NHS
Oxfordshire
Clinical Commissioning Group

Commissioning, Contracting & Procurement Intentions 2017/18 and 2018/19


North


North East


Oxford City


South East


South West


West

1.0 Chief Executive's and Clinical Chair's Foreword

Our clinical leaders across Oxfordshire are working with patients, carers and families day in day out, they see, experience and recognise the challenges we face, both in terms of the way we provide care but also in the experience for patients and the outcomes of their treatment.

We recognise the increase in demand our health services are facing and the resources required to meet the needs of an increasingly complex cohort of patients, that is forecast to increase, and under these pressures it is apparent that our current system is unsustainable.

At the moment, the NHS in Oxfordshire often provides good or excellent care, but that is not the case for all of our services. It does not consistently provide the right care every time to everyone who needs it. Too often people suffer avoidable ill health and experience care that is less effective than it should be, whether in general practice, community services or in hospital. Nor does our health and care system always actively and consciously help people to stay well and prevent ill health. These are things we know we have to change.

There is agreement across the system that the demand and our financial pressures cannot be overcome through a 'business as usual' approach. If we don't change anything we could face a potential funding gap of £209m (including Social Care and Specialised Commissioning) by 2020/21. Through the Oxfordshire's Transformation Programme we have developed new models of care and new patient pathways which are high quality and best practice so that patients get the best possible care.

2.0 Introduction & Context

This document provides formal notice for healthcare providers about Oxfordshire Clinical Commissioning Group's (OCCG) commissioning and contacting intentions for 2017/18 and 2018/19 in accordance with contract and national planning requirements.

The detail contained herewith reflects the work required to support delivery of both the Buckinghamshire, Oxfordshire and Berkshire Strategic Transformation Plan (STP) and the Oxfordshire system's shared ambition and commitment to deliver transformational change to:

- prioritise prevention
- improve patient outcomes
- manage demographic growth pressures
- manage operational pressures within the system and;
- operate within our financial envelope.

Currently, the system is developing its local transformation plans and it is anticipated that some elements of these plans will involve substantial and significant changes to service. We have been engaging on these areas and will expect to initiate public consultations in 2017. The intentions reflected in this document are those changes in the next 2 years which will be undertaken in line with our duties regarding public engagement and public consultation.

The planning and growth assumptions agreed with providers and contained within the STP in the summary provides the platform upon which two year contracts will be negotiated within the STP footprint. The contracts agreed will be fully compliant with national requirements and reflect the national planning guidance, the National Standard Contract, National Tariff and CQUIN guidance. Any payments currently made, but not supported by national guidance, will cease as of 1st April 2017.

Provider delivery of NHS Constitutional Standards remains a priority for OCCG. The improvement trajectories agreed between NHS Improvement and providers will deliver the constitutional standards by 31st March 2017. This has been supported through the provision of additional financial resource via the national Sustainability and Transformation Fund. As such, OCCG is not planning for and will not purchase any additional activity to be sought by providers to maintain constitutional standards as the remedial actions undertaken in year have been structured to support sustainable delivery going forward.

The rebasing exercise initiated in 16/17 with Oxford Health NHS Foundation Trust will continue, to ensure service costs are accurately attributed to service lines and service values revised accordingly. This continues to include alignement of service specification to datasets, review of the currencies used to capture and cost activity and adjusted as appropriate. OCCG seeks to make full use of the national contract flexibilities available to support our transformation agenda within our financial control totals and will explore the use of new models of contracting e.g. joint venture arrangements, prime provider and alliance contracts with local providers as an enabler of the transformation required.

As part of our commitment to the STP and developing system transformation agenda, OCCG will prioritise effort and resource to support programmes of work aligned with our transformation plans. Provider proposals that do not directly correspond with the transformation agenda and/or our shared responsibility to operate within our control totals will not be considered as part of contract negotiations.

3.0 Oxfordshire CCG's Strategic Priorities 2017/18 – 2018/19

The agreed service improvements, subject to public consultation, we need to make over the next 5 years include:

- Ensuring our in-county obstetric services can sustain safe practice
- Ensuring we deliver paediatric care that matches best practice
- Reducing delayed transfers of care - in May 2016, there were 3,785 days of delay in discharging patients from hospital; compared to England averages, we know this is too high
- Ensuring Oxfordshire people stay no longer in care homes than the national average
- Supporting our GPs to effectively manage the current and rising workload and are able to support our transformation plans
- Supporting our emergency departments to meet national standards for patients being seen, treated, admitted or discharged within four hours
- Re-designing what we do to ensure we meet waiting time targets for all services, and meet cancer waiting times
- Re-designing stroke care to ensure the service always meets the national standards and to reduce the number of Oxfordshire stroke patients that have to be admitted to care homes from hospital

4.0 Engagement

In developing our plans for change we have ensured robust engagement with key stakeholders, patients and the public. Listening to and acting on feedback from stakeholders, patients and the public is important for us because we want to be confident that decisions about our healthcare services reflects the needs and views of those who use them.

Through our current engagement people have told us:

- There is a need for more local services, especially as good transport outside the City is an issue
- That those changes we make need to deliver increased patient safety, improve patient experience and deliver good health outcomes
- There is a need for much more prevention and health education for all ages about how to lead a healthy lifestyle
- They want better access to GP services
- We should make greater use of technology and innovation based on a belief that the NHS is out of date compared with other industries
- We need to improve communication between health professionals and departments and ensure NHS staff take more time to listen to patients, families and carers

5.0 Finance

The financial context for these commissioning intentions has been described in the case for change that underpins the Oxfordshire Healthcare Transformation Programme. If we do nothing, the financial gap faced by the health system in Oxfordshire will be c£170m, of which £43m falls to the CCG as a commissioning pressure. This pressure is a result of the increasing cost and increasing demand for healthcare services in the county. Over the next 4 years OCCG will receive the minimum level of growth funding for CCGs and the predicted growth in demand, expressed as healthcare activity, is in excess of this each year. Modelling indicates that if we do not change our models of care and reconfigure services, non-elective admissions will rise by 10% and bed days by 15%, with more complex admissions and a longer length of stay. Using our notified funding, allocation and the modelling to date this is set out in the table below:

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Allocation £k	679,763	729,492	744,104	758,889	774,661	803,748
Growth £k	-	49,729	14,612	14,785	15,772	29,087
Growth %	-	7.3%	2.0%	2.0%	2.1%	3.8%
Predicted Gap £k	-	-7,000	-12,000	-8,000	-9,000	-7,000
Gap %	-	-1.0%	-1.6%	-1.1%	-1.2%	-0.9%

The scale of efficiency improvements necessary to stay within our funding levels will not be met without a fundamental shift in both how care is delivered and also how care is paid for. Current contracting and payment mechanisms based on payments for activity (e.g. hospital admissions) create perverse incentives within the system; we need to move to mechanisms which focus providers on providing the right care for the individual in a fully integrated way.

In managing delivery of our financial control total we will work collaboratively with our main partners to take cost out of the system. We will challenge ourselves to improve productivity, efficiency and effectiveness through service redesign and service integration. We will explore the proposals from Oxford University Hospital, Oxford Health Foundation Trust and OxFed (other federations as they choose) to determine whether the proposed joint and integrated service model will significantly contribute to our integrated plans. We will not commission and pay for services or activity where they are identified to be of low value and low priority.

6.0 Oxfordshire CCG's Key Commissioning Intentions for 2017/18 and 2018/19 are:

6.1 Business Intelligence and Contracting

In 2017/19, OCCG will continue to ensure that robust negotiation strategies and effective contract management drives the achievement of the CCG intentions. We expect our intentions to influence and shape finance and activity plans which will facilitate the shift of patient activity to the most appropriate and sustainable setting. Quality requirements will focus on patient outcomes to ensure that high quality services are delivered, with an emphasis on assuring the delivery of value for money services. This will involve robust contract management, validation and ensuring that the most clinical effective care is delivered in the right place and at the right time. Increased focus will be placed on submission of contracted datasets from all providers for the CCG to accurately and robustly validate financial, patient activity and quality performance data of commissioned services. This will ensure our commissioning intentions are underpinned by a sufficient dataset from which the transformation agenda may be better informed and will enable the delivery of high quality and value for money health care services.

6.2 Planned Care

6.2.1 Outpatient referrals

To reduce (where clinically appropriate) contracted levels of all relevant Outpatient (OP) referrals (primarily Trauma & Orthopaedics, Ophthalmology, Ear, Nose & Throat, Gynaecology and Cardiology).

- Ensure all 1st OP referrals are relevant and necessary
- Instigate a rapid pre-referral process to better inform 1st OP referrals
- Monitor 1st OP referrals by treatment function (see follow-up ratios)
- Monitor 1st OP referrals via the Elective Care Incentive Scheme (ECIS)
- Use feedback from Practice Commissioning Packs (PCP) to inform commissioning decisions.
- Seek to minimise growth in referrals despite demographic changes
- Determine speciality areas where no FU activity is necessary within an acute and community setting

This will be achieved by the following:

- Pathway review by speciality including diagnostics and proforma review and expansion of mandatory proformas taking into account the LMC agreed criteria
- Review of GP referral rates and dashboard development and identifying incentives to reduce referrals (including incentivised use of email advice line)
- Development of instant email/telephone advice for urgent queries
- All referrals to be triaged before they are booked into clinics; develop appropriate systems to support this.
- Continued promotion of care planning with integration of care plans into EMIS and the introduction of an educational package to support this. Continued promotion of self-management and prevention (make every contact count)
- Review and implement a telemedicine and introduce a pilot for a self-management appointment for Cardiology.

6.2.2 Follow up appointments

To reduce follow-up appointments for selected treatment functions. Outpatient and follow ups ratios to be in accordance with clinical need. In more detail this resolves to work with each selected treatment function to reduce 1st OP: FU ratios to improve the 16/17 baseline ratio.This will be achieved by the following:

- Increase the use of telephone follow ups for patients who are stable
- Review of a provider's interdepartmental behaviour and encourage learning between departments
- The Commissioner will not pay for FU activity in excess of agreed ratios
- Only one chargeable first outpatient attendance for an individual to the same speciality within any 6 month period (with the same referral/condition)

6.2.3 Consultant to Consultant referrals

To reduce Consultant to Consultant (C2C) referrals outside of the agreed policy. This will be achieved by the following:

- Review the data and update the policy to ensure that the reduction in C2C does not simply transfer activity back to the GP for subsequent re-referrals.
- Appropriate first time, right place referrals
- Appropriate data on consultant to consultant referrals

- Consistent monitoring and challenging of C2C referrals
- Implementation of recommendations from 16/17 Consultant to Consultant audit
- Implementation of Consultant Connect to support referrals
- Commissioner will not pay for C2C referrals outside of the agreed policy.

6.2.4 Day case to Outpatient activity

Move current day case activity to outpatient procedure activity for selected treatment functions. Day case and Outpatient procedure ratios to be best practice and within the upper quartile or upper decile nationally. In more detail this resolves to:

- Work with selected treatment functions to identify and move day case activity to outpatient procedures activity where clinically appropriate - against specific HRGs and Treatment Functions where there are parallel tariffs
- Improve on the identified 16/17 baseline ratios and expand on the speciality selection
- Commissioners will not pay for Day case and Outpatient Procedure activity in excess of agreed ratios

6.2.5 Lavender Statements (further detail provided at 6.8.3)

To reduce the number of non-compliant procedures being undertaken against Oxfordshire Lavender Statements. This will be achieved by the following:

- Review of current clinical thresholds within the statements for appropriateness
- Implementation of recommendations from 16/17 Lavender Statement (MSK) audit and ‘other specialities’ audit
- Commissioner will not pay for procedures which do not follow the agreed policy
- The introduction of new statements where appropriate and having gone through due process.

6.2.6 Cancelled Operations

To reduce the number of non-clinical cancellations. Only provider cancellations due to patient’s clinical condition will be paid for.

- Providers will only be paid for WA14Z spells where cancellation was due to patient's condition only. A minimal tariff will be agreed for unavoidable WA14Zs, e.g. patient acutely ill with new condition.
- Implement DNA leaflet to patients via their GPs (similar to the TWEEK leaflet).
- Text message/telephone call reminders the day before.

6.2.7 Email Advice & Guidance

To support the reduction in Outpatient activity by ensuring all relevant speciality email advice services are providing responsive and quality guidance to GPs. In more detail this resolves to:

- Increase the number of speciality areas available and improve speciality areas of concern. Also, reinstate speciality areas that have been withdrawn
- Ensure regular submission of data by ensuring inclusion of key KPIs within Schedule 4
- Referrals for advice and guidance that results in an Outpatient referral will have the Email advice charge refunded
- Expand the scope of service e.g. include ECG results, test results etc.
- Increase the use of email and telephone advice prior to referral
- Audit the quality of response being given by the OUHFT
- Include 'Metabolic Bone Clinic' email advice line within the email advice service specification.

6.2.8 Gastroenterology

Review direct access endoscopy provision as a result of the NG12 NICE Guidance (suspected cancer) with a view to commissioning community wide direct access provision of this service to incorporate the 2 week wait (2WW) cancer pathway:

- Reduce demand, reduce redirection rates and ensure quick turn around on histology results back to the GP
- Review the incorporation of F-cal in referral process and inclusion of 2WW in direct access community based tests
- Give notice on current community and independent sector providers of endoscopies (inHealth)
- On conclusion of the review, amend the commissioning arrangements as appropriate to enable the provision of direct access community endoscopy services with the inclusion of 2WW diagnostics.

6.2.9 Diagnostics

Radiology: Maintain spend of radiology tests using 16/17 baseline. This will be achieved by the following:

- Review direct access provision with a view to commissioning community wide direct access services. ENT(excluding acoustic neuromas via MRI), Ultrasound, Endoscopy and Echo
- Incorporate the 2WW cancer pathway for community ultrasound and endoscopy
- Review use of radiology diagnostics by GPs to identify and work with outliers.

Pathology: Maintain spend of pathology tests using 16/17 baseline. This will be achieved by the following:

- Review and pilot Point of Care Testing in primary care if evidence is supportive and additional GP guidelines to be completed
- Anti-coagulation/Warfarin testing – development of a service within primary care (near patient testing)
- Review potential to procure direct access pathology under a block arrangement for tests or blocks of tests
- Review of 'yellow boxes' to ensure all IT links are working and additional boxes are added where possible
- To improve quality of data to enable on-going performance management, review and improvement the measurement of patient quality of care and satisfaction.

6.2.10 Cancer

The programme of work will focus on the following key areas:

- On-going review of mandatory referral pro-formas from GPs to provider
- Potential alternative rapid access clinics for underperforming specialties
- Rapid access for referrals that do not meet the 2WW criteria but where a diagnosis of cancer needs to be excluded
- Educational events
- Implementation of the new Suspected CANcer (SCAN) Multi-Disciplinary Centre (MDC) pathway (for early diagnosis)

- Increasing Cervical screening uptake
- Improving services for survivorship patients (introduction of the HOPE programme) and providers to carry out electronic holistic needs assessments and treatment summaries for each tumour site, which is shared with the patient's GP
- To improve quality of data to enable on-going performance management, review and improve the measurement of patient quality of care and satisfaction.

6.2.11 Neurology

The priorities for this programme of work are listed below, however the main aim is to move services to the community and focus on reducing the number of follow up outpatient appointments where activity levels are high to ensure a more efficient, clinically appropriate service offering. This will involve:

- Evaluation of potential new pathways
- Implementation of a new community headache pathway to reduce footfall at the OUHFT sites, decommissioning current provision as appropriate
- Evaluate the work of Gateshead CCG Community Acquired brain Injury Service (CABIS), which reduces length of stay in hospital following injury and implement as appropriate
- Movement Disorders - high volumes of follow up outpatient attendances to be reviewed
- Review Right care findings and implement as necessary (Parkinson's and Epilepsy)
- Epilepsy and Parkinson's – to reduce the number of follow up outpatient appointments and move to a community setting
- Funding and activity related to community headache pathway to be removed from contract (OUH).

6.2.12 MSK Integrated Pathway

Implement the recommendations following the whole service review of MSK. This will ensure that the most effective and efficient pathways are delivered in the most appropriate settings. This will involve:

- Facilitating rheumatology education to feed into the OCCG sponsored GP update training and review elective LOS activity to determine potential savings opportunities

- Varying the contract to remove MSK direct access physio at OUH and MSK hub service at OUH
- To establish an MSK outcome based contract including all orthopaedics, rheumatology, physiotherapy and podiatry
- Decommission MSK physio from OH Community contract and Biomechanics (MSK) from AQP Podiatry contract at OH
- The Commissioner will not pay Best Practice Tariff (BPT) for 'Early Inflammatory Arthritis' for those patients where a first outpatient appointment was within the MSK hub as part of their pathway of care.

6.2.12 Bladder and Bowel Services (includes Continence services)

The priorities for this work stream are as follows:

- The implementation of the most effective and efficient pathways delivered in the most appropriate settings.
- To provide an integrated Oxfordshire Bladder & Bowel service managing both adult and paediatric services.
- To improve quality of data to enable on-going performance management, review and improvement the measurement of patient quality of care and satisfaction
- To secure a prime provider outcome based contract to deliver an integrated acute & community service.

6.2.14 Ophthalmology

The monitoring and review of the newly implemented pilot and the development of phase 2 to implement additional pathways to be undertaken to ensure patient care is delivered in the most appropriate settings

- To develop additional pathways for inclusion into the MECs service - Wet age-related AMD pathways including stereotactic radiosurgery
- Audit cataract activity and implement recommendations further to the review of current thresholds
- Look to explore and adopt year of care payments for chronic conditions requiring regular FU outpatient attendances and clear pathways
- Decommission current pathways for management of cataracts and glaucoma at OUH
- Recommission new pathways for the management of cataracts and glaucoma.

6.2.15 Dermatology

To undertake a wider review of services and look to commission the most effective and efficient pathways delivered in the most appropriate settings. This will be achieved by the following:

- Review and extend the Minor Surgery Service to include other procedures
- Wider procurement of the Extended Minor Surgery Service across the county.
- Review findings/recommendations which could include decommissioning the existing service at OUH and procuring re-provision of a new care model
- Introducing an enhanced service for GPs excising low risk BCCs and for the management of other skin conditions as appropriate.

6.2.16 Pre-operative assessments

To reduce the amount of preoperative assessments being undertaken by providers and move to a community setting closer to home as appropriate.

6.2.17 Ear, Nose & Throat

The review and development of whole services will be undertaken to design and implement the most effective and efficient pathways delivered in a community setting. As a result of this we will:

- Exercise review findings/recommendations which could include decommission the existing service and contracting re-provision of a new service delivered by GPwSIs including a triage process.

6.2.18 Cardiology

Review of the pathways which generate the most referrals and provide specialist led GP education events. We will implement a new community cardiology pathway to reduce footfall at the OUHFT sites. This will involve:

- First location (with up to 4 weekly clinics) to be set up by April 2017

- Decommissioning existing related services and commission a new service for Heart Failure using an Outcome based contract model
- Working with OUH on the strategy to decommission current service to recommission community based service delivered by GPwSIs including triage.

6.2.19 Diabetes

To develop an outcome based contracting approach and to introduce a GP dashboard around care processes which will facilitate accessible integrated care records leading to the identification of high risk patients. This will involve:

- Improved access to tailored management and self-management advice and to pilot new models in the North East followed by the City
- Integration of dietetics, podiatry, psychology support and nurse support.
- Set up virtual advice and clinics from consultants
- Development of Oxfordshire CCG bid to the National Diabetes Prevention Programme
- Development of the Year of care approach within Oxfordshire
- In line with the agreed strategic direction, working to decommission the current provision of diabetes services
- Commission new model via an Outcome based contract

6.2.20 End of Life (EoLC)

Effective EoLC commissioning will be driven by Oxfordshire Care Summary availability live to South Central Ambulance Service and Out of Hours providers to ensure real time information. We intend to implement the following:

- A 24 hour End of Life Co-ordination centre and Community Palliative Support Service (OPAL)
- Review existing Community Palliative Care Services to support reduction in avoidable admissions with same day MDT assessment and support where necessary
- Review of the current bereavement service model available across the county
- Develop and promote an Oxfordshire web-based resource for health care professionals and patients/families/carers

- Provide rapid and multi-disciplinary assessment and support, and where necessary same day home-based services for people at the end of life
- Achievement of the above will involve decommissioning and recommissioning a service that best meets the need of our population.
- Review of existing Community Palliative Care Services to support reduction in avoidable admissions.

6.2.21 Gynaecology

- Review of all Gynae pathways and identification of which could become community based.
- Increase the number and use of One Stop Shops
- Specialist service for hysteroscopy patients
- Review potential of gynae services within the community
- Assessment/audit of current FU policy by providers in terms of national benchmarking and local data
- Review findings/recommendations which could include decommissioning the existing service and contracting re-provision of a new service (e.g. one stop shop including hysteroscopy)

6.2.22 Respiratory

To reduce COPD readmissions against the 16/17 baseline. This will be achieved by:

- Primary care – 30 minute annual assessment by practice nurse for COPD and Asthma patients
- Secondary care – HOT clinic for acute COPD patients
- Discharge letters – better quality and timeliness
- Commissioning a new model via an Outcome based contract

6.2.23 Urology

- Review of all existing urology pathways for NICE compliance
- Identification of those services should be one stop shop and /or community based

- Review of 2WW services and pathways including the use of diagnostics in 'straight to test' to improve the national targets achieved.

6.2.24 London Contracts

- Ensure commissioning intentions and locally agreed policies such as Lavender statments are incorporated into all London contracts via Optum
- Review of referral management approaches in London contracts
- In-depth data review on referrals activity into London
- Introduce a referral management approach across London contracts.

6.2.25 Best Practice Tariffs (BPT)

- OCCG will only pay the BPT where a provider is able to evidence compliance with the qualifying pathway
- OCCG will undertake audits to verify compliance and will adjust payments to reflect the audit findings as appropriate.

6.2.26 Prior Approvals (further detail provided in 6.8.3)

- In the event a provider has charged for a treatment without seeking prior approval in accordance with OCCG's Prior Approval policies, the provider will not be paid for the treatment.

6.2.27 Prioritising Prevention

All providers will be mandated to focus on the continued promotion of self-management and prevention initiatives (make every contact count). We will agree indicators within contracts which will evidence prevention strategies and patient outcomes as a result of successful patient preventative pathways.

6.2.28 Health Inequalities

In accordance with the Oxfordshire Health Inequality intiative, we will mandate providers to evidence equitable access to all. There will be no disadvantaged groups in Oxfordshire and we will require evidence from providers of reasonable adjustments made to services to reduce any inqualities. We will focus on the implementation of the accessible information standard.

6.3 Urgent Care

6.3.1 Ambulatory Pathway by default

The intention of the CCG is to increase the number of patients being treated on an ambulatory care pathway, reducing non-elective admissions and improving patient outcomes. We will also aim to sustain and monitor the non-elective care pathway to ensure patients experience the most appropriate journey for their healthcare needs and care closer to home is at the forefront. Key actions required to facilitate delivery are as follows:

- Complete the review of AEC services
- Develop robust data and business intelligence protocols including data collection methods to ensure accurate measurement of patient outcomes
- Work with the acute and community services to develop cross service protocols for effective treatment and outcomes for patients. Joined up IT is an enabler for this – increased access to shared records with read and write capacity.

6.3.2 EMU Ambulatory Pathway

Our intention is to analyse the impact and cost effectiveness of the EMU services, a review is currently underway. This review looks to make recommendations for the commissioning round 2016-17, that looks to respond to the following challenges:

- Developing and increasing usage and capacity within current services
- Improve and formalise the relationship protocols between EMU and other services, especially the varying number of acute services
- Reducing usage and reliance on acute beds and admissions into acute beds
- 48hr turn around beds as opposed to 72hr
- Develop outreach to provide clinical support to Primary care and Care & Nursing Homes, incorporating the care home support service in a redesign of available of work force drawing from susccessful models such as the Airedale model
- EMU services for the under 5s to be explored alongside current and existing EMU or AAU services. This may include Rapid Assessment in primary care & Ambulatory pathways for under 5s.

6.3.3 Review of Community Beds

A review of patients within community hospitals in Oxfordshire is in progress and will continue to be undertaken to assess the type and appropriateness of the care being provided, including a review of the pathways that have been involved and the patient outcomes. The review will include:

- Assessment of patients care needs
- Community Hospital Length of Stay
- Review pathways and identify gaps in current existing services
- We will contract for community hospital inpatient services in a way that reflects case-mix and benchmarked efficient expected lengths of stay and improved outcomes set within the context of the required system capacity for this service.
- Any agreed Provider Indicative Activity Plan will be revised to reflect EMU activity and fair pricing
- A single bed management function will be in place for the county.

6.3.4 DTOC

Our intention is to reduce the number of Delayed Transfers of Care within the Oxfordshire Health System. The following enablers for this are;

- Consider the use of personal health budgets to support the discharge of DToC
- Formal agreement of service specification to set out effective discharge processes (including outputs and deliverables from the coordination hub and effective management of self-funders within the choice framework)
- Agreeing, delivering and maintaining an optimal length of stay within the community hospitals and reduced DTOC waiting for a community hospital bed.

6.3.5 Emergency Department, MIUs and 111

We aim to ensure appropriate use of the Urgent and Emergency Care resources. This includes more appropriate use of services such as: Pharmacies, MIUs/FAUs, Access to Primary Care, A&E, EMUs/AAU and Self-Care. All of this will be undertaken with an “Ambulatory by Default” approach to each patient. Our main priorities will be:

- Delivery of the 95% 4 hour access target
- Increase the catchment footprint and attendances for each MIU
- Review the findings of the MIU/FAU reviews and develop business case for the future services. Serve notice on FAU contracts as appropriate to redesign into an integrated model
- Tariffs and payments reviews
- We intend to align all support services (X-ray etc.) with the opening hours of all Oxfordshire MIUs
- Develop a business case and options appraisal for an urgent care centre within the Oxford City locality
- 24/7 mental health integrated services in line with the “core 24 standards”. Ensure Mental Health Emergency Care Pathway patient experience adheres to parity of esteem to improve care for patients when in crisis
- Effective management of dementia, depression and delirium across the Oxfordshire Health System
- Mandatory Daily Systems Escalation Status; Inclusion within all contracts for system partners; including development of the technological solutions behind it.

6.3.6 Social Prescribing

Investigate funding streams, finalise the business case to develop social prescribing and the community network. Establish stronger relationships with the Voluntary Sector to support the urgent and emergency care agenda.

6.3.7 Hospital at Home (H@H)

To serve notice and redesign the existing Hospital at home services and commission an integrated ambulatory focused H@H service to ensure equity in provision of service across the county. To manage sub-acute patients within their own home, and to support admission avoidance and discharge facilitation.

6.3.8 South Central Ambulance Service (SCAS) 999 and 111

We aim to ensure that the most frequent users of “999” are engaged with and the continuation of the 999 High Users project, this will also link to 111, Clinical Triage and Integration with Mental Health. There will be increased focus on:

- Outlying areas in the KPIs aiming to improve Reds (Red 1 and Red 2) performance

- SCAS workforce development to increase “hear and treat” and “see and treat”
- Development of pathways for alternative/most appropriate conveyance e.g. frail elderly pathway
- Build on the Integrated UC clinical hub model to have the same professionals within the clinical call centres that may be able to help triage patients.
- Integrated commissioning of 111 to support clinical decision making and appropriate dispositions in line with national guidance
- SCAS will work with our partners in mental health trusts to ensure timely and appropriate transport for mental health patients in crisis, to a destination that is suitable and sensitive for their needs. This is to ensure that patients in mental health crisis are not conveyed inappropriately to A&E departments and police premises and that their needs are met and outcomes Enhanced.

6.3.9 Stroke Pathway

These stroke intentions are subject to the Health Oversight and Scrutiny Committee approval of level of required engagement and consultation. We aim to ensure all stroke patients receive the best quality care. We aim to reconfigure services with a view to increasing the size of the Hyper Acute Stroke Unit at the John Radcliffe and ceasing acute stroke care are the Horton hospital site.

We also believe that the best place to receive your rehabilitation following a stroke is in your own home and your own bed. We currently have a service that supports early discharge for eligible patients for part of the county; we want to expand this service to cover the whole of Oxfordshire for eligible patients. As part of the Oxfordshire Sustainability and Transformation Plan we will be looking at the provision of Rehabilitation units within Oxfordshire.

6.3.10 Oxfordshire Care Summary

Enhancing the use of OCS in maximising the sharing of relevant clinical information across the urgent and emergency care system– making sure urgent and emergency care services access OCS to inform clinical decision making in the sharing of care plans, End of Life plans etc. and the development of read and write capability. Enable wider access of relevant information to other providers e.g. community pharmacy, hospices, nursing homes.

6.3.11 Single Points of Access / Integrated Locality Teams

Scope and review existing Integrated Locality Teams, look to redesign or recommission service to involve:

- 24/7 district nursing service,
- Functionality based on Berkshire model
- Integrated hub with GPs and Childrens Services
- Mental Health Team including Psychiatrists
- Direct access to pathways, booking appointments.

6.3.12 Improved Urgent and Emergency Care Communications Strategy

There needs to be more communication regarding Urgent and Emergency services in Oxfordshire, we aim to engage with the student population to ensure there is awareness of what services are available for them. We will be looking to take advantage of the follow:

- Choose well campaign and app
- Freshers week and refreshers weeks
- Ensure System Resilience is robust for Urgent and Emergency Care and review such areas that arise during year as agreed per NHS E A&E Delivery Board recommendations

6.3.13 Emergency Centre without Specialist Services

Integrated services model to be commissioned in the north of the county which will involve aligning GP access, OOH and ED.

6.3.14 Out of Hours (OoH)

We will aim to scope and establish Urgent Repeat Prescription Requests community pharmacy service and further develop the Patient Group Directions through community pharmacy.

- OCCG will review the OoH service to ensure performance standards and investments are optimal and can offer all benefits through integration

- OoH services will work closely with GP access funds where applicable

6.3.15 Flu

Expectation of providers to meet NHSE and local flu plan requirements in a timely manner. We will ensure increased immunisation uptake in high risk groups to achieve in top decile and will include housebound patients and those in care and nursing homes.

6.4 Primary Care

We will engage in a programme of work that will focus on the following key areas:

- Development of sustainable primary care by implementing measures to address the workforce crisis and reduce GP workload where appropriate
- Commission services from groups of practices/neighbourhoods to maximise the benefits of working at scale
- Review the use of the local investment scheme
- Developing the neighbourhood (population around 30,000) as the building block for sustainability in primary care
- Delivering improved access to general practice services through the GP access fund providing extended access for the population after 1830 Monday to Friday and at weekends
- To consider alternatives to the national Quality and Outcomes Framework (QOF) to enhance the care of identified cohorts of patients, e.g. those with cardiovascular disease.
- The STP is looking to increase the capacity in primary care by 15% for clinical triage. The additional consultations arising from these plans and the increase in capacity for each locality, the multi disciplianary teams and partnership with voluntary agencies will support sign posting to other areas
- Create planned care alternatives to outpatients through developing an additional range of skill sets and practitioners in primary care to offer shorter pathways of care.

6.5 Children & Maternity

We will engage in a programme of work that will focus on the following key areas:

- The provider will implement the new model for Oxfordshire CAMHS including an Eating Disorder Service. A new contract for CAMHS to be agreed following the outcome of the Most Capable Provider process. This will include the following contracting assumptions:
    - Reduction in waiting times
    - Increase in overall activity managed by provider

- Delivery of the service redesign outcomes for Children's Continuing Care, this will include expanding the offer of Personal Health Budgets
- Implementation of the new service model for an integrated Looked After Children and Edge of Care Team
- Delivery of the recommendations of the national Maternity Review
- Delivery of the new model for Perinatal Mental Health
- To jointly commission a new Children with Disabilities residential respite service

6.6 Medicines Optimisation

We will engage in a programme of work that will focus on the following key areas:

6.6.1 Transfer of care

Improving the transfer of information about medicines across all care settings remains a key priority and should help to reduce incidents of avoidable harm to patients, improving patient safety and contributing to a reduction in avoidable medicines related admissions and readmissions to hospital. We aim to work collaboratively to improve communication to enable safe transfer of information about patient medication at admission and discharge.

Providers are asked to develop an action plan, monitor and report progress on the key priorities for implementation, specifically:

- Medicines Reconciliation
- Systems for identifying, reporting and learning from medicine-related patient safety incidents
- Code medicines related admissions for analysis, learning and prevention

- Medicines related communication systems when patients move from one setting to another-discharge transfer of care communication will contain a minimum data set of information particularly the reason why medicines are stopped, started or changed
- We wish to improve the prescription turnaround time for take home medicines to support timely discharge and improve patient flow. This requires pathway review to encourage proactive planning for discharge, efficient communication and prescribing, timely transfer of TTO to pharmacy, dispensary turnaround time to enable discharge. Prioritisation for patients on an ambulatory pathway - turnaround time to be agreed.
- TTO supply on discharge to be minimum **14 days** for all patients on discharge (including MDS)
- We wish to consider a quality measure/penalty for Trusts when requests are made to GPs to prescribe drugs which are not recommended for primary care prescribing in line with local agreed traffic light classifications for prescribing.

6.6.2 National Tariff Payment System Excluded Drugs & Devices

The CCG wishes to consider further opportunities in line with horizon scanning to improve cost effectiveness in the prescribing of high cost drugs. We will make additions and removals to the high cost drugs and devices list to reflect changes in the market, clinical practice and HRG design. We will identify opportunities for gain share, particularly with regard to biosimilars. In particular we will:

- Implement Blueteq for agreed Tariff Excluded High Cost Drugs. The CCG and Trust will work together to implement in a co-ordinated approach across agreed Specialities and in a phased manner. It would be envisaged that this would apply to new patients in the first instance.
- The CCG will review and define commissioning criteria for supply of devices to ensure value for money and clear criteria for commissioning.
- We intend to commission treatment pathways and charges in line with the charges taken into account by the NICE costing templates. We would expect the providers to implement these charges (or less) unless specifically agreed otherwise.
- We will only pay the actual cost of the drug or technology at which the provider procured the treatment (including any discounts received by the Trust or Patient Access Scheme discounts), in line with National Tariff Guidance. Any additional (administrative or other) charges applied to drugs or technologies will not be honoured unless specifically agreed otherwise in the contract. The same will apply to drugs/technologies which have been approved following submission to the Individual patient Funding Request panel.

- Medicines provided through the homecare route should adhere to all national policy or guidance published as a result of the Hackett Report, including the Royal Pharmaceutical Society's Professional Standards for Homecare Services.

6.6.3 Medicines Optimisation & Efficient Use of Resources

- Review current dressing supply arrangement – consider transfer of all to non-prescription supply model within defined criteria and in line with local formulary.
- During 17/18 we will continue to develop and look for new models of commissioning, continence and stoma products.
- Anticoagulation and/or AF review and commission effective services for patients on anticoagulation including warfarin, self-monitoring, NOACS, and ensure the pathway includes the housebound
- The CCG will seek to consider services which could best be commissioned via community pharmacy e.g. for acute conditions UTI.

6.7 Mental Health and Learning Disability Services

We will engage in a programme of work that will focus on the following key areas:

6.7.1 Delivery of 150 more Personal Health Budgets

In line with the requirements of Five Year Forward View develop and implement a plan to deliver 150 more people holding a Personal Health Budget. These may be developed in a range of care pathways, not just mental health, learning disability and Continuing Health Care.

6.7.2 Implementation of an integrated mental health and physical health service.

To support the management of long term conditions in Oxford Health's TalkingSpace Plus contract. Funding has been secured from NHSE. This will also drive forward:

- Development of a specialist service for people with autism that sits across learning disability and mental health services

- To commission specialist services for people with learning disability from our local mental health provider (Oxford Health NHSFT).

- To explore the potential for an IAPT model to support people with mental health problems to stay in or return to employment and increase the scope of TalkingSpace plus contract to include an employment service which will be subject to a bid for NHS England funding

- To develop a comprehensive psychiatric liaison service to meet the needs of people across primary care, community care and acute care.

- To bring together and redevelop the mental health urgent care pathway aimed specifically for people with mental health presentations (crisis, onset of psychosis and suicide risk, to deliver parity of esteem and support suicide prevention)
- Remove duplication of service provision and dementia diagnosis.

6.8 Quality

6.8.1 Quality Requirements (NHS National Standard Contract Levers)

We intend to impose greater discipline and consistency in how contract levers are applied with providers, in order to resolve instances of sustained and suboptimal care. Financial penalties will be applied where applicable against any deficiencies in performance or breaches of agreed targets and thresholds in provider contracts.

6.8.2 Stroke Care Pathway

In addition to the above, we intend to work with providers to improve the current care pathway for stroke patients. Specifically, to improve the quality of rehabilitation and improve value for stroke patients across Oxfordshire. OCCG will be scoping opportunities for improving the support offered to stroke survivors to recover and live well after their first 6 weeks of intensive rehabilitation. OCCG will be seeking to implement a model of care for post-acute rehabilitation that improves patient outcomes and flow through the system. In particular we will:

- Consult on a new model of post-acute rehabilitation. All options currently presented will involve procurement.

- Ensure contract specifications for post acute inpatient and community rehabilitation are enforced and amended where necessary to ensure NICE compliant stroke specific rehabilitation.

- Scope a gap in services for long term rehab and recovery from stroke by understanding the market, what can be offered, and what is of value to patients.

6.8.3 Clinical Commissioning Policies (Lavender Statements) & NICE Guidance

We intend to reduce the number of non-compliant procedures being undertaken against Oxfordshire Clinical Commissioning Policies (Lavender Statements) or which have not been recommended by NICE Guidance. This will be achieved by the following:

- Review of current threshold and tighten or clarify where required and add further Clinical Commissioning Policies (Lavender Statement) to give additional clarity on criteria.
- Expand the electronic Prior Approvals system to manage all Oxfordshire Clinical Commissioning Policies (Lavender Statements). We will also extend the electronic approvals system to manage Individual Funding Requests (IFRs).
- Implementation of the electronic prior approval system for all services within OUH
- Implementation of the electronic approval system in Primary Care to manage Individual Funding Requests (IFRs) and identified Prior Approvals
- Undertake audits (clinical & non clinical) against Prior Approval and NICE
- Roll out the electronic approvals system country wide to capture patient choice activity
- Implementation of recommendations from 16/17 Clinical Commissioning Policies (Lavender Statement) audit (MSK) and ‘other specialities’ audit

OCCG will not pay for any procedures that have not followed the prior approvals process as detailed within the policy.

6.8.4 Pressure Sores

To work with providers to innovate methods to resolve and eventually eliminate all grade 3 and 4 avoidable pressure damage in Oxfordshire. We will continue to improve all aspects of nursing care across healthcare providers to eliminate avoidable pressure sores. Inparitcular, we will work with OHFT to reduce the prevalence of pressure ulcers in the housebound community-care dependent population.

6.8.5 Surgical site infections

To work towards all surgical teams in Oxfordshire complying to best practice surgical site infection surveillance standards, and effectively addressing surgical site infection risks at the team, theatre or site level. We will negotiate surgical site infection surveillance, reporting and quality improvement as requirements in surgical provider contracts and report outcomes in the public domain .

6.8.6 Urgent surgical care pathways

To work towards responsive, patient centred, and safe urgent surgery with effective shared decision making, timely booking, and quality post-operative care across Oxfordshire.We will investigate current practice and capability in urgent surgical pathways and work closely with providers to improve performance and care.