk Management systems

RECOMMENDATION	INDIVIDUAL RESPONSIBLE	TIMESCALE	EVIDENCE
Every member of staff must report incidents in line with the Trust's Incident Reporting system; this will be monitored by the Clinical Governance team.	Clinical Governance Manager	Start and agree monitoring process in April 2013.	
Opportunities for staff to meet with senior management will be put in place and details of how concerns should be escalated highlighted to every member of staff.	Clinical Midwifery Manager/Head of Midwifery	Finalise arrangements – April 2013.	
Workplace assessments should be completed as appropriate.	Clinical Midwifery Manager	As necessary.	

4. Environment

RECOMMENDATION	INDIVIDUAL RESPONSIBLE	TIMESCALE	EVIDENCE
The environment within the CMU will be reviewed to make the necessary changes e.g. remove the resuscitaire from the birthing room and relocate to another area within the unit.	Team Leader/ Clinical Midwifery Manager	Complete June 2013.	
The telephone system must be changed so calls can be heard by all staff wherever they are in the unit.	Team Leader	May 2013.	
The front door bell must be changed so it can be heard by all staff in the unit.	Team Leader	May 2013.	

5. Women's expectations

RECOMMENDATION	INDIVIDUAL RESPONSIBLE	TIMESCALE	EVIDENCE
The OUHT policy for length of stay and discharge procedures should be made clear to women at booking and be consistent in all MLU's.	Team Leader	April 2013.	
The OUHT policy for length of stay and discharge procedures should be made clear to women at booking and be consistent in all MLU's.	Team Leader	April 2013.	
The provision of antenatal sessions and breastfeeding support should be reviewed because current practice is not using staff resource efficiently and does not provide women with peer support.	Team Leader	May 2013.	

6. Staff

RECOMMENDATION	INDIVIDUAL RESPONSIBLE	TIMESCALE	EVIDENCE
The clinical midwifery manager will meet every member of staff working in the CMU to understand their choice of place of work.	Clinical Midwifery Manager	April 2013.	Meetings with staff have taken place during April 2013. Action plan to be agreed.
The clinical midwifery manager will review and agree the on call arrangements and links with other community teams.	Clinical Midwifery Manager	May 2013.	
Appropriate midwifery cover in GP		May 2013.	

practices should be provided to improve continuity and communication.	Clinical Midwifery Manager		
The clinical midwifery manager will review night time cover within the CMU; considering either an on call system or the employment of individuals on an annualised hours contract.	Clinical Midwifery Manager	Complete June 2013.	
Staff must comply with the European Working Time Directive.	Team Leader	Immediate.	
The clinical midwifery manager will arrange team building sessions to ensure a cohesive, positive working environment for every member of staff.	Clinical Midwifery Manager	Start May 2013.	

7. Supervision of Midwives

RECOMMENDATION	INDIVIDUAL RESPONSIBLE	TIMESCALE	EVIDENCE
Supervisors of Midwives must monitor practice, ensure staff are aware of guidelines and monitor compliance.	Supervisors of Midwives	Agree process with the LSAMO – April 2013.	Discussed at the Supervisor of Midwives meeting on 4 April 2013. Plan to be agreed.
Supervisors of Midwives must provide updates for staff on the importance of contemporaneous record keeping, audit and feedback through the Divisional governance structures.	Supervisors of Midwives	Agree process with the LSAMO – April 2013.	Discussed at the Supervisor of Midwives meeting on 4 April 2013. Plan to be agreed.
The Midwives Rules and Standards 2012 should be discussed with every	Supervisors of Midwives	Annually.	Discussed at the Supervisor of Midwives meeting on 4 April 2013.

midwife during their annual review meeting to ensure all staff are aware of their professional responsibilities, in line with the Nursing and Midwifery Council.			Plan to be agreed.
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8. Marketing and communication

RECOMMENDATION	INDIVIDUAL RESPONSIBLE	TIMESCALE	EVIDENCE
The Trust will develop strategies to ensure there is a robust structure in place to communicate effectively with the local GP's in Chipping Norton.	Senior midwifery and Media and Communication teams	May/June 2013	
The Trust will develop ways to meet and communicate with the local population of Chipping Norton about maternity services.	Senior midwifery and Media and Communication teams	May/June 2013	

9. Monitoring

The action plan will be approved by the Director of Clinical Services and will be monitored by the Childrens and Womens Division through the Clinical Governance structures.

Updates will be provided at Trust Board in May and June 2013.

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Oxfordshire Clinical Commissioning Group

Operational Plan 2013-2014

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Domain 5- Treating and caring for people in a safe environment and protecting them from avoidable harm

Appendices

Appendix A: Expected Rights and Pledges for the NHS Constitution 2013/14

Appendix B: OCCG Benchmarked performance against NHS Outcome Domain Indicators

OCCG Operational Plan 2013/14

1) Overview

The Oxfordshire Clinical Commissioning Group's (OCCG) Operational Plan for 2013/14 outlines the direction of travel for commissioning across Oxfordshire, describing our Vision and how we are working across the health system to improve quality and drive efficiency. The Operational Plan clearly details the end state for the Oxfordshire healthcare system in the longer term and the how commitments made to implement the Vision are being translated into programmes of work.

The Operational Plan describes our major programmes of work, highlighting 'what' we are doing and 'how' we plan to do it amidst a national context of profound financial challenge. Being clear about our financial position, our underlying activity assumptions and risks allows us to demonstrate the level of ambition we are aspiring to when planning service change, redesign and increased efficiency savings for the Oxfordshire healthcare system.

OCCG Team has held individual discussions with both Oxford University Hospitals Trust (OUHT) and Oxford Health Foundation Trust (OHFT), our main providers, outlining the main elements of this operational plan and ensuring we are strategically aligned. Additionally we have held a system wide meeting involving the OCCG, Primary Care, OUHT, OHFT, Social Care and the Ambulance Trust to discuss and align commissioning intentions.

We are working together as a health and social care economy to be clear about how the system will achieve sustainable service and financial performance whilst delivering quality and productivity improvements.

1.1 Vision for Oxfordshire

The Operational Plan articulates OCCG's vision for what the Oxfordshire system will look like in the next 4-5 years. This Vision has been developed with member practices through the County's six Localities.

"By working together we will have a healthier population, with fewer inequalities, and health services that are high quality, cost effective and sustainable."

This Vision builds on the Joint Strategic Needs Assessment (JSNA), jointly agreed priorities with the Health and Wellbeing Board, the views of people of Oxfordshire, health and social care professionals, the voluntary sector and other stakeholders.

To achieve this Vision the OCCG has declared in its Mission statement that;

"We will work with the people of Oxfordshire to develop quality health services, fit for the future. Through clinical leadership we will-

- *Achieve good health outcomes for us all within the money available*
- *Balance the needs of you as individuals with the needs of the whole county."*

1.2 OCCG Operating Model: Leading change locally

OCCG is a clinically led membership organisation made up of 83 general practices across the county, grouped in to 6 Localities supported by a central commissioning team. This combination of pan-Oxfordshire and Locality focussed leadership (clinical and managerial) allows us to address local priorities as well as systemic problems at scale without losing locally tailored implementation. Each Locality plan has incorporated both local projects and priorities but also clearly articulate their role in supporting and implementing countywide programmes. All programmes of work are supported by the CCG as a whole and all practices sign up to deliver their share of the plans. Locality plans will be finalised once the overall Operational Plan is agreed and Locality apportionment of projects discussed and agreed.

We are by definition a membership organisation and whilst in some areas we have chosen to adopt a county wide approach to improving healthcare services these do not lose sight of the Locality foundations the programmes will be delivered and supported through. The Locality specific projects are equally supported by the central programmes of work which ensure economies of scale for contracting and strategic alignment across the county.

The 4 central work streams (Adults, Children and Young People (CYP), Major Programmes, Older People) are building on proposals from, and working closely with Localities to develop a clear countywide framework for these service areas. Each Locality will then own and tailor elements of the overarching strategies to fit with their individual needs.

Locality input to plans and their delivery is fundamental and whilst some of the projects have been encompassed in the wider programmes of work the overall drive for improvement in all areas is very definitely owned by the OCCG's 83 practices through Locality Executives.

1.3 NHS Outcomes Framework

OCCG adopted the 5 domains of the NHS Outcomes Framework as its core corporate objectives and has chosen to structure the plan in this way making it both locally and nationally aligned.

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
Domain 4	Ensuring that people have a positive experience of care; and
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

The NHS Outcomes Framework also helps the CCG in demonstrating its alignment with both the Adult Social Care and Public Health Outcomes Frameworks- all frameworks reinforce OCCG's commitment to improve outcomes for patients rather than measure individual service encounters.

The Outcomes Framework is supported by a robust indicator set which allows us to benchmark our performance so we can be assured that we are continually improving the quality of services. Measuring and evaluating information on health outcomes and the programmes of work which support them is key to driving quality improvements.

1.4 Delivery over 3 years

The focus for the planning process with full agreement from the Governing Body has been on delivering a clear and credible plan- one which acknowledges the scale of change needed to deliver challenging financial targets whilst ensuring deliverable programmes of work are developed.

Savings in 2013/14 have been adjusted for implementation time and confidence in delivery and OCCG is confident in its decision to concentrate on wider transformational service redesign which will deliver a financially sustainable health system over 3 years, rather than having unrealistic activity reduction targets in the current year.

The financial baseline and inherited pressures mean OCCG requires a medium term approach to improving the financial footing. We have identified savings and QIPP plans that will deliver over a 3 year period and beyond, increasing the financial headroom available to OCCG which is based on realistic, achievable contractual settlements with providers.

Key elements of our plans to deliver over three years are the shift to commissioning for outcomes and ensuring greater integration. These are covered in more detail in later sections of this plan.

1.5 Equality Objectives

OCCG has adopted the following Equality Objectives and these run through all work programmes outlined in this plan.

- To improve the capture and analysis of population, workforce and patient information broken down by protected characteristic as required by the Equality Act
- To improve access to specific information and communication requirements; to ensure patients are kept fully informed and asked about their communication needs, so that reasonable needs can be met
- To improve access to services by involving and listening to patients from all protected characteristics; targeting those people whose voices may not usually be heard by NHS organisations
- To ensure considerations of Equality, Diversity and Human Rights are included in mainstream processes through the use of Equality Analysis
- To ensure that Oxfordshire CCG is supported to take the Equality, Diversity and Human Rights agenda forward using the EDS system

2. Transforming services and the way we work

2013/14 is the first year where the health service reforms have truly allowed greater local control over decision making. This allows OCCG to have more local ownership of the Quality, Improvement, Productivity and Prevention challenge (QIPP) and better understand the clinical changes needed to ensure wider service and financial sustainability.

For us to improve health outcomes across the 5 domains within limited resources, we have to change the way we work. There is support for change from the transition in to clinically led commissioning as evidenced by the engagement from our clinical leads and their GP colleagues. To this extent all work streams, irrespective of domain will embody the national drivers for change such as a shift to community based care. All our work will capitalise on the NHS Commissioning Board's (NHS CB) 5 offers to commissioners which aim to give more insights and a greater evidence base upon which to make commissioning decisions:

- Offer 1- NHS services, seven days a week
- Offer 2- More transparency, more choice
- Offer 3- Listening to patients and increasing their participation
- Offer 4- Better data, informed commissioning, driving improved outcomes
- Offer 5- Higher Standards, safer care.

To take full advantage of these offers we have outlined some themes and principles which all our major programmes of work are built on.

2,1 A shift to commissioning for outcomes

OCCG recognises that there is a need to move away from commissioning for activity alone and commission for outcomes as defined by the patient or service user themselves. A

simple example would be: rather than commissioning for a knee operation to take place, we want to commission for an increased level of mobility after a knee operation...can Mr. Jones walk to the shops again? Through three work streams: Frail Elderly, Mental Health and Maternity, OCCG is responding to the mandate given to the NHS CB which requires the NHS to deliver a range of population health outcomes. These three areas account for about a third of our commissioning budget so this is a significant shift.

This shift in focus from activity to outcomes is already underway in Oxfordshire where phase 1 of the work has been completed, itself building on outcomes-focussed foundations in the county i.e. the Oxfordshire Older People's Joint Commissioning Strategy 2013-2016. This takes as its starting point the need to focus on the person requiring health and social care services and their carer with all priorities and outcomes defined by them.

This transformational change in thinking and commissioning has been fully embraced by OCCG and we see it as a chance to develop our 'assumed liberty' and to be at the vanguard of innovation. Our work in Outcomes Based Commissioning in phase 2 moves the 'vision' in to action, working with providers and stakeholders to explore the detail of commissioning and contracting for outcomes. Mental Health specifically aims to use the commissioning for outcomes as a way of bringing together health, social care and housing to deliver integrated care that meets the needs of the service user. Our Engagement Strategy and stakeholder workshops in early January all demonstrated our commitment to commissioning for outcomes which matter to the service users themselves- phase 1 of this project has had an emphasis on listening and phase 2 focuses on taking these lessons forward in to measurable outcomes and exploring possible commissioning models. Through this programme of work OCCG is able to respond effectively to Offer 3: Listening to patients and increasing their participation.

Our early work in Phase 2 indicates that there is significant scope for delivering better services at reduced cost. Phase 2 will be completed by September 2013 and will ensure robust service and cost models.

2.2 Promoting integrated care through joint working.

Integration is built on collaborative working, shared decision making and jointly (as well as locally) defined priorities. We recognise that in order to make the best use of available and limited resources we need to integrate across the health system. Our Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy are proven mechanisms for effective partnership working. In planning for 13/14 and beyond we have worked with the Health and Wellbeing Board, County Councils and patient representative groups to refresh our local priorities and define three more which will contribute to our Quality Premium (see Quality section).

Integrated care is a key part in commissioning for outcomes. From direct NHS health care services through to social care and voluntary services which can provide additional on-going support for recovery and management, every service provider will be incentivised to work together to improve overall health outcomes of a service user. Shared accountability will facilitate integration to produce improved outcomes.

We are at the forefront of driving forward integrated care, giving explicit consideration to ways we can increase joint working. One such way has been the establishment of pooled budgets for areas of Mental Health, Learning Disabilities and Older people's services; pooled budgets will continue to be a priority for the OCCG in 2013/14 as a way to reflect and commission for local needs. In recognising integrated care as a key theme we can take advantage of the NHS CB's offer to better inform commissioning through improved and integrated information systems. More recently we have agreed in principle to expand the Older People's pool and will be working on this in 2013/14.

2.3 Moving care closer to home

OCCG aims to keep people out of hospital when better care can be provided in other settings such as the community- this is in line with a national drive to reduce unnecessary admissions to the acute sector and provide patients with local services. Our multidisciplinary assessment unit at Abingdon Hospital has proved a success in our South West Locality, reducing admissions to acute care settings and facilitating the discharge and return home of patients following a spell in an acute trust. Similar intermediary units and services are to be developed for other areas in the county as the OCCG looks to commission innovative approaches to caring for patients in the community- the Healthier at Home blueprint (section ?) explains this approach further.

OCCG fully supports the national recognition that emergency and acute care should not be used when patients would benefit from care in other settings. Offer 1 from the NHS CB (to move towards seven day service provision) will reduce weekend and out of hours admissions in to emergency care and will require more effective utilisation of care settings beyond acute trusts. Meetings with providers have confirmed their support of these commissioning intentions.

The provision of locally available services means we can ensure our population has rapid access in to all care services when they require it. As early implementers of the NHS 111 service we have lead the way in improving a single point of access in to the healthcare system and will seek to enhance this further over 2013/14. This service is patient-centric using a consistent means of assessment allowing us to direct patients to the appropriate care setting, preventing unnecessary visits and waits at A&E by promoting the availability of other options and care settings. The notion of "Right place first time" will rely on the increased provision of out of hours and community services.

2.4 Commissioning patient centred services.

Outcomes based commissioning, increased integration and the movement of care closer to home all testify to our commitment to put the patient first; each transformation seeks to increase the quality of services and commission around service user needs. We are taking the key message of "No decision about me without me", traditionally applied to shared patient-clinician decision making in frontline health services and applying it to our commissioning approach.

This will support the offer from the NHS CB for increased patient participation and increase listening to patients (Offer 3). We take this as a welcome opportunity to show case our consistent and successful examples of patient engagement in our commissioning activities.

At our *Outcomes Based Commissioning* and *Living Well with Dementia* events we engaged with patients, patient representatives and support groups and took the time to simply listen to first-hand accounts of using services we commission. These listening exercises have provided the scope and the first draft of the outcomes to be taken forward in the Outcome Based Commissioning project in to 2013/14. Key to our drive for commissioning patient centred services is having the ability to monitor how we are doing and the introduction of the Friends and Family Test will align with local initiatives to measure and act on patient experience feedback.

In practice our patient centred services will strive to enable service users to maintain or regain independence allowing them to choose their care from a wide range of quality and qualified providers.

3. Quality- at the centre of all our work

Quality is about delivering an excellent service in an as effective way as possible and is central to all aspects of commissioning within OCCG; we will ensure quality is incorporated into all aspects of commissioning including: health needs analysis, procurement, service redesign and performance management of our providers

OCCG will ensure all providers deliver the expected rights and pledges from the NHS Constitution, comply with national quality standards such as the National Institute for Health and Clinical Excellence (NICE) and operate to the high standards expected within the NHS. Safety of patients is the number one priority of OCCG and we will expect our providers to comply with the national standards relating to safeguarding vulnerable adults and children, reducing hospital acquired infections such as MRSA and reducing community infections such as TB. Further details are in Domains 4 and 5 below (section 6).

OCCG monitors the quality of healthcare provision in Oxfordshire by reviewing quality and performance indicators, serious incidents, clinical audits, patient experience information, morbidity and mortality data and GP feedback. Over 2013/14 we will be ensuring greater utilisation of the GP feedback route and several of the Localities are focusing on this (see projects under Domain 1 and 2, (section 6).

3.1 Quality focus

Our main quality drive is centred around patient feedback and then addressing the smaller but high impact areas of quality concern such as delays in letters and ease with which appointments can be booked, changed and organised. Key work streams for 2013/14 will include:

- Improving administration and capacity issues in Ophthalmology and ENT specialities;
- Ensuring all Providers have robust Quality Assurance procedures to monitor and manage capacity, administration processes and clinical communication;
- Developing clear pathways so that patients are seen at the right time, by the right person in the right place.

- Improving communication between Community Mental Health Service and GP Primary Care services
- Improving the safety culture within the Learning Disabilities services commissioned from Southern Health NHS Foundation Trust
- Improving access to diagnostic ultrasound

OCCG will use a standard escalation policy to ensure Providers rapidly improve sub optimal services. This includes the use of contractual levers where necessary such as contract queries and performance notices.

OCCG will also monitor provider compliance with safety alerts, review CQC inspections and monitor mortality rates using information from Dr Foster. The above quality information will also inform the CCG's selection of commissioning priorities.

After reflecting on the recommendations of the Francis report into the failings at Mid-Staffordshire NHS Trust OCCG will be increasing the amount of information on quality we receive and broadening the sources from which we receive it. From 2013/14 this will include information from commissioners' inspections and visits to providers, information from providers' complaints and more information directly sourced from clinicians and patients. Multiple sources of information will be scrutinised together to enable a comprehensive view of quality in provider organisations.

3.2 Quality Premium

OCCG intends to achieve the NHS CB "Quality Premium" incentive for clinical commissioning groups; for OCCG this will be worth approximately £3.5 million for full compliance which would be available in 2014/15.

This requires OCCG to meet 4 national targets / measures:

- Reducing potential years of life lost from amenable mortality (12.5%)
- Reducing avoidable emergency admissions (25%)
- Improving patient experience of hospital services (12.5%)
- Preventing health care associated infections (12.5%)

3 local indicators have been agreed through a Joint Priority Setting process. A joint workshop (involving Health and Well Being Board, County Council, Districts and LINK representatives) was held in February to review available indicators, current OCCG performance and discuss areas where we should align improvement programmes and incentivisation across the system. There were key themes highlighted for OCCG to consider taking forwards which were: Prevention, patient experience (specifically of older people) and integration. These then lead to the following areas being chosen as our Local Priority indicators for 2013/14:

- Reduction in the number of excess bed days resulting from delayed transfers of care (12.5%)

- Increase the percentage 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 (12.5%)
- Increase flu vaccinations for at risk individuals under the age of 65 excluding pregnant women and carers. (12.5%)

Subject to regulations, OCCG will have its Quality Premium reduced if our main providers do not meet the NHS Constitution requirements for the following rights and pledges:

- 18 weeks Referral to Treatment pathway
- 4 hour A&E target
- 62 day cancer target
- Cat A Red 1 Ambulance achieving 8 minute response time

3.3 CQUIN for 2013/14

3.3.1 Pre Qualification Criteria

In order for providers to qualify for CQUIN payments, they will need to satisfy at least 50 per cent of the pre-qualification criteria that apply to them. Trajectories are being set with Providers for each of the relevant pre-qualification criterion. These agreed trajectories will be part of the contract.

3 million lives	
Telemedicine to provide whole system care delivery close to home	Telemedicine to support the more accurate assessment of patients who have become acutely unwell in community settings, to determine whether they would benefit from an assessment in an acute hospital, or whether their needs are best served in the community.
Intra operative fluid management	Trajectories to be established for 2013/14 based on specific OPCS coded procedures (in progress at OUH) and local targets of 80% will be identified for relevant procedures (via OPCS codes)
Child in a Chair	Assessment of the child for the right equipment solution, so that equipment is delivered within a reasonable time-frame with the appropriate level of funding “ <u>right assessment, right equipment, right first time</u> ” <i>Supporting national guidance will be published shortly on www.innovation.nhs.uk</i>
International and Commercial activity	Capitalise on the value of commercial intellectual property (standalone or collaboration with Academic Health Science Network) Ref: OUH IP policy 2012
Digital First	BRC funded study comparing pattern of antenatal appointments for gestational

<p>Reduction in antenatal visits for gestational diabetics</p> <p>Physiological outcomes post MI</p> <p>ICE</p>	<p>diabetics with reduced no + mHealth. Recruiting 175 women over 14 months. Patients will use smart phones to record data & blue tooth to Dept.</p> <p>For 13/14 deliverables:</p> <ul style="list-style-type: none"> No of women recruited per quarter Patient satisfaction Healthcare costs <p>Improve the physical outcomes post MI – long-term disease prevention. Jointly funded by Astrazeneca and involves the Rehab team. Patients will use an iPad to record data</p> <p>Roll over & expand to include radiology requesting / reporting</p>
<p><i>Carers for people with dementia</i></p>	<p><i>Each person admitted to hospital with diagnosis of dementia and their carer receives relevant advice & information.</i></p> <p><u><i>Provision of advice & info relevant to acute trust</i></u></p>

3.3.2 CQUIN value by organisation in 2013/14

CQUIN for 2013/14 is set at a level of 2.5 per cent of the value for all the healthcare services commissioned through the NHS Standard Contract. Based on the latest estimated values of the contracts that OCCG will have with other organisations, the following is the total CQUIN value:

Organisation	Value (current approx.)
OUH	£6,500,000
Oxford Health (Community)	£1,629,672
Oxford Health (MH)	£1,040,934

3.3.3 OUH CQUINS 2013/14

National CQUINs

One fifth of the entire CQUIN for the contract links to the national CQUIN goals where they apply, for OUH all four apply and we have given them equal weighting.

<p>Friends and Family Test</p>	<ul style="list-style-type: none"> 30% for phased expansion, required to deliver the nationally agreed roll-out plan to the national timetable missing any element of this will result in non-payment of the CQUIN 	<p>£325,000</p>
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	<ul style="list-style-type: none"> • 40% for increasing response rate in acute inpatient and A&E. • 30% for increasing score in Friends and Family Test within 2013/14 staff survey compared with 2012/13 survey results. 	
NHS Safety Thermometer	Reduce pressure ulcer prevalence by 50%	£325,000
Dementia	<ul style="list-style-type: none"> • 60% for: <ul style="list-style-type: none"> a) identification 90% of non-elective admissions ≥ 75 yrs for >72 hrs b) patients with potential diagnosis of dementia – 90% assessed and referred to specialist services • 10% linked to clinical leadership and training • 30% linked to supporting carers 	£325,000
VTE	<ul style="list-style-type: none"> • 95% of all adult inpatients VTE assessment on admission 	£325,000

Local CQUINs

Our agreed CQUIN areas are focused to drive quality improvement and support delivery of our QIPP priorities. The agreed areas and approximate financial value attributed are:

CQUIN	Notes	Approximate Financial value
Psychiatric liaison service	Roll on from 2012-13	£975,000
Baseline data for frail elderly patients/DTOC	Identify how urgent care is used currently.	£975,000
Medical Support for complex elderly patients	Expand medical outreach to Surgical areas, to reduce: complications, EDD, total LOS and improve outcomes (death, dependency, delirium).	£975,000
Single point of access	Develop rapid & efficient SPA for urgent referral	£975,000
Nursing	Roll over from 2012-13 Focus on stable workforce / nursing preceptorship / extended nursing leadership / HCA development / value for money from postgraduate courses.	£975,000
Diabetic foot disease	Develop multidisciplinary foot protection team and patient pathway.	£81,250

CQUIN	Notes	Approximate Financial value
Learning disability	Increase neurologist involvement in management of people with LD who present with seizures. Potential reduction LOS & mortality	£162,500
Diabetic support for young adults (16-25yr old)	Additional MDT support for young adults, (DSN plus dietetic and psychology input)	£81,250

3.3.4 OHFT CQUINs 2013/14

The only national CQUIN that applies to OHFT is the Safety Thermometer. In addition to this we have agreed there will be a patient experience CQUIN applied. The local areas agreed for focus this year are:

CQUIN	Area	Approximate Financial value
Discharge Pathway support	Community	TBC
Reducing non-elective admissions	Community	TBC
Rehabilitation Pathway	Community	TBC
Integrated pathway for people with Dementia	Community	TBC
Integrated Psychological Medicines Service	Mental Health	TBC
Dementia support	Mental Health	TBC
Restraint	Mental Health	TBC
Physical Health	Mental Health	TBC
Outcomes Based Commissioning	Mental Health	TBC

Implementation plans, trajectories and indicators are being finalised as part of contract negotiations and will be included in the contract and reported and monitored through our Quality Report.

3.4 Innovation - Creating a system to deliver innovation

OCCG will support the Oxford Academic Health Science Network (AHSN) and providers to develop a stronger relationship with the scientific and academic communities and industry to create solutions to health care problems and get existing solutions spread at **pace** and **scale**. OCCG will use national and local incentives to encourage all providers to embrace innovation.

In 2012/13 Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Trust both had CQUIN initiatives relating to high impact innovations included in their contract. Some of the objectives that the Trusts were required to achieve were:

- **Intra Operative Fluid Management (IOFM):** In 2012/13 OUH achieved their 20% use of IOFM in appropriate procedures. For 2013/14 this has been re-set to 80%. Trusts that did not participate in this CQUIN last year will be gathering baseline information to achieve as a CQUIN in 2013/14.
- **Integrated Clinical Environment (ICE) electronic requesting:** Over 2012/13 GPs were given access to electronic ordering for laboratory tests from a list with corresponding prices. OUH can now share the most appropriate tests for request-advocating the uptake of this forms part of the Digital CQUIN pre-qualifier.

There is a national and local intention to utilise technological solutions to improve the quality and efficiency of healthcare and ultimately patient experience. OCCG will promote the benefits of technology in improving outcomes and efficiencies by:

- utilising tele-health and tele-care in line with patient need;
- providing patients greater access to digital tools to help them manage health and care as they choose;
- moving to paperless referrals in the NHS by March 2015 so that patients and carers can easily book appointments in primary and secondary care;
- implementing paperless electronic radiology requesting in 2013/14. This is picked up in the Quality Premium local priorities with the ICE radiology reporting trajectory)
- Developing and implementing an improved informatics infrastructure and interoperability

3.5 GP Information Management and Technology

The detail behind the accountability, responsibility and on-going management of GP IT is yet to be agreed between the Area Team, OCCG and CSCSU. OCCG's preference is for GP IT support and development to be countywide and sit within the CSCSU with OCCG as service customer, provided that it is appropriately resourced and there is access to capital. This would deliver economies of scale and access to scarce skills and knowledge. An agreement is to be drawn up between OCCG and CSCSU which reflects OCCG priorities and

development of or changes to existing systems. This would be in addition to the existing CSCSU contract. This is a priority area for focus in 2013/14.

The priorities for CCG and GP IT, to be achieved over a five-year delivery plan, are as follows:-

- Delivering broad-based intelligence services in addition to CCG Knowledge Management, corporate e-communications and IT infrastructure to enable the CCG commissioning role
- Shared records – local and national solutions to enable authorised secure patient records access – from specific records accessed by targeted individuals to integrated record access anytime, anywhere
- Offer a diverse mix of tools and technologies to address public and government expectations which supports self-care, including telehealth and telecare, appointment reminders, on-line booking and repeat prescribing for patients and enables patient/citizen empowerment
- Delivery of an enabling infrastructure which supports all of the above, including information governance, informatics and IT support services, training, data standards, common IT infrastructure and programme governance.

4. Performance Monitoring and delivery

4.1 Progress against 2012/13 indicators

Oxfordshire CCG is performing well against many of the headline and supporting operational plan targets. However, the keys areas which the CCG is currently *not* delivering against in 2012/13 which also present the greatest risk in 2013/14 include:

- ***Delayed Transfers of Care (DTOC):***
In spite of improvements, Delayed transfers of Care have remained a significant challenge in 2012/13. Further effort to reduce DTOCs is currently being applied and the whole system approach will continue in 2013/14, specifically through on-going work around the Whole System Discharge Pathway. The current trajectory aims to reduce DTOC from 180 (end of February) to 100 by end of Q1 and 72 by end of Q2.
- ***Specialty Level of 18 Weeks Referral to Treatment Time (RTT):***
Since 2011/12, ORH and NOC have both been consistently achieving admitted, non-admitted and incomplete RTT targets and OUHT's performance has not deteriorated in 2012/13 (To date). The focus in 2012/13 was about delivering RTT targets at speciality level. Monitoring at speciality level has taken place during 2012/13 as part of contract monitoring processes and where needed remedial action identified. The remaining challenge area is General surgery. The expectation is that all targets will be met by the end of the financial year and maintained in 2013/14. This is informing current contract negotiations for next year.

- **A&E 4 hour Waits:**
The urgent care system has been under unprecedented pressure this winter and the 4 hour target has been missed. Whilst this is not an Oxfordshire specific issue, it is anticipated that the whole system's approach and the focus of the major work programmes on enhancing rapid access points within the community, will address the problem. This will be an area of continued focus in 2013/14.
- **Diagnostic test waiting time:**
Performance shortfalls were associated with capacity issues affecting non-obstetric ultrasound and echo cardiology. Remedial action implemented and target expected to be met from February onwards. The expectation is that performance will be maintained in 2013/14.
- **Category A ambulance calls:**
Performance has deteriorated recently and we are working closely with Berkshire West (lead Commissioners) to rectify this and bring performance back on track to be maintained in 2013/14. Both targets have been affected:
 - Category A calls resulting in an emergency response arriving within 8 minutes: 75% target vs. 68.4% year to date performance
 - Category A calls resulting in an ambulance arriving at the scene within 19 minutes: 95% target vs. 93.5% performance.

4.2 New indicators

Additionally, the NHS CB has specified new measures for 2013/14, most of which have yet to be measured. Benchmarks have been established and performance issues against targets will be addressed in 2013/14.

Performance against two of the new indicators currently falls below acceptable performance and we will require providers to submit improvement plans in order to address this:

- **Zero tolerance for over 52 week waits.** There have been 281 in the first 9 months of 2012/13. This will need to be addressed in 13/14.
- **All handover between ambulance and A&E must take place within 15 minutes and crews ready to accept new calls within a further 15 minutes.** Current performance is approximately 15% short of the 100% target. As we monitor performance and gather new data we will gain a better understanding of the potential areas we will need to focus on.

Appendix A contains the more detailed performance breakdown against all expected rights and pledges from the NHS Constitution 2013/14.

5. Financial Plan

5.1 Financial Objectives

For the first year of the OCCG as an authorised body it is essential to ensure a viable and sustainable financial baseline going forward. This will be challenging for Oxfordshire given the scale of the activity reductions required to deliver the system's QIPP challenge.

In line with NHS CB guidance the high level financial objectives for OCCG in 2013/14 are:

- **To achieve a 1% surplus**- this has required an increase of £1.0m to the 2012/13 (share of the PCT) surplus.
- **To agree (PbR compliant where applicable) contracts with providers**
- **To meet demographic driven demand pressures**
- **To maintain sufficient financial headroom to manage in-year financial risks:** 2% budget headroom (an additional budget reserve) to be invested non-recurrently in-year to support QIPP etc. This is not supposed to be committed at plan stage
- **Budget provision for MRET-** Maintain a budget provision for the balance of the marginal rate emergency tariff (MRET). All emergency activity above 2008/09 levels is contracted for at 30% of the full tariff price. OCCG are expected to hold a budget reserve for the balance of 70% which should be used for investment in-year in admission avoidance initiatives
- **Hold a 0.5% contingency reserve.**

The financial assumptions and requirements for NHS organisations are described fully in the NHS CB operational planning guidance for 2013/14, Everyone Counts: Planning for Patients 2013/14. These have been profiled into a three year financial plan for the OCCG forming part of this overarching Operational Plan.

The financial planning principles that have been discussed and agreed by Governing Body and subsequently applied to underpin this approach are:

- To constrain the in-year savings and QIPP requirement to a figure that is deliverable and credible.
- To prioritise investment funding and secure maximum value for money.
- To maximise the activity to be funded in contracts.
- To utilise a minimum of 50% of headroom at plan stage to support QIPP pump-priming and risk transfer in contracts.

5.2 National benchmarking: high performing CCG

An economic diagnostic exercise was undertaken in 2012 by KPMG who benchmarked the available spend and activity profile of Oxfordshire against other health and social care systems. It found that Oxfordshire spends 3% **more** per weighted head of population than the average for the NHS South of England.

Benchmarking following the 2013/14 allocation exercise indicates that the OCCG's allocation for secondary and community healthcare is approximately £14.5m less than the average for NHS South of England CCG's, on a weighted population basis. The allocation for prescribing is £7.8m less.

Financial benchmarking:

- We spend £6.0m more on Primary Care services
- £8.6m more on dental services
- £17.5m more on public health services
- £16.4m more on specialised services; but,
- £14.8m less on general secondary and community care
- Oxfordshire spends 23% less per head of population on social care than average for other local councils in the Prospering Southern England Cluster. A significant proportion of this represents spend on learning disabilities. (nb: the social care budget does not sit with OCCG but with the Local Authority)
- Oxfordshire spends significantly less on residential care than peers. However, we spend significantly more on residential based nursing care for elderly people.

(source: NHS South data following the national 2013/14 baseline allocations exercise)

Activity benchmarking:

- GP referrals are significantly lower than peer group.
- A&E attendances are lower than other PCTs.
- Overall elective admissions are significantly lower than peers relative to population size.
- Emergency admissions are in line with average.

From a CCG perspective the OCCG budgets are funded significantly less than average, while the performance responsibilities that it takes on are better than average in many areas (i.e. already a top performer). Performance benchmarks from the DH indicate that there may be limited opportunities for efficiency improvements as in most areas OCCG is already performing well (top decile). Appendix B includes the detail of OCCG delivery against the NHS Outcome Indicators. . **This does not mean we cannot improve** rather it means that any improvement will be more difficult to make and will likely require significant resource allocation- both in time, money and system wide engagement.

Funding would not be an issue if activity levels were within line with those budgets but there is significant activity over-performance against affordable contract levels. This manifests itself primarily in cost pressures on secondary and community healthcare contracts and in higher than average QIPP requirements. 2012/13 performance has seen a significant increase in acute secondary care activity, particularly urgent care activity. The failure of existing QIPP schemes to keep pace with and address this demand means that we start 2013/14 with a significant baseline financial risk, likely to crystallise within contract baselines.

The estimated value of this risk is £25.6m.

5.3 Financial Envelope Summary

The NHS CB has confirmed the CCG's baseline recurrent allocations for 2013/14 as:

- Commissioning - £645,566k
- Running Costs - £16,260k

Both of these figures include an amount for the Rycote practice, Thame which has transferred to Oxfordshire CCG.

The commissioning allocation has been based on an exercise run in 2012/13 to split recurrent PCT allocations by each new commissioner based on their responsibilities. This share of the plan has then been uplifted for 2013/14 growth at 2.8%. Running costs allocations have been set based on a figure of £25 per head of CCG population.

A key area of uncertainty at this stage is the impact of the Specialised Services Maximum Take transfer exercise. OCCG, through its allocation, has been notified that a net £25.5m will transfer from its commissioning baseline to the NHS CB. What is not known at this stage is the value of actual activity associated with this plan adjustment. Providers of specialised services are working through this exercise currently with the NHS CB, Specialised Commissioning Group (SCG) and Area Team. At this point of financial planning the transfer has been assumed to be revenue neutral.

A second, high risk area of uncertainty remains the accuracy of the baseline allocation exercise, particularly the share and application of existing PCT reserves into the CCG position and the split of budgets between OCCG, NHSCB and Local Authority.

5.4 Overview 3 year Financial Plan

The key planning assumptions used by the OCCG that underpin the financial plan are shown in the table below with indicative figures for 2014/15 to 2015/16 being established in line with similar assumptions:

Financial Planning assumptions: 3 year overview

Summary Assumptions:	13/14	14/15	15/16
Allocation Growth	2.3%	2.5%	3.0%
Inflation	2.7%	3.5%	3.5%
National CRES	-4.0%	-4.0%	-3.0%
Net Tariff	-1.3%	-0.5%	0.5%
CQUIIN	2.5%	2.5%	2.5%
Drug cost inflation	5.0%	5.0%	5.0%
Demand	1.3%	1.7%	1.7%
Other PbR (on acute contracts)	0.1%	0.2%	0.2%

Financial Planning: High Level 3 year overview

		Memo:				
		12/13	13/14	14/15	15/16	CAGR
		£'000	£'000	£'000	£'000	%
Income						
	Baseline	673,301	645,131	665,608	678,079	0.7%
	Growth	0	22,177	18,981	26,812	
	Sub-total	673,301	667,308	684,590	704,891	4.7%
Expenditure						
	Baseline	(662,387)	(627,310)	(648,228)	(660,767)	-0.2%
	Outturn	0	(23,475)	(6,473)	(9,971)	
	Demand	0	(7,944)	(9,210)	(9,484)	
	Tariff	0	2,179	(4,477)	(10,249)	
	Other	0	(7,396)	411	429	
	Reserves	(5,432)	(21,494)	(21,946)	(22,751)	318.8%
	QIPP Investment	0	(4,350)	(2,400)	(2,000)	
	QIPP Savings	0	28,992	14,579	16,950	
	Sub-total	(667,819)	(660,797)	(677,744)	(697,842)	4.5%
Surplus		5,482	6,511	6,846	7,048	28.6%
% of turnover:						
	Surplus	0.81%	0.98%	1.00%	1.00%	
	Reserves	0.81%	3.22%	3.21%	3.23%	
	Net QIPP	0.00%	3.69%	1.78%	2.12%	
	Gross QIPP		4.34%	2.13%	2.40%	

5 2013/14 One Year Financial Plan

2013/14 Financial Plan Summary

	13/14 Baseline	Draft 13/14 Financial Plan	Annual Growth Rate
	£'000	£'000	%
Income			
Commissioning Allocation	631,052	645,566	-1.5%
Running Costs Allocation	14,079	16,260	15.5%
Return of Surplus	0	5,482	n/a
Total Allocations	645,131	667,308	-0.9%
Expenditure			
Secondary + community healthcare			
OUH	309,460	298,638	-6.5%
Oxford Health	107,981	109,392	2.3%
RBFT	19,254	18,196	-7.8%
Out of County Providers	9,462	9,335	-6.3%
Ramsey Healthcare	5,730	5,661	-13.2%
London Providers	4,087	4,038	-1.2%
Non-Contract Activity	7,332	7,245	24.2%
Other (excluding 'pass through' payments)	14,483	16,084	-3.0%
Patient Transport	23,378	23,066	5.0%
Sub Total Secondary + community healthcare	501,167	491,656	-3.8%
Continuing Healthcare	15,781	16,126	7.2%
Funded Nursing Care	10,726	11,016	26.7%
ABI	1,884	1,935	2.7%
Equipment	761	582	88.8%
Mental Health Pool (non Oxford Health)	5,820	6,987	16.1%
Learning Disability	12,086	12,007	-3.5%
Prescribing	77,015	81,019	-0.5%
Local Enhanced Services	2,168	3,227	48.8%
Out of Hours	5,956	5,877	-1.3%
Other - services hosted for Local Authority	1,538	1,538	n/a
Running Costs	15,883	16,260	2.4%
Total Expenditure	650,785	648,228	-2.1%
Operating Position	(5,654)	19,081	74.8%
Budgetary Reserves			
Return of Previous Year Surplus	0	0	0.0%
Unallocated QIPP	0	(15,992)	n/a
100% NEL Tariff	0	5,300	0.0%
Growth Reserve	0	7,042	n/a
Investment Reserve (2%)	0	12,911	137.7%
Contingency Reserve (0.5% from 13/14)	0	3,309	0.0%
Surplus	(5,654)	6,511	18.8%

NB. Annual growth rate calculated from 2012/13 baseline (including CQUIN). The 2013/14 baseline shows figures as they stand prior to Annual Growth rate etc. being applied.

NB Figures by provider in the plan above are prior to the application of the full maximum take impact on the contract value plus any further contract adjustments including the application of the CCG QIPP planning requirement

Savings and QIPP requirements years 2 and 3 of the financial plan are sensitive to prior year performance and outturn pressures and any change to NHS growth and tariff changes.

Non-recurrent headroom

The financial guidance given to OCCG specifies the requirement to set aside 2% to cover non-recurrent commitments. Given the financial context described above it may be necessary for OCCG to commit some of this fund upfront during contract negotiations to fund double running costs of initiating QIPP schemes, and thereafter restructuring costs associated with reducing capacity. This will be an area for discussion with the Area Team. If this is managed over the three years of the medium term financial plan the OCCG would plan to taper down the up-front commitment of this reserve.

The 2013/14 draft plan for the use of this funding is shown in the table below:

Table 11: Use of the 2% Headroom Reserve

		£'000's
Headroom @ 2%		12,911
Contract Negotiations / Provider Transitional Costs	16%	2,105
QIPP Pump Priming and Locality Investment / Delivery	34%	4,350
In-Year Initiatives to Manage Risk	50%	6,456
	100%	12,911

5.6 Pressures on Financial Position

The pressure on the starting point for 2013/14 means that there is significant risk to the delivery of the objectives in year 1 of the financial plan. At summary level, a gross savings and QIPP requirement of £28.9m (4.4% of the CCG's commissioning allocation) will support a £6.6m, 1% planned surplus for 2013/14, while still leaving some financial headroom to manage in-year risks. This position remains dependent upon reaching a contract agreement with our major provider (OUH) that is within OCCG's target financial envelope and being able to cap and manage additional financial risk. The contractual agreement with the OUH is crucial to the deliverability of financial plan of the OCCG.

The first call on growth, tariff deflator and savings/QIPP is to create a surplus and reserves. This constrains the amount we can apply to contracts for 2013/14 growth pressures upfront and puts immediate activity pressure on the contracts through the QIPP. **The challenge for the system is not just to keep pace with demand but to reduce 2013/14 activity levels significantly below 2012/13 outturn.**

The scale of the savings and QIPP Programme is driven by the 2012/13 outturn activity pressures and at 4.4% is likely to be in the top quartile of NHS South CCG QIPP requirements. The activity reductions required to deliver a savings and QIPP challenge of £28.9m are in the order of:

A&E attendances	-10%
NEL admissions	-15%
NEL XS bed-days	-50%
EL admissions	-2%
OP 1st	-5%
OP follow up	-15%

There is significant financial risk in year 1 of the plan. This is expected to reduce through year's 2 and 3 of the plan as the CCG is able to address baseline activity pressures and demand through its QIPP schemes. This however, is sensitive to prior year performance and the delivery of the planned underlying recurrent position.

Balancing 2012/13 baseline issues with forecast 2013/14 demand and the overarching financial objectives, the CCG needs to take a medium term approach to securing financial stability, viability and sustainability. Over the 3 years of the plan the OCCG will look to deliver a higher planned surplus, additional financial headroom and address the affordability of its healthcare contracts through a robust, deliverable QIPP and cost reduction programme.

5.7 Commissioning & Contracting

Given the scale of the savings and QIPP challenge and its impact on the OUH, the most material and immediate risk to the plan is the negotiation of an affordable and risk balanced contract with the Trust. This has to be both affordable in the context of the available resources and achieve sufficient risk sharing and transfer to leave the CCG with enough headroom to manage in-year risks. It is expected that the OCCG will need to commit some of its headroom at plan stage into securing this contract.

Unless addressed at contract stage the most material in-year financial risks will be failure of the QIPP initiatives to achieve the planned activity reductions and demand growth beyond that planned for. Both risks will manifest as activity over-performance on the contract.

Commissioning budgets reflect either agreed contract values or contract financial envelopes with the OCCG's providers for 2013/14. The OCCG is agreeing commissioning intentions for its key providers that acknowledge the potential cost of outturn activity through the national payment by result framework and adjust this position for demand growth and the impact of the range of commissioning initiatives across the OCCG.

The baseline for setting contracts is 2013/14 contracted values adjusted to reflect the following:

- Planning Assumptions associated with PBR and Non PBR tariff uplifts, efficiencies and CQUIN as described in the NHS planning guidance (see table 3)

- National changes to the application of the tariff as outlined in the latest PbR guidance and adjustments to local prices
- National requirements such as the need to set aside specific funds to cover costs of NICE recommendations.
- Anticipated costs of demand in 2013/14.
- Transfers of services between the new commissioning bodies such as the NHS CB and Local Authority.
- Additional funding to reflect outturn positions of the major acute contracts
- Impact of the CCG's Commissioning Initiatives as described in the QIPP programme
- Business Cases and/or Service Developments.

Main Contracts

The context for contract negotiations with all providers will be:

- Maximum activity purchase upfront in the contract
- Agreements on risk share and risk transfer
- Management of joint objectives
- Achievement of improved outcomes
- Focus on quality improvements and driving out waste (error, delay, duplication).

The activity and financial impact of each of the schemes within the Savings and QIPP programme will be aligned to the appropriate provider as they develop. Work will progress to develop an activity management plan to ensure that it is embedded into the organisation with leads, key milestones and monitoring arrangements in place.

The impact of provider's internal CIP plans will be shared and understood as part of this process particularly in relation to the capacity and workforce changes which need to be implemented to ensure the activity reductions are matched by a genuine cost reduction.

The CCG will develop business rules to support the 2013/14 contractual process. These will be designed to ensure the CCG can exercise explicit control over compliance with expected standards.

Draft Financial envelopes for Major Contracts

	£'m
Oxford University Hospitals NHS Trust	252.7
Oxford Health NHS Foundation Trust	109.4
Royal Berkshire nhs Foundation Trust	18.2
South Central Ambulance Service	23.1
	403.4

5.8 QIPP 2013/14

OCCG has been working closely with its key stakeholders to develop a series of initiatives focused on delivering sustainable system change which drive efficiencies, manage demand and ensure that patients are being treated in the most appropriate care setting. Clinical Leads have been actively risk assessing and reviewing achievement of these with engagement from consultant colleagues at local provider trusts. For 2013/14 OCCG is targeting a series of QIPP programmes that deliver a minimum of £13m worth of activity related reduction with up to £4.3m investment available to pump-prime service change.

The table below gives a high level summary of the proposed investment and gross savings plans for 2013/14. It shows two savings columns; one adjusted for implementation time and one also adjusted for confidence of delivery.

	Investment £000	Savings adjusted for implementation time £000	Savings adjusted for both implementation time and confidence £000
Adults	350	1,433	1,209
Children and Young People	50	384	97
Locality specific	160	1,183	708
Major Programmes	1,320	3,246	3,229
Older People	922	8,935	4,894
Quality and Innovation	1,548	0	0
TOTAL	4,350	15,181	10,137

The impact of the QIPP Programmes on activity has been modelled where projects expect to make savings in secondary care. The summary below does not include any savings unrelated to secondary care activity reductions. Elements of this activity reduction will be a consequence of agreed system redesign projects that will result in a shift from secondary care activity to increased activity within social care and community services.

	Adjusted for implementation time	Adjusted for both implementation time and confidence
A&E attendances	931	741
Non-elective admissions	4,097	2,256
Excess bed days	4,894	2,447
Elective admissions	0	0
Outpatient first attendances	903	648
Outpatient follow-up	21,004	20,553

It is clear from these tables that the full £13m activity savings have not yet been identified in the detailed bottom up projects; there is a gap of just under £3m when taking into account implementation time and confidence. In addition, at the moment, the savings delivered by reduction in non-elective admissions are calculated on the basis of full tariff whereas they are currently paid at marginal rates (30%); this would add about an additional £3m to the gap (ore require that non-elective admissions are reduced by an additional 5,000).

OCCG is looking at the following areas to reduce the £3m gap:

- Targeting of £1m from elective pathways (reduction in first outpatient attendances, consultant to consultant)
- Bringing forward delivery of the projects focused on reduction in no-elective admissions to deliver an additional £1m
- Reduction in pump-priming investment by £1m

The debate about the savings released through reduction in non-elective activity will need to be part of the contract negotiation discussions with OUHT and OHFT.

5.9 Running Costs

OCCG will be expected to demonstrate that their administrative costs are reasonable and in line with the nationally determined benchmark of £25 per GP registered population which equates to £16.4m for OCCG in 2013/14.

OCCG running costs will include all costs associated with the corporate and operational management of the OCCG, including any outsourced commissioning support services. OCCG has entered into a service level agreement with Central Southern Commissioning Support Unit for the provision of some commissioning support services.

The planned breakdown of the OCCG's running costs are shown in the table below:

Table 6: CCG Running Cost Budget

Running Cost Commitments			
	£'m	%	£ per head
Allocation	16,260		25.0
CCG Own Costs	7,916	49%	12.2
CSU Costs	6,302	39%	9.7
Accomodation Costs	800	5%	1.2
Running Costs Contingency	1,242	8%	1.9
	16,260	100%	

5.10 Financial Risk Assessment

There is significant financial risk in year 1 of the plan. This is expected to reduce through year's 2 and 3 of the plan as the CCG is able to address baseline activity pressures and demand through its QIPP schemes. This however, is sensitive to prior year performance and the delivery of the planned underlying recurrent position.

The most material and immediate risk to the plan is the negotiation of a contract with the OUH. This has to be both affordable in the context of the available resources and achieve sufficient risk sharing and transfer to leave the CCG with enough headroom to manage in-year risks. It is expected that the CCG will need to commit some of its headroom at plan stage into securing this contract.

Unless addressed at contract stage the most material in-year financial risks will be failure of the QIPP initiatives to achieve the planned activity reductions and demand growth beyond that planned for. Both risks will crystallise as activity over-performance on the contract.

The following table summarises the identified financial risk at this stage of planning:

Financial Risks

Financial Risks	£'m	%
QIPP non-delivery	13.0	2.0%
Demand growth (based on 12/13 trend and in excess of funded amount)	6.4	1.0%
Pooled Budget Risk - LA risk share	2.5	0.4%
CHC retrospective risk	1.0	0.2%
Rycote Practice overspend	0.8	0.1%
Community Hospital over-performance	1.0	0.2%
Non-contract activity	0.5	0.1%
	25.2	3.9%

The OCCG has set aside a contingency of £3.3m, (0.5%) which is in place to cover any further pressures which might arise in year. Traditionally the health system has been required to cover additional costs of over-performance predominately generated from demographic demand, rises in local prices above inflation (in areas such as high cost drugs) and failure to achieve QIPP programmes linked to activity redirections.

The table below is a summary of the current risk management and mitigation plans to address the 2013/14 risks:

Financial Risk Management and Mitigation Options

Management/Mitigation Options	£'m	%
Contingency/Headroom	9.8	1.5%
Cap pooled budget risk share	2.5	0.4%
Move community hospitals to block	1.0	0.2%
Specialist Commissioning (Base case benefit)	4.8	0.7%
Limit QIPP investments	1.0	0.2%
Control running costs	1.0	0.2%
Cap over-performance risk in contracts	5.1	0.8%
	25.2	3.9%

This position would appear to cover the identified financial risks, however, many of the management and mitigation options have delivery risks in their own right. Most notable of these is the target to transfer c£5.1m of activity risk to providers through the contract negotiation.

6 NHS Outcomes Framework Domains: Delivering our Work Programmes,

The remaining sections of this plan outline, by Domain, our main work programmes for 2013/14. Together these contribute to the activity reductions and financial savings shown in section 5.8. Each Locality and Programme Lead (Adult, CYP, Major Programmes and Older People) is developing detailed implementation plans with milestones and key performance indicators (KPIs). Implementation of our plan will be monitored against these more detailed plans. All of the programmes described below begin to deliver change in 2013/14 but will be delivered in full over the next three years.

Domain 1

Preventing people from dying prematurely

Domain 1: Reducing health inequalities

Oxfordshire has a very diverse population and our aim is to reduce health inequalities which exist across the county by improving identification of unwarranted variation in uptake of and access to service provision. We are targeting unwarranted variation with the aim of improving health outcomes- specifically amongst groups which have a consistently low uptake of health care services and who may be harder to reach.

The six Localities are collating and assessing available data through their member practices, using different methods, such as Adjusted Clinical Group (ACG) data and Eclipse Live, to identify local priority areas where work can be focussed. In addition, the Public Health team

have identified key areas which will tackle variation across the county and reduce overall health inequalities.

The locality ownership of this county wide programme of work means that each Locality can work together with Public Health to focus and deliver on area specific issues which are resulting in health inequalities- each Locality has responsibility for identifying and addressing particular health and social inequalities and for working to reduce them. This is supported by the local priority related to the Quality Premium which aims to increase flu immunisations for at risk under 65s.

Domain 1: Increasing access to preventative services

This work will rely on effective joint working between OCCG and the Public Health team within the remit of the Joint Health and Wellbeing Strategy- it has a particular focus on groups which have a low uptake of services. The reduction of health inequalities and ACG work will support this line of work by allowing clear identification of groups which have a lower uptake of preventative services.

Localities are focussing on:

Screening and immunisation projects

The City has chosen to focus on increasing uptake in public health interventions in areas of deprivation (Blackbird Leys). These will include screening, immunisation, health check and lifestyle change programmes to be made available in community settings by June 2013 through a programme of active outreach. The North East has identified a more targeted programme to increase the uptake of flu immunisation amongst people under 65 who have an LTC. North Oxfordshire (NOLG) and West Oxfordshire (WOLG) are additionally focussing on cervical and bowel screening at selected practices as identified by ACG data evaluation.

Improved access to diagnostics

By providing GPs direct access to standard diagnostic test results the pathway for the patient can be quicker and deliver a better patient experience. This programme of work seeks to define which tests all GPs can and should have direct access to and will review these pathways into diagnostics. There is also a focus on increasing access to new diagnostic pathways around MRI and ultrasound services which the Quality team is leading on. The South West locality has placed an emphasis on diagnostic pathways in its Locality plans whilst diagnostic pathways in general are a focus of work more centrally through contract discussions.

Domain 1: Improving Children and young people's services

We have a joint set of agreed priorities for improving children's services with Oxfordshire County Council. The following are the priority areas agreed for 2013/14.

Extending Children and Adolescent Mental Health Services (CAMHS) thresholds

Improve provision of mental health services for young people beyond the 18 year old threshold- specifically those with delayed cognitive development. This is in line with new

developments such as Oxfordshire Autism Strategy and new NICE Guidelines. There is clinical evidence that extending CAMHS services to young adulthood will improve recovery and future self-management of young people with mental health problems.

Reviewing Learning Disability and CAMHS community services

We will continue to work to try and minimise the need for placement in inpatient beds whilst securing safe, cost-effective inpatient provision if and when it is needed. These inpatient beds are necessary in a very small number of cases but the lack of provision is providing a poor experience of care for the patients and their families. The financial impact of being able to reduce commissioning spot purchases is significant. Another community service which will benefit from review will be the pathway for diagnosing autism in children who do not present with an accompanying physical health problem- a more tailored pathway would mean enhancing the quality of esteem of mental health as is required by the national challenge issues by the Department of Health.

Commissioning for End of Life Care

Helen and Douglas House is a nationally recognised centre of excellence in providing respite and end of life care to terminally ill children and their families. We plan to evaluate a local service specification (with clear referral criteria and quality standards) for end of life care in Helen and Douglas House, involving the expertise of the third sector to deliver better value and high quality services to our local population.

Domain 1: Improving outcomes in Maternity Services

This project comes under the Outcomes Based Commissioning programme. The focus in maternity will be on maintaining the high standard of service we currently provide whilst improving the overall experience of care and reducing variation between care settings. The demand for more continuity of care across the maternal pathway (from ante through to post natal care) will require services to be delivered very differently.

We have just completed phase 1 of this project- this has given greater detail of scope, financial outcomes and next steps. Phase 2 has commenced and the Maternity work stream is developing links with Public Health and the Area Team to ensure we have captured services delivered on the periphery of the pathway (Health Visiting and Obesity management courses for example), as well as working with providers to explore potential models of service redesign.

Domain 2

Enhancing quality of life for people with long-term conditions

We want to empower and support the increasing number of people living with Long Term Conditions (LTC), across the physical and mental health spectrum. We aim to provide the right support to these people- who often have a multitude of needs- so they do not needlessly end up in hospital or find their work or home lives impacted by their condition. As far as is possible we want those patients who have Long Term Conditions to live healthy

and independent lives where they are in control of their own care and receive appropriate support as and when it is necessary.

Domain 2: Mental Health

OCCG has designated Mental Health as one of three areas in which to commission on the basis of patient outcomes. This approach should enable OCCG to commission approaches that will enable more people with mental illness to progress towards recovery and self-manage their health independently. Phase 1 of this projection has reached completion in January 2013 and we now have the scope, detail and overview of finance implications for the project. Phase 2 will focus on working alongside all stakeholders both in their advisory and provider capacities to explore further the contracting changes which could drive this new focus on outcomes.

All key projects which comprise the Mental Health programme of work are aligned to an outcomes based commissioning approach and it is seen to underpin all work:

Developing an outcomes based commissioning approach that incentivises providers to deliver better outcomes for people living with Anxiety and Depression and Psychosis.

In moving to outcomes based commissioning and contracting we will drive to increase the number of people accessing psychological services, ensure more people are in recovery, and that more people retain or enter work and settled accommodation. We are focussed on achieving greater patient reported levels of satisfaction in services and better outcomes for people with LTC through a focus on Mental Health

Review psychological therapy services in light of development of integrated psychological medicine service (IPS)

Along with commissioning for outcomes, a priority is to improve the care pathway for people with anxiety and depression by reviewing the Improving Access to Psychological Therapies (IAPT) and counselling services and creating better mapping into Step 3 and 4 psychological services.

Develop an intervention to support the physical health of people with severe mental illness (SMI)

These interventions will consist of joint physical health reviews and care planning between secondary mental health and primary care. We will ensure that people with SMI are supported within the integrated care teams.

Redesign and implement housing and employment pathways to deliver better outcomes

Improve access to housing and support to enable the move on and recovery for people with SMI through the implementation of Supported to Independent Living, SIL+. A business case including this was approved by the Mental Health Joint Management Group in November 2012. There will also be a review of employment services for people with mental illness within the IAPT work stream and secondary mental health services. Oxfordshire has an IPS model to support people with SMI *in* to work however we have identified the need to improve

job *retention* across the mental health spectrum and to look at different models. We will evaluate potential models in collaboration with experts from our providers.

Additional pathway reviews will be undertaken for people with Personality Disorder by integrating the Complex Needs Service (CNS) into mainstream provision and to look at the needs of homeless people with mental health problems in Oxford City.

Why is it being done?

At the January 2013 Engagement Event on Outcomes Based Commissioning, service users and stakeholders in mental health services scoped the outcomes they would like to see from Mental Health services:

People will:

- Receive appropriate and timely diagnosis and be able to understand their condition
- Be engaged and involved in treatment and care planning to support individual recovery
- Will not unnecessarily be admitted to hospital
- Have improved physical health
- Be able to build and maintain quality relationships that support recovery and resilience
- Be engaged and active in their community
- Retain or regain work, and have secure housing and the resources to maintain stability

Domain 2: Physical Disabilities including neurological Long Term Conditions.

This programme of work will centre around a review of the current community-based interventions and will increase levels of self-management of long term conditions to improve patient outcomes and reduce unnecessary hospital admissions.

Review the pathway for supporting people with neurological LTC

This reviewed pathway will support prevention and self-care approaches and will focus on the integration of health and social care to achieve a reduction of unnecessary admissions to hospital. The review will look at the role community neurology nurse specialists, specialist community physiotherapists, occupational therapists and Personal Health Budgets. There will be a particular focus on epilepsy.

Develop pathways & provider protocols for supporting the more complex cases

The focus will be on developing preventative pathways for people with complex and rarer conditions. Reviewed pathways will avoid or delay high cost placements which currently occur due to the lack of a pathway. This will cover Acquired Brain Injury, Huntingdon's and

other rarer conditions and will increase preventative and rehabilitative support in the community reducing the need for unnecessary use of MHA1983.

Review the impact of commissioning changes on service provision

This work stream will involve mapping community services against the impact of the move of neurology and ABI to specialist commissioning and the impact of the new major trauma and specialist rehab pathways.

Why is it being done? (what problem is being addressed, what is being improved)

The Oxfordshire Joint Physical Disability Strategy wants to see more people with a physical disability and/or conditions that may lead to a physical disability able to live as independently as possible and self-manage their health. **This will be achieved by-**

- Commissioning the best possible assessment, care and support
- Helping people live as independently as possible for as long as possible through approaches that support prevention and enablement
- Developing a better deal for carers that recognizes both their crucial role in delivering care, and the importance of helping reduce stress on them in their caring role

Currently there are a number of patients who fall between services and for whom there is not a satisfactory preventative service; they receive a poor quality response in the first instance and there is an opportunity to better support them after this first contact in the community. There is scope for improved outcomes by adopting more preventative and self-care approaches linked to community specialists and the development of integrated teams. Ultimately there are risks to local health and social care commissioners from non-pathway commissioning at specialist regional level and these are also addressed.

Domain 2: Learning Disabilities

We are already working with the County Council in commissioning and providing support and services to patients with a Learning Disability- we operate pooled budgets and share accountability for delivery of health outcomes. We aim to provide seamless support for the health and social care needs of people with a learning disability, focusing on supporting people to live ordinary lives, safely and healthily, in their local community. The ways we achieve this are by working together through jointly managed Learning Disability Teams covering health and social care needs. With the increase in life expectancy and survival rate of people with complex physical and health needs there is a pressure on the service to deliver not only more support but higher levels of support. As with all services the Learning Disability work streams will work towards an improvement in quality and safety outcomes.

The key projects to address the changing needs of patients with Learning Disabilities are:

Further strengthen support for people with learning disabilities and mental health or challenging needs to be supported at home.

Introduction of Intensive Support Teams to improve joint working between inpatient services and Learning Disability Teams to prevent admission and ensure timely discharge.

Meet demand from demographic growth, and deliver contracted savings, through more efficient working across Learning Disability Teams (LDTs).

Implementation of Beehive plans.

Increase uptake of annual health checks and screening.

LDTs work with GPs, providers and families to increase the uptake of annual health checks and screening, in particular working to encourage people living with family carers to attend.

Domain 2: Long term conditions

Implementing ACG risk stratification tool to model and understand variation

We plan to model and review variations in non-elective admissions (NEL) of patients with LTC at a locality and individual practice level. Using ACG we will support practices and localities to then understand the opportunities for avoiding NEL for people with LTC and instead support self-care in the community. Performance in 2012/13 has suggested that LTC pathways are in place but the number of NEL admissions has increased slightly rather than reduced in line with QIPP plans. We believe there may be variations between practices but do not understand these in full nor why they might exist. This understanding is necessary to benchmark and identify the most effective intervention to address the variation- Domain 1 builds on this project to increase uptake of preventative approaches alongside Public Health Initiatives.

Eclipse Live

Localities will develop use of the Eclipse live tool to manage medication-related and other activity.

GP education and pathway support to mitigate variation

Offer education and pathway support to practices and localities to make best use of existing community specialist provision. This project aims to reduce non-elective admissions for people with Long Term Conditions county wide with strong emphasis on ownership within Localities.

IAPT for LTC and self-care.

Implement IAPT for people with LTC to support job retention and self-management of care. This project will be in parallel to a review of psychological therapies and the implementation of Integrated Psychological Medicines Services. OCCG approved a business case for the development of this work in October 2012. The self-care agenda is a county wide one with variations on the theme across localities. North Oxfordshire will trial the SPACE model- a self-management programme for people with Long Term Respiratory conditions. This will be used first in practices which have significant variation in their treatment of LTC or high deprivation indices. The project will be subjected to 6 and 12 month reviews to assess its effectiveness. The North East is developing a Carers Identification project to enhance

support to carers, both in their caring role and as individuals who are susceptible to poor health as a direct result of caring responsibilities.

Pathway improvements

Working with providers we will develop a new model for the diabetes pathway addressing the disjoin between specialist/community and primary care interface whilst reviewing the effectiveness of the current LES for diabetes. Other pathways will also be developed where indicated from the ACG risk modelling tool- working jointly with our providers will be key to implementing all these projects. We will also review the case management service to support integrated community care.

Why is it being done?

OCCG wants to use integration of service provision and the shift to commission for outcomes to increase levels of self-management of long-term conditions and reduce unnecessary hospital admissions. OCCG has developed a LTC strategy which states-

People with long-term conditions will have an enhanced quality of life.

- They will be much better supported to manage their health and wellbeing
- They will make fewer visits to hospital and other healthcare providers
- Those who care for people with LTC are better supported
- *No decision about me without me* becomes a reality for Oxfordshire
- Clinicians are supported to enable people to make more control of their own care where this is appropriate and within the patient's capacity

Domain 3

Helping people to recover from episodes of ill health or following injury

Domain 3- Proactive support for older, frail and vulnerable people

OCCG and Oxfordshire County Council (OCC) have been working with the City and District Councils, health and social care providers, users and future users of services, carers and other major stakeholders to develop the Oxfordshire Older People's Joint Commissioning Strategy 2013 – 2016 (OOPJCS). The consultation on this strategy finished on 31st January, 2013. It will be agreed through the appropriate governance process during quarter 1.

The strategy has six priorities:

Priority 1: I can take part in a range of activities and services that helps me stay well and be part of a supportive community. (in line with NHS Outcome 1)

Priority 2: I get the care and support I need in the most appropriate way and at the right time. (in line with NHS Outcomes 2 & 3)

Priority 3: When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.

Priority 4: As a carer, I am supported in my caring role.

Priority 5: Living with dementia, I and my carers, receive good advice and support early on and I get the right help at the right time to live well.

Priority 6: I see health and social care services working well together. (this included expanding the pooled County Council and Clinical Commissioning budgets that cover community services)

This strategy has been used to inform the development of implementation plans in the form of a blueprint called "Healthier at Home" which describes the end state components that need to be in place for people to receive the right care that ensures they can remain at home. The key change outlined by the blueprint is to develop three more urgent care multidisciplinary units across the county which will avoid acute hospital attendances for all people needing assessment and care who have not had a major trauma, strokes, myocardial infarctions but who require treatment that can only be delivered in an acute hospital setting.

This focus on sub-acute bed based care is strategically aligned with major providers and the aim is to gain agreement on this by the end of March 2013 for inclusion in the Oxford Health Community Contract and the OUH contract with milestone plans agreed.

We aim to have fully pooled budgets in place in shadow form from April 2013 until the end of Quarter 1 and following this to be fully pooled with a risk share in line with the proportions of the contributions.

Why is it being done (what problem is being addressed, what is being improved)?

The problems are fourfold:

- Older People are saying they want help with managing their long term conditions, help with planning for the future and access to activities to keep them well and avoid isolation
- Older People are saying they and their carer want good treatment at home or close to home, at the right time – currently too many people are going to acute hospitals for treatment as there are few quality integrated service alternatives.
- Older People who are admitted in to acute hospitals are staying there too long then being transferred to community hospitals and delayed there too. All too often people are going in to care homes when they may be able to stay at home but currently are not able to as the care at home support is not available.
- We have not transformed our services that will enable them to be fit for the future increase in population and reduced financial environment.

We have a plan in place to transform services so that Older People will be able to better receive information and advice about their health and early support services. This is OCCG's push to address urgent care needs, using a single pathway, which where possible will be met in their own homes or through attendance at an urgent care multidisciplinary unit. When

they do require treatment in acute hospital service that this takes place in a timely way and that people are returned home or an appropriate bed based sub-acute unit, directly following that treatment, without a delay.

The improvements will be:

- More people will stay healthier for longer
- There will be an enhanced capacity and capability in primary care to treat older people who are frail in a predictive way, and for those who are ill and have urgent care needs medical decision making will be brought into or close to the person's home.
- The assessment that older people receive will be multidisciplinary, this will be followed by a single care pathway to receiving a care package at home or a short episode of bed based care followed by rehabilitation or re-ablement services at home

Domain 3: Right place first time (e.g. 111, single point of access)

Over the last year the single point of access (SPA) service for professionals and the NHS 111 service have been implemented in Oxfordshire. Both are designed to simplify access to services and ensure that individuals are provided with the right response first time.

The 111 number has resulted in the whole scale review of the responsiveness of urgent care in the community. Services will provide a 0-4 hour response. The 111 number will also provide better whole system resilience in times of surge and the urgent care 'nerve centre or air traffic control' will for the first time, bring a better level of control and understanding of the urgent care system.

This is in turn supported by the continuation of the Paediatric Urgent Care project which is working to improve the pathway for acutely sick children in to emergency care- rapid access in to the appropriate healthcare setting is a key priority for the county and specific groups therein.

We need to continue to implement and develop these services over 2013/14 to maximise benefits to patients.

Why is it being done (what problem is being addressed, what is being improved)?

Right Place First Time and Choose Well campaigns

This ensures access to the right urgent care, in the right place and time, away from hospital and closer to home. This will reduce unnecessary admissions and includes the Choose well Campaign

Single Point of Contact – 111 number for local population

To centralise a single phone number to access all urgent care, linked to both the 'phone first' message and scheduling of urgent care. This will also provide a service which is accessible 24/7 to answer the urgent health and social care needs of both public and professionals. Work is being done to analyse where the gaps on service provision may be for Out of Hours

capacity. Delivery of performance standards is not consistently achieved by the NHS 111 service and the SPA service and we are working closely with Oxford Health (Lead Contractors) to jointly understand and improve delivery issues.

How will we know it is done?

- Consistent delivery of NHS 111 performance standards
- Right services provided to patients (review of data and patient experience) through NHS 111 and SPA
- NHS 111 expected to deliver reduction in non-elective admissions, A&E attendances and ambulance call outs, but this is not expected to be until towards the end of 2013/14.
- Feedback on SPA from GPs and referrers in to system will reflect performance.

Domain 4

Ensuring that people have a positive experience of care

Domain 4: Patient experience feedback

The experience of patients is a core aspect of assessing quality. The focus on gathering patient experience feedback is necessary to alert OCCG to possible quality issues, facilitate improvement and maximise patient experience and improve outcomes.

OCCG routinely monitor the experience of patients using services it commissions. This is undertaken using a range of information such as:

- national and local surveys,
- complaints and PALS queries from provider organisations.
- Patient feedback to GPs
- User feedback on services

In 2013/14 OCCG will enhance its existing knowledge by ensuring providers implement the 'friends and family test' (FFT). The FFT provides each trust with a net promoter score which allows for comparisons of trust and individual specialties. At a local level breakdown information will allow for local improvement and remedial action if required.

Where providers are not yet required to comply with the FFT such as District Nursing services then OCCG will utilise local patient experience measures to monitor the quality of service. Providers will be incentivised or penalised depending on their performance in a similar way to the national CQUIN schemes. The OCCG local schemes will also incentivise providers to act on any findings and reward them for making swift improvements to their services.

To provide an additional route for patient experience OCCG will also invite feedback via dedicated OCCG web-page or contact with the OCCG patient experience team.

Within our outcomes based commissioning work the focus is on the outcomes that matter to patients. As part of the early development we involved patients and their representatives in determining the first draft of the high level outcomes. As these are refined and the work develops we will continue to involve patients.

Why is it being done (what problem is being addressed, what is being improved)

Collecting a range of patient experience data provides assurance about the quality of commissioned services and highlights in need of improvement. It also allows for the triangulation of other quality information described in the Quality section of the plan.

When will it be done?

The first FFT target is for all adult inpatients and patients using A&E to be asked whether they would recommend the service they have used to their friends and family by April 2013. The target is for 15% of those asked to be responding to the question. The test will be extended to include maternity services from October 2013 and subsequently to cover most services.

The OCCG webpage inviting feedback will be in place by April 2013.

Domain 4: Outpatient appointments

The focus here is on providing quality services and improving the experience of care in OP appointments. Integral to this is reducing unnecessary OP appointments- these give a poor experience of care and cause delays in the system and waiting times which are equally major causes of poor patient experience.

What is being done?

There is agreement within the OUHT contract of the principles to be applied in the management of outpatient follow ups. The following work is being taken forward by the Trust:

- A review of clinic templates reducing the number of follow up slots available.
- More transparent and clear communication (to patient and GP) regarding the reason why a patient should be followed up in secondary care
- Briefing of new intakes of clinical staff on the approach to be adopted in managing Follow Up outpatients appointments effectively

Why is it being done (what problem is being addressed, what is being improved)

There is a consensus that some follow up appointments may be of low clinical value and also some follow up appointments could be achieved with alternative patient pathways. Therefore this project focuses on reducing such appointments thereby reducing waste, unnecessary patient journeys, and ensuring clinic capacity is available to see those patients who will most benefit

When will it be done?

Clinic templates are being reviewed and new templates will be implemented from April 2013. Reduction in activity will be seen from Quarter 2 2013/14.

How will we know it is done?

- Implementation of revised clinic templates at OUHT, according to OUHT timetable (due from 13 April)
- Improved quality of consultant led Outpatient follow up clinic
- Reduction in consultant led follow up appointments against target

Domain 5

Treating and caring for people in a safe environment; and protecting them from avoidable harm

Domain 5: Safeguarding

OCCG requires all its providers to comply with national best practice in order to protect vulnerable adults and children. It will work closely with key stakeholders to ensure services are safe, robust and fit for purpose.

Adult Safeguarding

What is being done?

OCCG will:

- continue to work closely with Oxfordshire County Council to protect vulnerable adults and support this work as part of the Oxfordshire Adult Safeguarding Board;
- ensure adult safeguarding requirements are specified in all contracts;
- use key performance indicators to monitor staff training in provider organisations;
- review all serious incidents to ensure investigations are thorough, that clear learning and change is identified and any remedial actions is taken;

Why is it being done (what problem is being addressed, what is being improved)

This work is vital to ensure vulnerable adults receive safe high quality care.

How will we know it is done?

The work of the Board is continually monitored via an annual User Survey completed by Oxfordshire County Council. The User survey gauges patients/service user's perceptions of care including how safe they feel. The 2013 survey is due to be completed in mid 2014. It will report internally to OCC and also to the Oxfordshire Adult Safeguarding Board. Key issues are shared with the appropriate sub group of the Oxfordshire Health and Wellbeing Board (H&WB) and with the Quality and Performance committee of the OCCG Board.

OCCG will expect all providers to comply with all KPIs, but there are few outcome measures established for demonstrating successful interventions in adult safeguarding. Oxfordshire County Council through the safeguarding team is supporting innovative research to explore if the safeguarding process in Oxfordshire allows the vulnerable adults voice to be heard? It will specifically research:

- How service users/patients are involved in the Safeguarding process?
- Are they able to determine the desired outcome?
- How can these outcomes be measured?

The research will involve consultation with a wide range of service users and professionals from a multi agency background.

Children's Safeguarding

What is being done?

OCCG will:

- continue to work closely with Oxfordshire County Council to protect vulnerable children and support this work as part of the Oxfordshire Safeguarding Childrens Board (OSCB);
- ensure children's safeguarding requirements are specified in all contracts;
- use key performance indicators to monitor staff training in provider organisations;
- review all serious incidents to ensure investigations are thorough and any remedial actions is taken;
- OCCG will work towards a multi-agency response to identifying, intervening with children at risk of sexual exploitation.

How will we know it is done?

Oxfordshire has in place a range of measures to seek feedback from Children and Young people (CYP) / parent's and carer's who have interfaced with child protection/safeguarding service interventions including but not solely:

- NHS Trust groups e.g. OUHT group "Yippee" which regularly consults with CYP
- OCC CYP Participation team leads on "Sounding Board" which undertakes thematic focus groups to directly seek views from CYP and parents/carers. This has included CYP/families who have been through the Child Protection system from a representative range of backgrounds and ages. The findings from these focus groups, positive and negative experiences of the Child Protection system, have been reported to agencies and to OSCB and have led to service improvements.

This work is ongoing, but monitored through a range of KPIs and audits as detailed above. Oxfordshire has agreed with the CYP Board 2 safeguarding targets:

- Repeat Child Protection plans to be less that 15% overall
- 50% of audits showing a positive overall improvement.

OSCB, with robust health representative, has a planned programme of themed multi agency audits in place. Integral to the measurement of positive improvement is family/CYP feedback.

Why is it being done?

This is ongoing; Section 11 of Children Act requires all services to ensure user feedback is fed into future service development. OSCB undertakes an annual S.11 audit which ensures all organisations, at least annually, consider what systems they have in place to learn from CYP/families reports on their interventions. Importantly the OCCG recognises there will likely

be recommendation from a local Serious Case Review and is setting aside investment in order to tackle issues.

Domain 5: Healthcare associated infections

What is being done?

Preventing Healthcare Associated Infections (HCAI) continues to be a key safety measure in protecting patients from avoidable harm. Through clear identification of where, when and how cases occur and monitoring cases against the monthly limit the Infection Prevention and Control Lead monitors the relevant provider organisations.

OCCG will:

- monitor provider's Infection Prevention and Control plans (IPC plans) and hold to account provider service action plans;
- undertake provider and commissioner joint Root Cause Analysis (RCA) for Clostridium difficile infections (CDI);
- scrutinise Post Infection Reviews for MRSA bacteraemias on a live IT system and input evidence when there is a community case.
- incentivise Primary Care GPs to continuing the reduction in high risk antimicrobial prescribing across primary care;
- comply with best practice antimicrobial prescribing guidance.

Why is it being done?

Reduction of avoidable HCAs is a key tenet of treating and caring for patients in a safe environment. The need to continuously reduce numbers of MRSA bacteraemias and incidences of Clostridium difficile is included in NHS Outcome Framework, Domain 5, and rewarding quality through OCCG's Quality Premium

When will it be done?

A continuous process of reduction in incidences of both MRSA bacteraemia and Clostridium difficile will be monitored and measured throughout the year through the OCCG Quality and Performance Committee.

How will we know it is done?

Through zero avoidable MRSA bacteraemias and continuous reduction in cases of Clostridium difficile and by bringing Oxfordshire in line with the best performers

For 2013/14 there is a zero limit for avoidable MRSA bacteraemias and a CDI limit of 256 which is split between OUH (having a limit of 70) and the community (having a limit of 186).

Domain 5: Implementing NICE guidance

What is being done?

- Implementation of NICE Guidance
- new guidance is widely disseminated,
- patient numbers and costs are estimated,
- lead clinicians and managers contacted,
- contact with provider services regarding implementation,
- ensuring correct designation of treatment on prescribing traffic lights,
- ensuring NICE guidance is incorporated within commissioning agreements,
- tracking of conformity with NICE Quality Standards.

Health, Wealth and Innovation require

- all NICE Technology Appraisals recommendations should – where clinically appropriate- be automatically incorporated into local formularies
- a reduction in variation and uptake to NICE technology appraisals through the publication of the Innovation scorecard
- Formularies to be published on organisations website

OCCG will also expect providers to assure the commissioners that they meet their obligations and that they are compliant with NICE technology appraisals and formularies are updated and published in a timely manner.

Why is it being done (what problem is being addressed, what is being improved)

There is a legal requirement to fund NICE Technology Appraisals and an obligation under Innovation, Health and Wealth to implement them. Other NICE Guidance provides an evidence base for improving care and stopping low value treatments and interventions.

When will it be done?

Formulary will be published by 1st April 2013 and the innovation scorecard will be reviewed for details of local variation within 30 days of it being nationally published,

On going- NICE publishes every month.

How will we know it is done?

Monitoring using a variety of methods e.g. audit, using electronic data, information from providers

Domain 5: Medicine Optimisation

What is being done

OCCG will continue its work in conjunction with providers and the wider network by improving and enhancing the use of medicines across Oxfordshire. This will include:

- Improving prescribing systems in both primary and secondary care through redesign of outpatient prescribing and better use of community pharmacy to deliver this agenda
- Reviewing and redesigning the medicine pathways. Priority areas include diabetes pathway and wound management, the evidence based and cost effective introduction of the new drugs e.g. new oral anticoagulants
- Reducing medication errors through shared care protocols and improved systems
- Improving the safety of medicines through review of specials and 'unlicensed drugs', continued reduction in medicines considered to be high risk in terms of safety eg ;the use of non steroid anti-inflammatory drugs and use of computer software to develop a more proactive system for addressing medicines related safety issues
- Continuing the reduction in high risk antimicrobial prescribing across primary and secondary care to contribute to an improved healthcare acquired infection rate
- Reduction in medicines not taken in accordance with instructions from clinicians so as to reduce waste
- Maximising cost effective prescribing in primary care

Why is it being done (what problem is being addressed, what is being improved)

Medicines are the most common health intervention and in 2012/13 £75m was spent in Oxfordshire on primary care prescribing and £31m on secondary care prescribing of drugs that are excluded from tariff. OCCG needs to ensure that this resource is used effectively to maximise the benefit to the population of Oxfordshire. By improving quality in the use of medicines we can enhance the health of the patient. In 2008/9 over 542,000 bed days in England and Wales were attributed to adverse events caused by medicines and at least 6% of emergency admissions are a direct result of problems with medicines.

When will it be done

Many of these initiatives will be started in 2013/14 and will continue into 2014/15 and beyond. Milestones include redesign of the medicines pathway for diabetes by December 2013 and reduction in use of non steroidal anti-inflammatory drugs and high risk antibiotics by 31st March 2014.

How will we know it is done

- Reduction in the rates of HCAIs
- Controlled growth in costs of prescribing – OCCG's growth in prescribing will not be more than 1% greater than that of the NHS South of England
- Care is tailored to the patient- patient experience will be enhanced
- Release of agreed efficiency savings
- Reduction in the number of bed days associated with inappropriate medicine use and adverse events

- Maximisation of the public health outcomes associated with medicines by improved concordance
- Reduction in the amount of waste medicines.
- Reduction in specific prescribing such as reduction on the number of high risk antimicrobials prescribed

In the latter cases this will be done retrospectively through audit and evaluation of the projects.

Domain 5: Emergency planning

What is being done

In order to ensure that OCCG meets its needs under the Civil Contingencies Act 2004 we will:

- Identify an accountable emergency officer to assume executive responsibility and leadership
- Contribute to co-ordinated planning for emergency preparedness through local resilience partnerships
- Support the NHS CB in discharging its Emergency Planning, Resistance and Response (EPRR) functions
- Ensure that resilience is commissioned in as part of the standard provider contracts
- Enable NHS funded providers to participate fully in regular EPRR exercises and testing processes as part of the NHS CB EPRR assurance process
- Establish an escalation route for providers on a 24/7 basis for providers who fail to maintain their performance levels
- Develop an assurance process for providers business continuity plans

Why is it being done (what problem is being addressed, what is being improved)

EPRR across the NHS remains a core function of the NHS and for OCCG. OCCG is required to meet its duties in line with the Civil Contingencies Act 2004.

When will it be done

This will be done during 2013/14 with the Chief Pharmacist designated as the Accountable Emergency Officer reporting to the Director of Quality and Innovation Senior Officer 24 hour on call arrangements have already been put in place.

APPENDICES

Appendix A: Expected Rights and Pledges from the NHS Constitution 2013/14

Position to date, and mitigating actions

KPI and Targets	Current Position	Action and expected outcome
Referral To Treatment waiting times for non-urgent consultant led treatment		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	92.4%	Overall Target met – remedial action taken for individual specialties not meeting the target.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	97.9%	Overall Target met – remedial action taken for individual specialties not meeting the target.
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	95.1%	Overall Target met – remedial action taken for individual specialties not meeting the target.
Diagnostic test waiting times		
Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral – 99%	95.6%	Performance shortfall was related to non-obstetric ultrasound and echo cardiology where there was inadequate capacity. Remedial action implemented and target expected to be met from February onwards.
A&E Waits		
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%	91.9%	Target Not Met
Cancer wait – 2 week wait		
Maximum Two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%	95.2%	Target met
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast	96.1%	Target met

symptoms (where cancer was not initially suspected) – 93%		
Cancer wait – 31 days		
Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers – 96%	97.2%	Target met
Maximum 31 day wait for subsequent treatment where that treatment is surgery – 94%	96.4%	Target met
Maximum 31 day wait for subsequent treatment where that treatment is anti-cancer drug regimen – 98%	100%	Target met
Maximum 31 day wait for subsequent treatment where that treatment is a course of radiotherapy – 94%	97%	Target met
Cancer waits – 62 days		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%	87%	Target met
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%	95.1%	Target met
Maximum 62 day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers) – No operational standard set – Local target 85%	66.7%	The target has not been met. However, patient numbers are very low. The only referrals for the year to date elapsed in May 2012 and therefore the reported YTD position reflects only this 1 month of activity and will not change until further referrals are received. No remedial action
Category A Ambulance calls		

Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)	76.4%	Target met
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%	95%	Target met
Mixed Sex accommodation breaches		
Minimise Breaches - 0	8	Action plan in place.
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 binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.		?
Mental Health		
Care programme approach (CPA): 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%	95%	Target met
Additional Measures NHS Commissioning Board has specified for 2013/14		
Referral to treatment waiting times for non- urgent consultant led treatment		
Zero tolerance for over 52 week waiters.	281	0
A&E Waits		
No waits from decision to admit to admission (trolley waits) over 12 hours	0	Maintain current good performance in 13/14

Cancelled operations		
No urgent operation to be cancelled for a 2 nd time	0	Maintain current good performance in 13/14
Ambulance handover		
All handovers between ambulance and A&E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties in both cases for delays over 30 minutes and over an hour.	83.9% (JR) and 84.2% (Horton)	100%

Appendix B – OCCG Performance against NHS Outcome Framework Indicators

NHS Oxfordshire CCG Summary spine chart

The chart below shows the distribution of the CCGs on each indicator in terms of ranks. This CCG is shown as a red diamond. The yellow box shows the interquartile range and median of CCGs in the same ONS cluster as this CCG. The dotted blue line is the England median. Each indicator has been orientated so that better outcomes are towards the right (light blue).

This CCG is in the Prospering UK cluster

