Appendix 3.12: Operational Plan

Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Governing Body

Date of Meeting: 31 March 2016	**Paper No: 16/20**

Title of Presentation: OCCG Operational Plan 2016/17

Is this paper for	**Discussion**	✓	**Decision**	✓	**Information**	

Purpose and Executive Summary :
This paper updates the Governing Body on the development of the CCG's 2016/17 Operational Plan and outlines the next steps to submission of our final plan on 11 April 2016. This year's Operational Plan should be seen as year one delivery of local Sustainability and Transformation Plans that are being developed on different footprints.

Purpose and Executive Summary (if paper longer than 3 pages):
None

Action Required:
The Governing Body is asked to note progress on the development of the Operational plan, agree the content of the Operational Plan narrative and agree delegated authority for sign off

NHS Outcomes Framework Domains Supported (please tick ✓)	
✓	Preventing People from Dying Prematurely
✓	Enhancing Quality of Life for People with Long Term Conditions
✓	Helping People to 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

Equality Analysis completed	Yes	No	Not applicable ✓

Author: Libby Furness, Head of Planning and Transformation	**Director Lead:** John Jackson, Director of Strategy and Transformation

1. Introduction

This paper provides an update on the development of the CCG's 2016/17 Operational plan and next steps towards final submission on Monday 11th April 2016.

This year's operational plan, and those of our providers, outline the first year delivery of Oxfordshire's 5 Year Sustainability and Transformation Plan (STP), currently being developed under the auspices of the Transformation Board. Our plans are being developed through a shared and open book process.

The 2016/17 submission includes an:

- Operational Plan narrative, final draft attached as appendix 1
- Finance template – including QIPP savings
- Activity template – with a monthly profile activity for achieving the Constitutional Targets
- Systems Operational Resilience template –detailing assurance of sufficient year round capacity to manage current pressures and surges in demand

2. Progress to Date

Full draft plans were submitted to South Central on the 8th February and 2nd March. In addition to the plans detailed above we have submitted a range of strategies and documents as supporting evidence and a key lines of enquiry template.

Feedback on our March submission has been positive but has generated a number of queries which we are addressing in our final submission.

On 18 March we submitted a revised activity template and continue to develop and stress test our savings (QIPP) plans. Our plans for savings (QIPP), linked to RightCare, are being considered by the Finance and Investment Committee.

3. Better Care Fund Plans

Better Care Fund Plans are also being developed with an initial draft submitted on the 2 March and a full draft submitted on 21 March 2016. Final submission of the 2016/17 Better Care Fund (BCF) plan is 25 April 2016.

4. Key Operational Plan Deliverables

2016/17 is our opportunity to drive forward our plans for transforming the system over the next five years including:

- Developing care outside hospital in line with the Care Closer to Home Model
- Taking on delegated responsibility for commissioning primary care and ensuring it is sustainable and able to support transformational change

- An increased focus on prevention, self-care and schemes to address inequalities
- Developing plans for improved maternity and end of life services that enable choice
- Implementing plans for transformed mental health and learning disability services

There is also a focus on delivery of core business including:

- Achieving a balanced financial plan - including robust savings plans
- Delivering our ambition for reduced delayed transfers of care
- Delivering constitutional targets
- Improving ambulance response times
- Ensuring 7 day services
- Improving safeguarding

5. Next steps

We will continue to refine the finance and activity templates in line with NHSE queries, contracting conversations, the development of our savings plans and the BCF plan.

To enable the submission on the 11th April 2016 the Governing Body is asked to delegate authority for sign off of our final plans by the CCG CEO supported by Executive Directors.

6. Action

The Governing Body is asked to:

a. Note progress on the 2016/17 Operational Plan, the next steps towards the submission of a final plan and the request for delegated authority for sign off.

Appendix 1

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group

Final DRAFT V8.1

2016/17 Operational Plan

Oxfordshire CCG

Draft Operational Plan 2016/17

1. Oxfordshire's Strategic Priorities

Oxfordshire is developing a 5 year Transformation Plan that will be used to consult with the public about the transformational changes needed across health and social care over the coming years to enable more and more services to be provided in community based settings. The Transformation Plan is the strategic document that will capture our sustainability and transformation plans (STP).

Oxfordshire's Transformation Plan will outline new pathways of care and 5 year action plans for:

- Urgent and Emergency Care
- Planned and Specialist Care
- Long Term Conditions, Integrated Care and Primary Care
- Mental Health Services
- Learning Disability Services
- Maternity Services

Workstreams have been set up to identify the health and wellbeing, care and quality and finance and efficiency gaps. In parallel we have initiated working groups to create a vision for 2020/21 for each of the service areas outlined above, supported by IM&T, Estates and Workforce groups, that will provide solutions for closing the identified gaps. See the Transformation Programme Plan, submitted. The workstreams have been timetabled to provide outputs that will inform the end of June STP submission and provide appropriate detail to support public consultation later in the year.

The new pathways will illustrate how as a system we intend to drive transformation to re-shape the system, releasing £270m of savings for re-investment in services in the community. The footprint for our transformation plan is largely Oxfordshire however we have formed an alliance with Buckinghamshire, Berkshire West and East (BOB), led by OCCG's CEO, to provide an 'umbrella' transformation plan on a wider footprint for services such as Urgent Care, Ambulance services and workforce planning.

Some of the workstreams are being progressed at an alliance level led by a nominated CCG CEO; others have a local project lead and system membership overseen by a chief operating officer group reporting to Oxfordshire's Transformation Board.

Our priority in 2016/17 is to kick start programmes of transformation that over the next 5 years that will impact on the three STP gaps, deliver the NHS Mandate 2020/21 goals and deliver significant system change. The 2016/17 Operational Plans for OCCG and its partner organisations aim to show how individually and collectively we intend to deliver the first year of the STP. Our plans are being developed through a shared and open book process.

2. System Leadership

Oxfordshire has a strong history of working together through its Health and Wellbeing Board and Pooled Budget arrangements. Over the past year Oxfordshire has been working as a system through a variety of governance arrangements including the Systems Leadership Group, Transformation Board, Systems Resilience Group and the Joint Commissioning Group. This means:

- System leaders, including health and social care colleagues, are meeting regularly to work on day to day operational issues as well as working together to lead on strategic plans
- Relationships between organisations in the system are vastly improved
- System wide working is becoming embedded

Guiding Principles for the System
A set of guiding principles have been agreed by Oxfordshire CCG (OCCG), Oxford University Hospitals Foundation Trust (OUH) and Oxford Health Foundation Trust (OH). They include:
- Working to a common goal of providing the best care for patients within available resources.
- Providing care close to people's homes when safe to do so and financially viable.
- Total transparency in sharing operational and planning information, operational pressures, quality issues and finance.
- Ensuring parity of esteem
- 2016/17 contracts consistent with our developing 5 year transformation strategy.
- 2016/17 growth used to help us transform our system of care delivery.
- Collectively getting best value from 'one' pot of money, maximising value and taking out "high cost low value" activity where possible.
- Resources invested in agreed priorities.

3. Transforming Health and Social Care

Developing Care Outside Hospital
Through the Transformation Board we have developed a case for change, agreed a Care Closer to Home model and are developing a Care Closer to Home Strategy which will set out our vision of enabling more people in Oxfordshire to access care at or closer to home. Our ambition is to achieve a step change in developing community based services and reduce demand for hospital care by:
- Developing local systems of care that bring together general practice, community health, social care and the voluntary sector, supported by specialist advice, to proactively manage local population health.
- Integrating care around patients not organisations, promoting self-care and prevention, offering rapid community based access for urgent problems and supporting those with long term conditions to stay well longer.
- Engaging partners, front line staff, clinicians and the public in the development of our transformation plans.

Community Integrated Locality Teams
Demands on community teams have grown rapidly with demographic changes, issues of recruitment and retention of care and nursing staff, developments in technology and Oxfordshire's ambition to move more and more care closer to home.
To address these issues, support implementation of a greater level of ambulatory care and our Care Closer to Home plans we are piloting the delivery of integrated care based on establishing 17 co-located Community Integrated Locality Teams across the 6 localities. The aim is to bring together health and social care colleagues in neighbourhood teams working alongside 4-6 GP practices. The outcome for individuals will be 'one plan and one approach' to meeting their needs, a better life experience and more efficient use of resource. Detail can be found in the Community Integrated Locality Team document, submitted.

Sustainable Primary Care
Sustainable Primary Care is essential for delivering our Care Closer to Home plans. However Primary Care in Oxfordshire is experiencing serious pressures, driven by issues that are similar to its community and social care colleagues.

To support and develop Primary Care we plan to:

- Design and implement new models of care based on our Care Closer to Home model
- Evaluate the impact of local Prime Ministers Challenge Fund (PMCF) pilots, funding those that are successful
- Increase patient education and use of technology to support increased 'self-care'
- Increase the use of ambulatory sub-acute/acute pathways for people who become acutely unwell
- Make available an Innovation, Quality and Support team to share innovative practice and support practices in crisis.
- Pilot and learn from a range of new workforce roles to support delivery of primary care services such as:
    - Emergency Care practitioners that provide an early patient visiting service
    - Pharmacist support that provides help for vulnerable practices.
- Develop a system wide transformation workforce plan through the Transformation Board that includes primary care.
- Provide funding and seconded staff to pro-actively support the spread and development of Federations.
- Include Primary Care Infrastructure plans in Oxfordshire's Estates Plan to secure funding in 2016/17 onwards. .

NHSE carried out a risk assessment of vulnerable practices, including those the CCG has concerns about, in line with the Support for Vulnerable GP Practices Pilot Programme and 8 practices have been identified. We have also identified a number of practices at risk of financial challenges and/or imminent loss of workforce as a consequence of reduction in MPIG. As a result of a successful bid for 'accelerating strategic estates plan' funding the CCG now holds information on the status of each of our GP practice premises enabling us to work with primary care to improve its infrastructure.

A GP has been appointed to lead on monitoring and improving the quality of primary care services. We use the General Practice High Level Quality Indicator Report on the Health and Social Care information centre website and the Primary care Web tool to ensure our GP practices are not outliers. We offer advice and support to practices on infection control and safeguarding. Six monthly updates are presented to the CCG Quality Committee to ensure our governing body are well sighted on these issues.

Delegated Commissioning of Primary Care (GP's)

The CCG will assume full delegated responsibility for commissioning Primary Care from April 2016. We are currently developing a set of Primary Care indicators based on two separate dashboards for commissioning and quality.

Our 2016/17 GMS Contract negotiations will include increased delivery of the use of technology for repeat prescriptions, booking appointments and patient access to primary care services.

However practices in Oxfordshire are high performers in terms of the use of Electronic prescribing. Use of EPS R for prescriptions sent and claimed in February is 52% compared to 46% nationally. Of the 76 practices 55 practices are 'live' with EPS, 7 have 'go-live' dates and 14 practices have yet to commit (13 of these being dispensing practices).

7 day Primary Care Services

To improve access to primary care over 7 days NHS England has commissioned extended hours in addition to the standard out of hour's provision and we have commissioned

Neighbourhood Hubs at weekends and evenings. We are reviewing this provision to meet local need and ensure effective delivery of the standard.

We are developing a bid for using technology to support enhanced access to primary care at evenings and weekends. The bid is subject to assessment through the Primary Care Transformation fund (PCTF) and will be subject to an NHSE process that includes due diligence. Implementation of a successful bid would be in line with the PCTF process.

Through PMCF we have created a 'one stop shop' website (COACH) that enables patients to find health services and local support.

Use of Technology
The CCG IM&T Strategy, submitted, has driven the successful delivery of shared electronic health records, patient consent for information sharing and electronic appointments and repeat prescriptions. The current strategy will be replaced by a system wide strategy developed by the STP IM&T Workstream as part of the Transformation Programme. Development of Oxfordshire's transformation plans, based on new pathways of care, will take every opportunity to identify and optimise technological solutions. More detail will be provided in the STP.

The CCG Board oversees the development of Oxfordshire's Digital Roadmap that is being developed in partnership with local providers.

Engagement
The CCG's Communication and Engagement Strategy, submitted, outline's our commitment and approach to involving the public, patients, carers, partners and other stakeholders in our work. Engaging partners, stakeholders and the public is central to the development of our transformation plans.

There are Patient Advisory Groups for all our current redesign projects, detail can be found in the submitted strategy. As well as this there are six voluntary, non-statutory, Public Locality Forums which have been set up to bring the patient voice into commissioning decisions. They were used successfully in the recent consultation on changes to services to be provided in the newly built Townlands Hospital in Henley.

We will build on these mechanisms to bring the public voice to transformation plans including inviting the chair of one of the locality forums to attend the transformation Board.
All the STP workstreams have clinical and local authority representation providing further engagement in the development of new pathways.

Prevention
The success of our transformation plans will rely on increased prevention and self-care. We are working jointly with public health and primary care on a range of prevention activities through the Out of Hospital Programme Board, Health Improvement workstream including:

- Review of current pathways and public health priorities for Oxfordshire starting with obesity, smoking and NHS Health Checks
- Identifying opportunities to maximise the benefits of prevention programmes and targeting interventions for those at risk of diabetes, coronary heart disease, stroke and people with long term conditions.

Our prevention plans for the coming year include:

- A joint business case for alcohol brief interventions, including a new Alcohol Worker post in A&E
- Collaboration with Public Health on local Pharmacy Campaigns

- Using NHS Health Checks as a means of identifying and reducing cardiovascular risk and diabetes by providing advice and referral to a range of lifestyle interventions
- Working with primary care to establish robust coded registers of pre-diabetic patients in preparation for a bid to participate in the NDDP pilot in the autumn
- Review and redesign of the Adult Obesity Pathway and scoping the development of services for childhood obesity linked to the School Nurse programme
- Working with GP's and Federations to improve smoking cessation quit rates as a means of preventing or impacting on respiratory conditions
- Exploring Social prescribing models and commissioning services from non-traditional providers as part of a whole system prevention approach.

We aim to monitor and learn from the impact of increased screening and lifestyle interventions on health inequalities for our most vulnerable and at risk populations.

We are working closely with district council colleagues in the north of the county on a bid for the Healthy Towns project that will promote healthy lifestyles, impact on obesity and improve the health and wellbeing of older residents.

The Public Health STP workstream is focused on assessing the Health and Wellbeing gap for service area workstreams as well as at a system level.

Impacting on Health Inequalities
Health Inequalities Commission: The CCG Clinical Chair is leading a multiagency Oxfordshire Health Inequalities Commission to identify 'What Oxfordshire needs to do over the next 5 years to narrow the inequalities gap'. The aim of the commission is to:

- Understand the barriers to accessing health services and identify the causes of poor health outcomes
- Identify evidence based, value for money best practice
- Agree key objectives for reducing health inequalities across Oxfordshire
- Recommend a clearly defined joint programme of work to be delivered over the next 5 years.

We will also be considering the effects of housing, employment, income, transport, rurality and a growing older population in our plans for closing the health inequality gap. The following projects will also have an impact:

- **Rose Hill:** Development of targeted service provision from a health hub in the new community centre.
- **Banbury:** 'Banbury- Brighter Futures' regeneration action plans and a health needs assessment of the gypsy and traveller community and European migrants
- **Abingdon:** A Health Needs Assessment of people living in Caldecott Ward

Improving Access for 'Seldom Heard' Groups

- The CCG has a new draft Equality and Diversity action plan, based on our 2016/2020 equality objectives
- The Equality Reference Group has patient/ public members representing the nine protected characteristic groups to ensure their voice is heard
- Joint information sessions with Katharine House Hospice and visits by BME community leaders to increase BME awareness of hospice services
- Increasing access for BME communities in Banbury to NHS Screening programmes through co-ordinated information sessions with health professionals.
- A commitment to ensuring that culture, faith and ethnicity is reflected in EOL services and contracts.

Transforming Services for people with Learning Disabilities

During 2016/17 we will be working with partners to deliver our Learning Disability Transforming Care Plan, aligning it to existing supported living and social care pathways. Historically we have experienced low levels of admission and inpatient care for people with learning disability both locally and in specialist services. Our Transforming Care Plan, submitted, aims to ensure comprehensive services are available, across health and social care, to support people with learning disability and/or autism to remain in the community, avoiding the need for inpatient services. Our plans to reduce learning disability in-patient beds from 8 to 6 will release funding for an Intensive Support Team that supports people and their families to remain at home, prevent and de-escalate crisis situations and avoid hospital admissions. To support this we are bidding for capital funding to enable local alternatives to admission and avoid out of county placement. Specifically, we are looking at a pathway for patients with intensely complex needs to help reduce out of county placements.

We are preparing to implement plans for transitioning current specialist health services for people with learning disability from the existing provider (Southern Health) to a local provider.

There is a system which ensures the notification of the death of anyone in Oxfordshire with learning disability and we will be piloting a Learning Disabilities Mortality Review (LeDeR) programme to analyse and learn from these deaths. In addition we will be conducting a review of learning disabilities mortality in line with the recommendations of the MAZARs review.

We will be implementing SEND reforms in partnership with Oxfordshire County Council as part of our CAMHS Local Transformation Plan and expect to achieve all CAMHS LTP deliverables in the coming year. Detail will be found in the CAMHS Local Transformation Plan submitted.

Implementing the Maternity Review
The national Maternity Review has just been published. Our plans for 2016/17 will be based on the Cumberledge report recommendations and the outcome of the Thames Valley Clinical Senate review. This is a key transformation workstream and a detailed transformation plan will be provided in the STP submission, including detail choice of maternity services and perinatal mental health which are currently being worked through.

4. Devolution and Integration of Health and Social Care

Closer integration of health and social care commissioning is one of our long standing priorities. Oxfordshire has an ambition to work towards devolution which creates a potential to join up the commissioning currently done by the CCG, NHS England and the County Council and create a single pooled budget and a set of joint contracts.

It would also facilitate the development of integrated care through providers working more closely together to deliver better outcomes, better patient experience and better value.

Taking this forward we are considering:
- Taking on delegated responsibility for £85m from NHS England to commission primary medical services from 1 April 2016
- Working with NHS England national government to take on devolved responsibility for all other primary care budgets and specialised commissioning.
- Integrating our NHS commissioning responsibilities (budget £700m) with those of the local authority for social care and public health (£270m)

5. Planned Care

Delivering Referral to Treatment Times (RTT): The key performance pressures are in Trauma and Orthopaedics (T&O), ENT, Neurosurgery, General Surgery, Gynaecology,

Ophthalmology and Urology. Lists of patients waiting are reviewed by the provider and those at risk of breach are offered the opportunity to be referred for treatment within the waiting time to another provider or retained on the list if that is the patient's preference.
The top 3 elective specialities in terms of growth include General Medicine (57.9% over plan), Plastic Surgery (17.6% over plan) and Ophthalmology (3.1% over plan). Ophthalmology has been subject to a service review and new pathways will be implemented in May 2016 to manage growth. Neurosurgery, Gynaecology, ENT and Urology services are currently being reviewed. Changes to T&O will be implemented in 2017.
It is anticipated that the top 3 specialities in terms of growth for 2016/17 will be Cardiology, General Medicine and Plastic Surgery. There has been significant growth in Cardiology Outpatients and an action plan has been drafted in collaboration with the acute trust to understand and manage this. At present it is unclear whether minor revisions of service or full service review and redesign (or a combination of both) will be necessary.

2016/17 mitigation plans include:

- Identifying the top areas of over performance and development of plans to reduce activity including the GP Elective Care incentive scheme, use of GPwSI's and provision of email advice
- IMAS modelling to understand capacity required to meet demand and deliver standards
- Monitoring and interpreting IMAS modelling to compare with previous months and identify and review patterns of high referral over time
- Review and analysis of monthly backlog reports to develop increased insight
- Monitoring the performance of incompletes, non-admitted and admitted, to ensure pathway problems are identified and triangulated with other intelligence
- Regular meetings with the trust to review plans and actions, escalating concerns through contract review meetings and using contract levers to deliver improvement
- Development of a Trust incentive scheme linked to achievement of standards
- Ensuring the incomplete standard continues to be met.
- Daily PTL's
- Meeting regularly with speciality leads to continue discussions around activity growth and demand management.

Specific plans include:
T&O

- Ensuring Saturday lists are included in consultants job plans
- Outsourcing activity where patients are prepared to accept a different provider
- Validation of the waiting list
- Implementation of the new MSK assessment and treatment service
- Introduction of real time validation for T&O
- Monitoring of cancellation rates
- Review of all processes in NOC Division for 18 weeks; specialist surgery, neurosciences and orthopaedics, feedback to staff, and implementation of the review recommendation and training
- Deep dive into pauses
- Quarterly audit programme with results to data the Quality Group and Divisional Directors for action.

ENT, Urology and Gynaecology

- Scoping targeted work to impact on primary care referral outliers
- Continuing to develop and refine the ENT community project in partnership with secondary care.
- Developing action plans

Ophthalmology

- Introduction of the MECS service delivered by Optometrists in the community (circa 20% of activity)
- Introduction of Community clinics to increase capacity
- Improved processes and ways of working with more ‘1 stop shop’ clinics
- Improved patient experience through changing processes to reduce waste including cancellations and incorrect or multiple bookings

Specialist commissioning: Spinal
- Introduction of dedicated surgical lists
- Increasing consultant capacity (2 new surgeons appointed, 1 already in post)
- Increasing spinal capacity through commissioning services from independent providers

Diagnostics:
All existing 2 week wait proformas have been reviewed and revised as a result of the new diagnostic and endoscopy NICE guidance and the recommendations based on a review of diagnostic capacity and provision are planned to be implemented from July 2016. This will help us align the service offer with NICE guidance and enable us identify and close any care gaps.

The joint focus of our work with the AHSN in 2016/17 is diagnostics and aspects of precision medicine. The aim is to ensure that we are able to support affordable cost effective innovation.

Cancer
Oxfordshire has a strong network of stakeholders who work collaboratively to improve cancer pathways. There are bi monthly meetings with the acute trust to monitor the progress of the cancer programme and regular meetings with lead clinicians in various specialities to review provision of cancer services and discuss ways to improve against national performance measures. Work in this area includes:
- Active participation of commissioners and providers in the Thames Valley Strategic Network Group.
- Joint working with the voluntary sector, including Macmillan and Cancer Research UK, on a number of areas, including the SCAN pilot, to achieve timely diagnosis of cancer for patients with non-specific but concerning symptoms. We have successfully secured funding for SCAN project management and analysis.
- Implementing recommendations from the Thames Valley audit of patients diagnosed with cancer following emergency presentation to improve primary and secondary care cancer services.
- Implementing the National Cancer Recovery Package including:
    - Holistic Needs Assessment (HNA) – electronic roll out of Macmillan tool across all tumor sites. 145 assessments and care plans per month. All breast patients to have a HNA at the start and end of pathway.
    - Health and Wellbeing events held by the provider (Gynae, Urology and Generic Cancer event planned for 13th April 2016).
    - Working with the acute trust to implement the recovery package on a wider than Oxfordshire footprint, including primary care, to ensure full pathway coverage.
- A commitment to clearing the Cancer 62 day wait backlog by March 2016.
- Driving up poor cancer target performance in neighbouring Trusts in partnership with the lead CCG.
- Use of revised 2 week wait referral proformas, based on new NICE guidance, to improve referrals into secondary care.
- Using the output of the acute trust’s external peer review to identify new specific tumour sites for improvement.
- Opening a multidisciplinary centre to identify patients at an earlier stage along the cancer pathway.

- A Cancer Project to improve one year survival rates, working with Macmillan to scope what is currently available for surviving cancer patients linking these services up to provide a comprehensive package of support.
- Joint Bowel screening campaigns.
- Regular bi-monthly meetings with the acute trust to discuss progress of the cancer programme, review existing schemes and develop new initiatives as appropriate.

Veterans Health
The requirements of the Covenant are included in all contracts and we are collecting data about the number of veterans using services. Where appropriate service redesign will consciously include the specific needs of veterans.

Primary Care briefings are used to remind practices of their role in supporting armed forces and veterans and there are systems in place to enable veterans to register with a GP and systematic transfer of medical notes.

In 2016/17 we will be doing more to ensure GP's routinely ask questions at point of registration about whether someone has a service history or is a reservist.

6. Urgent Care

2016/17 plans to improve urgent care include:

A&E –four hour waits:
The following actions to improve waits in A&E are based on breach analysis work and include:
- A review of total levels of resource and skill mix against growth and changing case mix
- A review of daily patterns of resource and skill mix against the two attendance profiles.
- A review of EAU capacity
- Improvement in the transfer of patients from emergency department to beds with a focus on portaging and communication.
- Alignment of the timing of discharges to predictable peaks and troughs in the emergency department
- Review of access and reporting in diagnostics taking account of issues with transporting patients, escalation processes, staffing levels and periods of pressure in the emergency department
- A deep dive analysis to inform a robust forecasting tool for operational planning
- An A&E 'Perfect Week' in early April to assess improvements and identify further opportunities, taking account of the impact of opening of the Adams Ambulatory Care Unit and 20 extra beds in EAU

In addition we are:
- Carrying out a review of Minor Injury and First Aid Units to maximise their use across Oxfordshire as an alternative to A&E
- Developing plans in the North of the County to support sustainable GP services, Urgent Care options and the sustainability of A&E at the Horton
- Undertaking a review GP extended hours, walk in services, Out of Hours, PMCF Hubs and A&E to identify those A&E attendances that could be managed by primary care
- Establishing a single point of contact for urgent care across the Thames Valley and aligning Out of Hours to ensure delivery of an integrated service.
- Supporting the development of an Integrated Urgent Care Hub across Thames Valley to deliver the NHS 111 service that includes multidisciplinary clinical triage, treatment and advice for a range of conditions, including mental health.

Ambulance response times:

- We are working with the lead commissioner to monitor the implementation of the Thames Valley action plan to achieve recovery by March 2016 onwards. Detail in the South Central Ambulance Trust Ambulance Plan Update, submitted.

Better Care Fund (BCF):
Oxfordshire's BCF Plans for 2016/17 build on an extensive programme of work over the past year and aims to provide greater system stability and integration through incremental improvement.

We were successful in halting growth for NELs in 2015/16 and analysis suggests that we are in a good position to repeat this again in the coming year. Therefore, we have committed to a reduction of 1.76% from the expected activity within plans for 2016/17 (including 1.9% expected demographic/activity growth). This equates to 1000 NEAs avoided during 2016/17 and the BCF plan and its composite schemes are in a position to deliver this.

This year's plans include a DToC action plan and trajectory, as well as system process improvement, to ensure we continue to reduce levels of delayed transfers of care. Our DToC action Plan, submitted, demonstrates how Oxfordshire will reduce DTOC to 3.5% of total occupied bed days by the end of March 2017, a weekly target of 68 fewer DTOC's per week.

This amounts to a 50% reduction on the current average monthly performance. Each of the initiatives within the plan has a trajectory for delivery overseen by a SRO appointed from across the system. The Control Group will monitor progress weekly and mitigate any risks to delivery. The metrics for the DTOC Action Plan 2016/17 used to monitor the impact of the range of initiatives have been developed from local learning and the ECIP High Impact Changes. These measures are currently being tested with a view to signing them off at the Oxfordshire DTOC Summit to be hosted by NHS England on 22 April 2016

Detail of the risk share allocation on a quarterly basis against achievement of a reduction in delayed transfers, monitored through the BCF Dashboard, is in the BCF submission.

111 (Integrated Urgent Care)
Our plans for improving 111 include:

- Working with the Urgent and Emergency Care (UEC) Network to re-procure a joint Integrated Urgent Care (NHS 111) service across Thames Valley that will offer patients improved access to a 24/7 urgent clinical assessment, advice and treatment. The new service opens in April 2017 and will bring together Out of Hours providers and the new NHS111service
- Participating in the UEC Networks stocktake of progress in implementing the Bruce Keogh Urgent and Emergency Care Review and "Safer Better Faster".
- Working with Health Education England to develop a Thames Valley Urgent and Emergency Care Workforce Strategy
- Working with local providers to improve 7-day services with the aim of improving weekend mortality rates. We have agreed a service development and improvement plan (SDIP), submitted, to ensure compliance with NHSE Clinical Standards for seven day services.

Delayed Transfers of Care (DTOC):
This is a major priority for the system. We are currently implementing Oxfordshire's DTOC Equilibrium Plan with the aim of:

- Delivering the 95% target, reducing the numbers of patients delayed in hospital and other parts of the system and balancing capacity and demand
- Enabling acute staff to be redeployed across the system to support new ways of working.

- Agreeing arrangements with neighbouring organisations to address out of county delays that reach 20 days.
- Increasing the number of people who benefit from reablement and supported discharge

7. Achieving Financial Balance - OCCG Financial Plan

The Context

2015/16 has been the first year that OCCG is forecast to meet the business rules set for CCGs by NHSE. This follows a trajectory of financial recovery from actual and underlying deficit positions in previous years.

Whilst the CCG financial position has stabilised, our system partners have seen considerable pressure on their own financial performance and standing. As a health and social care system, taken in aggregate, we may be at breakeven or a marginal surplus (<0.1%) at best.

Our approach to the 2015/16 financial year has given us the opportunity and headroom to plan for whole system transformation. This will be essential to allow the system to 'right-size' its services to match demand, within the constraints of our system's funding.

The Allocation

NHSE have set firm allocations for the next three years and indicative allocations for years 4 and 5. As part of this they have honoured a commitment to move all CCGs to being no more than 5% below the target allocation. We have benefitted from this in 2016/17.

In setting CCG allocations they have for the first time, taken into account the allocation for primary medical and specialised services, both of which are commissioned by NHSE. This works against the CCG in years 2 and 3, as we are spending more than our calculated target allocation on both primary care and specialised services.

The impact is that in 2016/17 the allocation is increased by 7.3% (£49.5m). This takes us to being 4.8% under our target allocation. However, when primary care and specialised commissioning budgets are added in, our allocation equals the target. This does not impact on 2016/17, but for 2017/18 and 2018/19 it means we get the minimum level of growth of 2% (c£14m).

	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%

Essentially NHSE have front loaded the funding in 2016/17 therefore we have to look at how we use this money to drive transformational change over the next three years. We cannot commit all of this funding recurrently in 2016/17 as this would put intolerable pressure on the 2% increase in 2017/18 and 2018/19. This years increased funding gives us an opportunity to do things differently rather than funding more of the same.

In our commissioning and contracting intentions for 2016/17 we stated our intention to protect as much of our allocation growth as possible and ring-fence this to be held as a system resource or reserve. The proposal was to use the ring fenced money to help manage system financial risk in the short term, while moving towards a genuine system investment (transformation) reserve, linked to the system transformation plan, which would seek to

address system risk in the medium term. Investment decision making criteria and access to these funds will be agreed with the system partners who form the Transformation Board.

(Draft) 2016/17 Financial Plan
OCCG will plan to deliver the business rule requirements for CCGs as follows:

- 1% surplus
- 1% uncommitted reserve
- 0.5% contingency reserve
- CHC legacy risk pool contribution as notified by NHS England

The move from 2015/16 DTR tariff to the draft 2016/17 tariff has been modelled and built into the plan; this contains a significant cost impact.

Activity growth of 1.9% overall has been modelled, again this has a significant cost impact for the CCG which would need to be funded from 2016/17 growth.

In addition the CCG will ring-fence a minimum of 1.2% (£9.0m) of its allocation for system transformation, including the sustainability of primary care.

Our ability to deliver this plan will primarily be dependent on the nature of the contract agreements to be reached with our two main providers, OUH and OH. These agreements need to reflect the approach outlined earlier in this document i.e. a balanced approach to risk share and support for system transformation.

The plan as modelled requires £22.4m (3.0%) savings to be delivered in CCG budgets and contracts. This level of saving requirement following allocation growth of £49.7m is an indication of the challenge that faces the CCG and system from 2017/18 when growth falls to c£14m per annum.

Risks
The risks to this financial plan are:

- The ability to negotiate balanced risk sharing contract agreements (£15.0m)
- Delivery of savings (£7.4m)
- Volume based financial risk such as:
    - Activity on cost and volume PbR contracts (£3.0m)
    - Primary Care Prescribing (£2.0m)
    - Continuing Healthcare packages and placements (£1.0m)
    - Any impact on healthcare funded services as a result of savings to be made in social care

These risks, if they materialise, will be mitigated to a limited extent by CCG reserves but beyond this will require additional savings to be made.

Our 2016/17 savings (QIPP) Programme will be focused on tackling unwarranted variation informed by the RightCare programme and is designed to ensure we close the 2016/17 financial gap, impact on current performance issues and deliver our longer term vision for transformational change.

Our savings (QIPP) requirement for the coming year is £22.4m determined by the need to fund demand and other pressures within programme budgets. Currently we have identified savings in the region of £7m, with a further £2.1m earmarked. This still leaves a significant gap that we are working urgently with our providers to close.

Our 2016/17 savings (QIPP) projects are part of a three year savings plan aligned to our Medium Term Financial Plan.

8. Improving Quality and Outcomes

We use our clinical assurance framework, submitted, to monitor and improve the quality of commissioned services. The framework ensures information such as national and local performance indicators, clinical audits, serious incident investigations and a range of GP and patient feedback is analysed and remedial action is taken to address identified issues. We are expanding the framework in 2016/17to include greater scrutiny of GP Primary Care services.

Our plans for improving quality and outcomes include:

Clinical Outcomes:

- Using the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor and improve acute trust avoidable mortality rates
- Using Dr Foster to monitor weekend mortality rates and acting on alerts regarding poor care to generate prompt investigation and action plans
- Working with non-acute providers and NHS England to implement processes for mortality reviews.
- Ensuring the reduction of mortality from sepsis. Improved early recognition of sepsis is a 2016/17 priority for 111, Out of Hours and Emergency Department services.
- Developing care pathways to improve outcomes for patients suffering strokes and long-term conditions such as diabetes and acute kidney injury (AKI). OUH Plan for sepsis and AKI submitted.

Clinical effectiveness

- Continuing to monitor provider compliance and performance with all nationally mandated clinical audits and agree a range of local audits to check provider compliance with NICE guidance.
- Continuing to monitor provider compliance with NICE Quality Standards, adding key indicators into contracts as appropriate.

7 Day Services

Oxford University Hospital NHS Foundation Trust scored exceptionally high in a self-assessment of 7 day services in 2015 and is a demonstrator site for implementation of 7 day services

However it did not provide access to 24 hour consultant directed diagnostic tests and completed reporting (clinical standard 5 for Seven Day Services). A SDIP has been developed to improve services and provide best outcomes for patients seven days a week.

We monitor provider compliance with the Keogh Clinical Standards 2,5,6,8 to improve 7-day services and weekend mortality rates and will be benchmarking 7 day services again in 2016/17.

Patient Safety:

Safety, continual improvement and innovation are key features of all our commissioning activities including:

- Measuring the safety culture of provider organisations using the MaPSAF tool
- Undertaking clinical assurance visits following ‘Never Events’ or as a result of Patient Safety Collaborative work with the Academic Health Science Network (AHSN);
- Encouraging providers to complete the ‘Sign up To Safety’ campaign

- Increasing the number of multi-organisational ‘end to end’ audits of patients on the urgent care pathway.
- Using social media as a means of sharing good practice
- Promoting good antimicrobial stewardship, setting targets to maintain current levels of good practice and including it in our GP incentive scheme
- Measuring prescribing and use of cephalosporins, quinolones and co-amoxiclav, as a percentage of total antibacterial items, to ensure they are below 11.3% and that the total practice antibacterial items per STAR PU is below 0.52.
- Monitoring secondary care performance to identify and reduce the number of avoidable MRSA bacteraemia and c. difficile infections and ensuring compliance with recently released with national MRSA and c. difficile infection rates.
- Developing plans with providers to reduce avoidable patient harm through:
    - Reduction of pressure ulcers
    - Falls prevention
    - Better nutrition and hydration
    - Reduction in Acute Kidney Injury (AKI)
    - Reduction in catheter acquired urinary tract infections
    - Improved dementia care
    - Early recognition of sepsis
    - Early identification of deterioration in acutely ill patients

Primary Care incident reporting is well established in Oxfordshire and we continue to provide feedback to individual providers to ensure quality improvement. The focus in 2016/17 will be commissioning improvements in:
- Management of test results
- Speed and accuracy of clinical communication

CQC inspections
We review all CQC inspections (Primary Care and other providers delivering NHS services) and for:

GP services
We offer support to all practices preparing for an inspection to ensure they receive a rating of “good” or above and to date no practices have been rated as “inadequate”. For the small number rated as “require improvement” we are working in partnership with NHS England to provide targeted support and a robust practice plan to achieve a rating of “good” or above.

NHS providers
We have an excellent relationship with local CQC inspectors sharing intelligence prior to a CQC inspection. Following an inspection we meet jointly with the provider to agree improvements with the CCG taking responsibility for monitoring delivery through the contract. Where a provider receives a rating of “inadequate” we will enforce CQC actions using appropriate clinical leavers.

Information Governance (IG)/Confidentiality
We use the NHS standard contract to ensure all our providers comply with the IG toolkit and/or ISO27001.

Improving Safeguarding: By:
- Strengthening contractual requirements to ensure that providers are detecting abuse and providing appropriate support.
- Closely monitoring delivery of recommended actions from Serious Case Reviews (SCRs) and Safeguarding Adult reviews (SARs).

- Increasing and monitoring the range of services commissioned to detect abuse and provide support to victims of Child Sex Exploitation (CSE) and Female Genital Mutilation (FGM), using case review findings and monitoring information to identify demand.
- Reviewing services for Looked after Children (LAC) and increasing provision.
- Developing and implementing an app to support patients and staff in the appropriate use of the Mental Capacity Act (MCA).
- Monitoring providers compliance with the MCA, implementation of training and awareness of modern slavery and levels of PREVENT training.
- Director level participation in both of the Oxfordshire Safeguarding Boards, with safeguarding young people at transition as a priority.
- Engagement of users and carers to ensure the voice of the child informs change.

Patient Experience:
- Ensuring the full roll out of the Friends and family Test (FFT) to enable comparison of services over time.
- Incentivising GP practices to use directly bookable services on the e referral system.
- Increasing efficiency and communication with patients on the two week wait pathway.

Personal Health Budgets (PHB)
We are fully compliant with the ‘right to have’ a PHB in NHS Continuing Healthcare, for both Adults and Children, and are currently working with NHSE colleagues to expand our offer to:
- People with an Acquired Brain Injury (ABI)
- People with learning disabilities, particularly those at risk of admission to hospital for challenging behaviour
- Children who are part of the Special Educational Needs and Disability (SEND) reforms

During 2016/17 we will be scoping additional client groups whose outcome could be improved through a PHB with an ambition of 100 people in Oxfordshire holding a personal budget in the coming year.

End of Life Care (EOL)
The CCG End of Life Care Strategy, submitted, outlines plans to help individuals with advanced, progressive or incurable illness to live as well as possible until they die. In 2016/17 we aim to increase choice for end of life by:
- Ensuring patient’s choice is detailed in their shared digital care record
- Undertaking an audit of the extent to which patient’s choice of place to die has been achieved, with an action plan to ensure end of life choices are met wherever possible.

Carers
Oxfordshire’s joint Carers Strategy, submitted, outlines plans to work together to drive real and purposeful developments for the benefit of carers across Oxfordshire.

‘Think Family’ is at the centre of all our commissioning plans to improve identification and support for carers. Carers already play an essential role in the development of health and social care services and we have a well-established network of carer forums that provide input and feedback on services.

We have a single point of access for adult carers for information, advice and signposting to a range of services (including the Carers Oxfordshire Service and respite) and we will ensure young carer's are tracked through the carer’s assessment process and ensure they are followed up by Carers Oxfordshire or the Young Carers Team.

There is a dedicated service for carers of people with mental health providing specialist mental health information and assistance with navigation of local mental health services.

Oxfordshire County Council (OCC) has significant savings to make in 2016/17 that could impact on carers. However we are working with OCC to review services for carers in light of these financial pressures. The review will focus on ensuring the needs of carers, respite, practical support, access to advice and information continue to be met.

Achieving Parity for Mental Health:
We will be monitoring the delivery of a new 5 year partnership contract with the community trust that includes a new model for extended wellbeing and IAPT services. Performance metrics have been included to ensure delivery of national standards for access, waits and recovery. The new contract incentivises the provider to go beyond the national standard and increase access to 17% by 2021 and maintain a minimum of 50.5% recovery rate.

The new arrangements increase the scope to support primary care and improve the flow of patients to IAPT services enabling people to access mental health information, advice and emotional support.

Based on current performance we will meet the national standard for 50% of people experiencing first episode of psychosis to access a NICE approved care package within two weeks from April 2016. In a recent audit the CCG was rated as assured by NHSE in its preparedness programme.

The community trust was part of a pilot to implement Children and Young People's IAPT which we will continue to roll out.

To reduce the reliance on in-patient stay and shift the focus to community services we will be incentivising the provider to ensure patients live independently and are working or volunteering. Good performance under the contract will be measured on the trusts ability to manage people's needs outside of hospital wherever appropriate.

We have expressed interest in taking on specialist commissioned secure beds and would be seeking to commission a more effective preventative, step down pathway in the coming year.

CQC recently rated the Oxford Health crisis service as "good" and our two places of safety adequate for the needs of Oxfordshire.

To improve crisis care and deliver the Oxfordshire Crisis Concordat All Age action plan we plan to:

- Work with concordat partners to deliver a joint protocol to ensure clear roles and responsibilities and timely access for patients.
- Commission a comprehensive mental health urgent care pathway with agreed KPIs.
- Develop a SDIP with the acute trust to review the current inpatient psychiatric liaison service, implement the programme across all acute inpatient specialties and roll out to out-patient clinics in a greater number of specialities.
- Incentivise providers to improve patient's physical health in relation to BMI and smoking, increased employment, independent housing and improved the experience for carers.
- Work with providers to reduce excess mortality associated with severe mental illness.
- Invest in Street Triage, 24/7 Emergency Department psychiatric care and evaluate the "ambulance triage" service pilot.

Dementia
We will be continuing to monitor and consolidate rates of primary care dementia diagnosis, reviewing performance on a monthly basis with practice managers and deliver the Prime Minister's challenge on dementia 2020 by:

- Jointly monitoring delivery of a new Dementia Support Service (DSS), partnership lead by Age UK, to ensure standardised wraparound support at diagnosis and an on-going basis to enable people with dementia and their carers receive information, advice and support that helps them live well at home. The DSS will decrease the impact on health and social care services by providing early intervention and pre-crisis support.
- Continuing to work with secondary care to improve waiting times from GP referral to diagnosis ensuring referrals for memory assessment are assessed within 40 working days.
- Raising GP awareness of post-diagnostic support services, ensuring strong links with secondary care and developing a model of specialist nurse support in the community.
- Having a named Dementia Advisor for each person with dementia and every GP practice ensuring strong links between GP practices and community support.
- Monitoring provider delivery of dementia training.
- Supporting the Oxfordshire Dementia Action Alliance (ODAA) to encourage communities and local businesses to become more dementia friendly.

Following the Prime Minister's challenge on dementia in 2012 we were awarded funding to develop 60 community learning groups and an action plan to make their community more dementia friendly. More than 600 people in the community have now been given dementia training and awareness. We will ensure the DSS continues to co-ordinate and deliver this work.

We are also:

- Working in partnership with Oxfordshire County Council to source specialist residential and nursing homes for people with dementia.
- Ensuring, where possible, that a diagnosis is given at the first appointment but where a second appointment at a memory clinic is needed ensuring that diagnosis is provided within 70 days of initial referral.
- Supporting GP's to provide a coordinated pathway of care to reduce fear, promote awareness and provide information, with specific KPI measures linked to these outcomes.

Children and Young People's Mental Health

Plans for transforming children and young people's services, including CAMHs, will be detailed in the June STP submission.