NHS
Oxfordshire
Clinical Commissioning Group

Health and Care in Oxfordshire - Developing Transformation plans for the Next 5 Years

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Programme Director Health & Care Transformation Oxfordshire

Tuesday 14th June

Objectives for today

1. Case for Change
- Improving quality & sustainability of health and care services

2. Understand the developing clinical models and locality plans.
- Clinically driven - improving quality & reducing inequalities

3. Plans for 2016/17 –
- 5 Year Sustainability & Transformation Plan for BOB
- Public consultation in Autumn 2016
- Key next steps (what, when and who)
- Next Steps - for you to understand how to get involved in the development of new emerging models of care

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1. Case for Change

In Oxfordshire we are facing many challenges

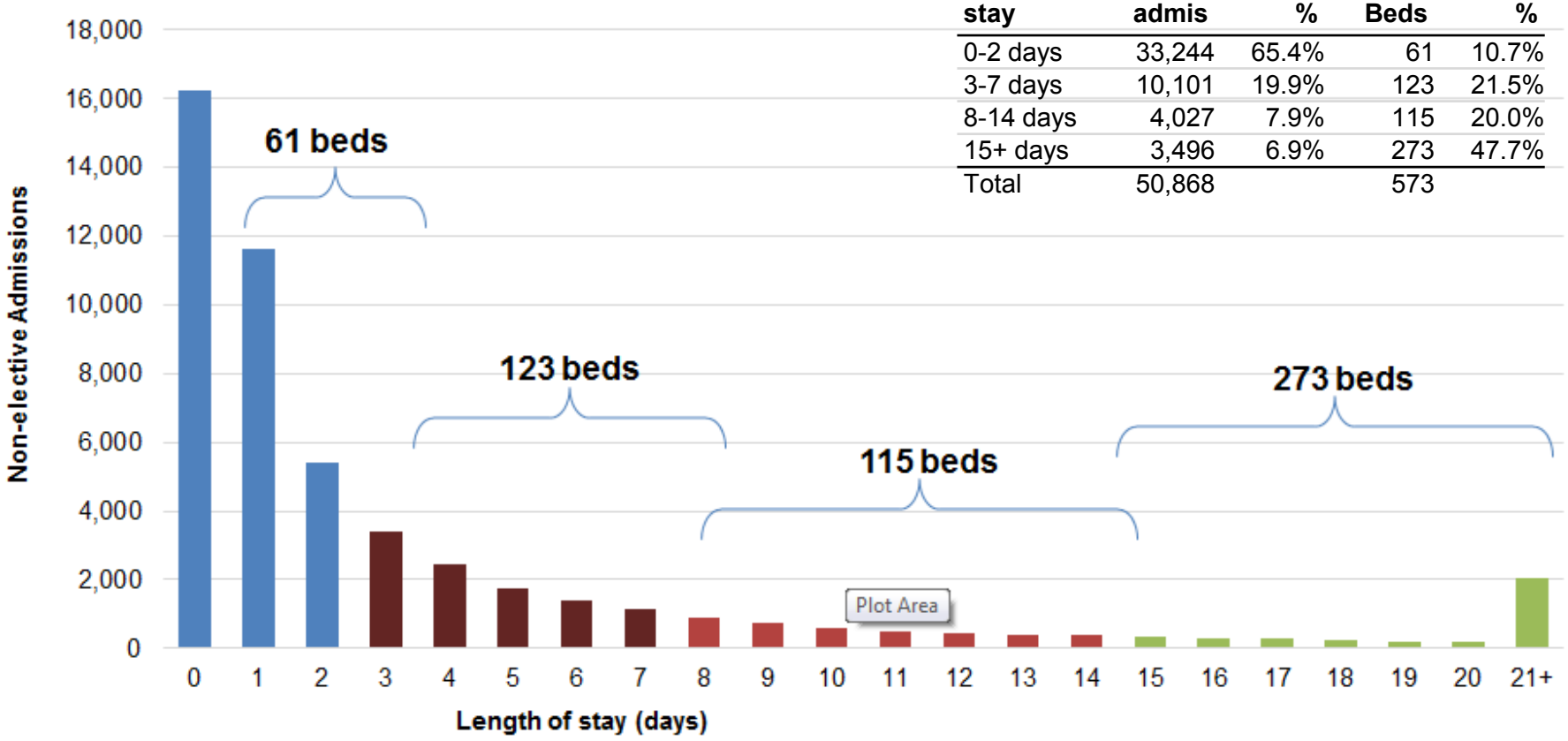
- Increasing hospital demand
- Increasing complexity
- Increasing cost pressures
- Workforce pressures
- GPs under pressure
- ‘Sickness’- crisis response
- Shift from sickness services to preventative services

- 15% over next 5 years
- Long term conditions & frailty
- New drugs and inflation
- Recruitment & retention
- Extended hours & 7 day services
- New model of ‘anticipatory’ care
- How to tackle inequalities at source

1. Case for Change

Are our limited resources spent in the right place?

Length of stay	NEL admis	%	Beds	%
0-2 days	33,244	65.4%	61	10.7%
3-7 days	10,101	19.9%	123	21.5%
8-14 days	4,027	7.9%	115	20.0%
15+ days	3,496	6.9%	273	47.7%
Total	50,868		573	



1. Case for Change

Much of this is preventable and stems from:

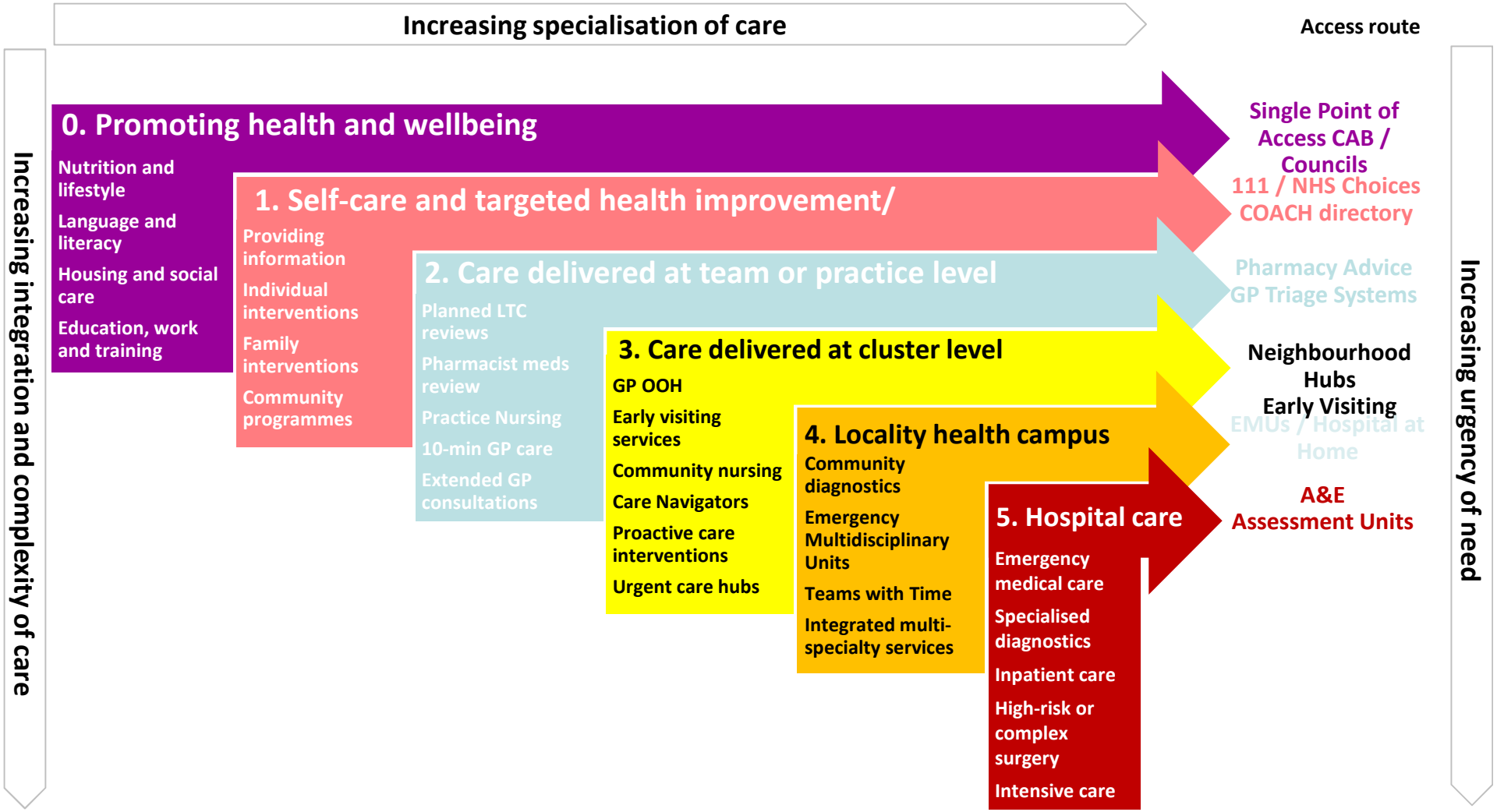
- **Unhealthy lifestyles e.g. inactivity, obesity, smoking and alcohol consumption**

- Smoking, drinking and lack of exercise are the biggest lifestyle conditions

- Inequalities in health e.g. smoking rates are twice as high in manual workers than the County average

1. Case for Change

Oxfordshire 'Closer-to-Home' Health and Care Model



This model enables the urgency, the need for integration and the specialisation of the care interventions to be considered independently within the six health 'settings'.

Questions?

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2. Clinical Pathway Reviews

The starting point in developing future models of care is to identify current challenges & discuss what good looks like for pathways & look at what patients are telling us about their care . . .

2. We are reviewing:

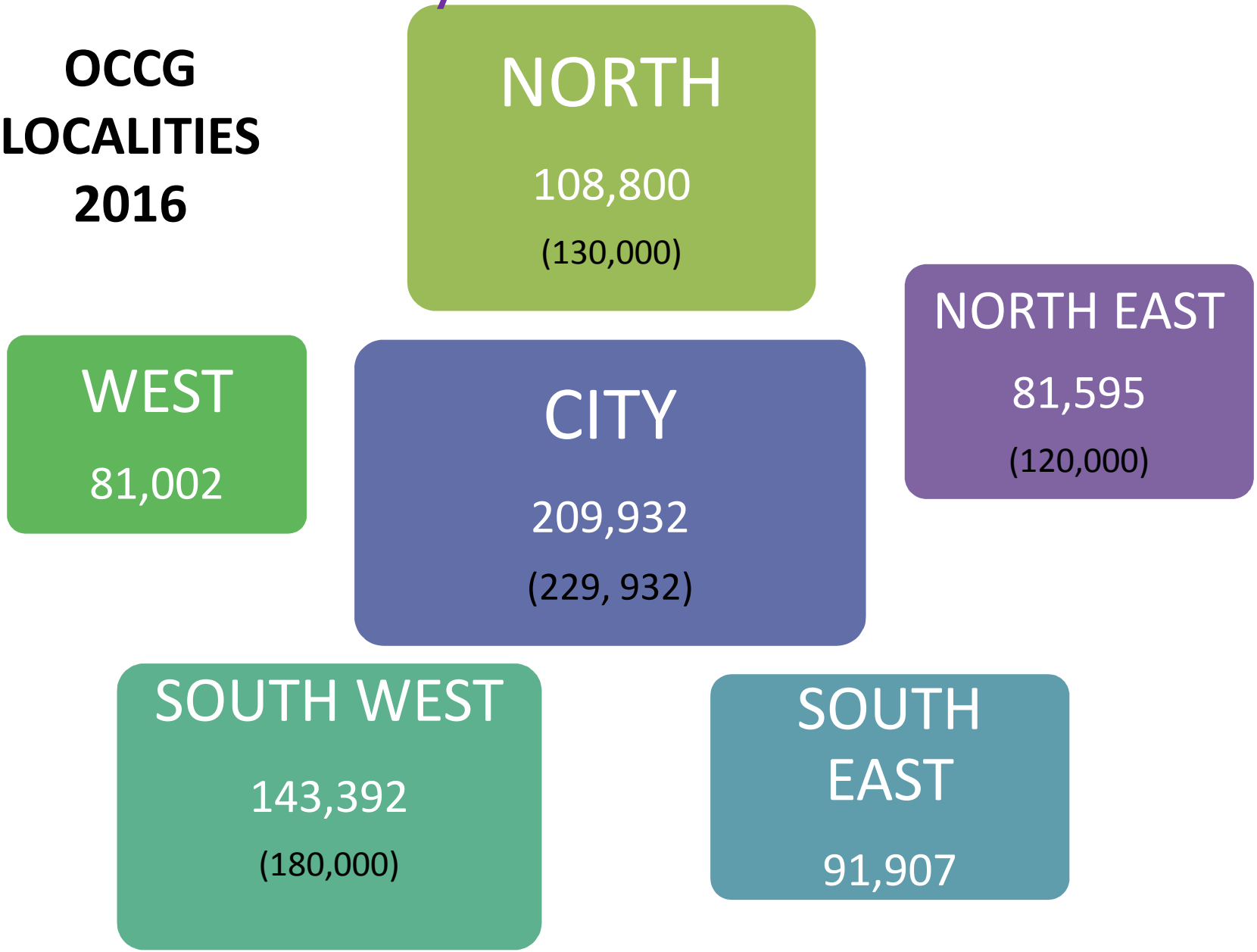
Maternity & children's services	▪ Care provision for women planning to have children and expecting mothers from pre-conception, antenatal, birth and post-natal. ▪ Care provision for children (below age 18) from universal prevention, primary and urgent care, more targeted community care and protection for vulnerable children to specialist acute and tertiary care
Urgent & emergency care	▪ Mostly healthy: people under 75 who are mainly healthy, but may require urgent care from time to time. ▪ People with long term conditions: people who either have a known, pre-existing condition or who are quickly and easily identifiable as having one so that they can be directed – or will direct themselves – to the service they need, thus avoiding overburdening the acute emergency pathway, including A&E. ▪ Frail, mostly elderly: people with 'undifferentiated', complex needs requiring rapid assessment and for whom A&E may not be the ideal way to access the care they need. They may also be best cared for outside the acute setting, at least after the first few days. ▪ The integrated provision of prevention, self-care, community, primary and ambulatory care are important for people with long term conditions and frail patients to avoid emergency admissions

2. What are we reviewing cont'd

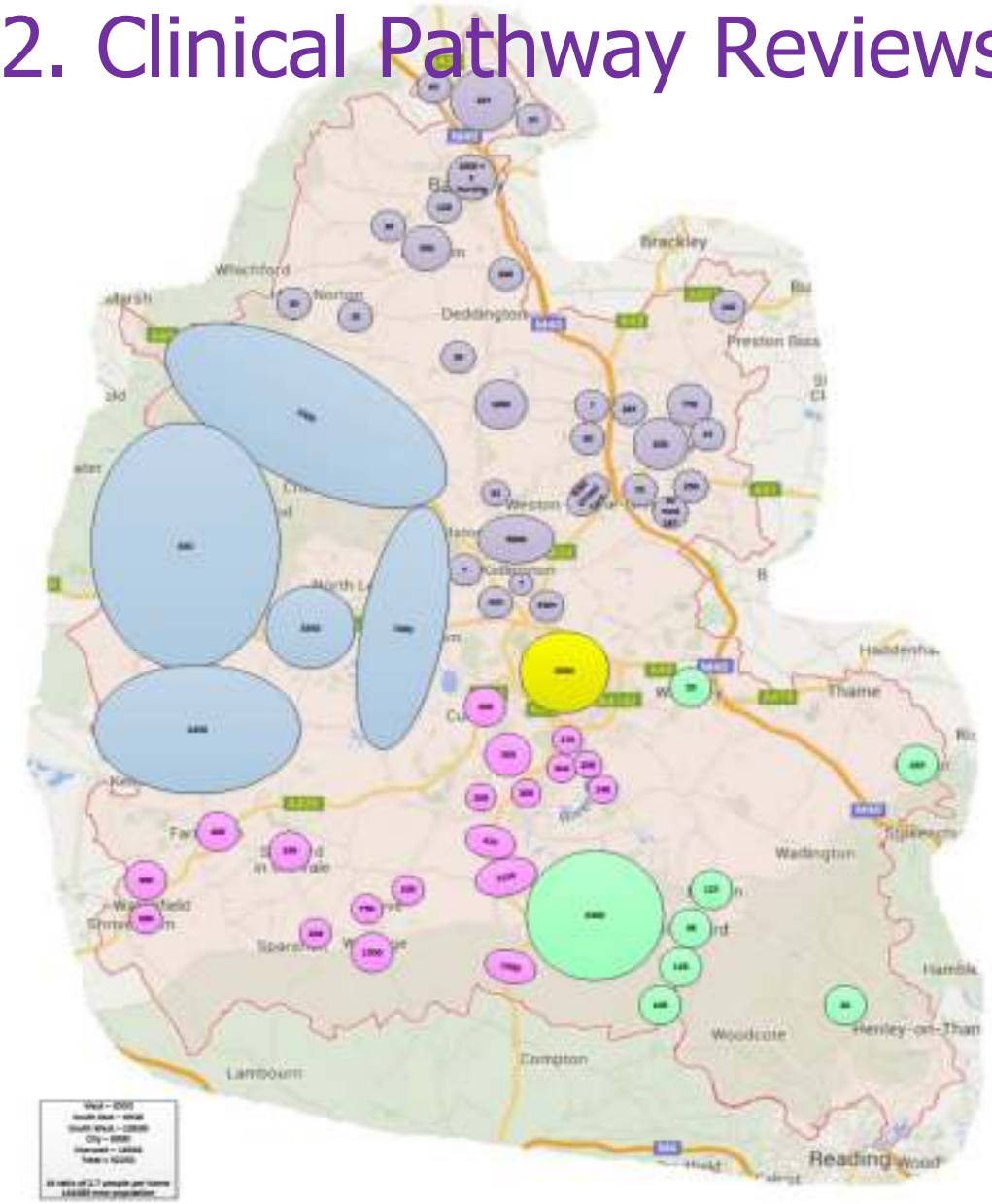
Elective, diagnostics & specialist care	▪ Care provision for people who require planned, routine or specialist medical or surgical services from self-care, self-assessment, diagnostics, consultation, treatments to rehab and follow up.
Mental Health	▪ Care provision for adults who require mental health services ▪ Care provision for children and young people (CAMHS) ▪ The integration of mental and physical health needs
Learning Disabilities	▪ Care provision for children and adults people who require services to support them with a learning disability and / or autism ▪ Access to health checks or health care, especially in an emergency ▪ Improve quality of care for people with higher functioning autistic spectrum disorder what often fall between services

2. Clinical Pathway Reviews

OCCG LOCALITIES 2016



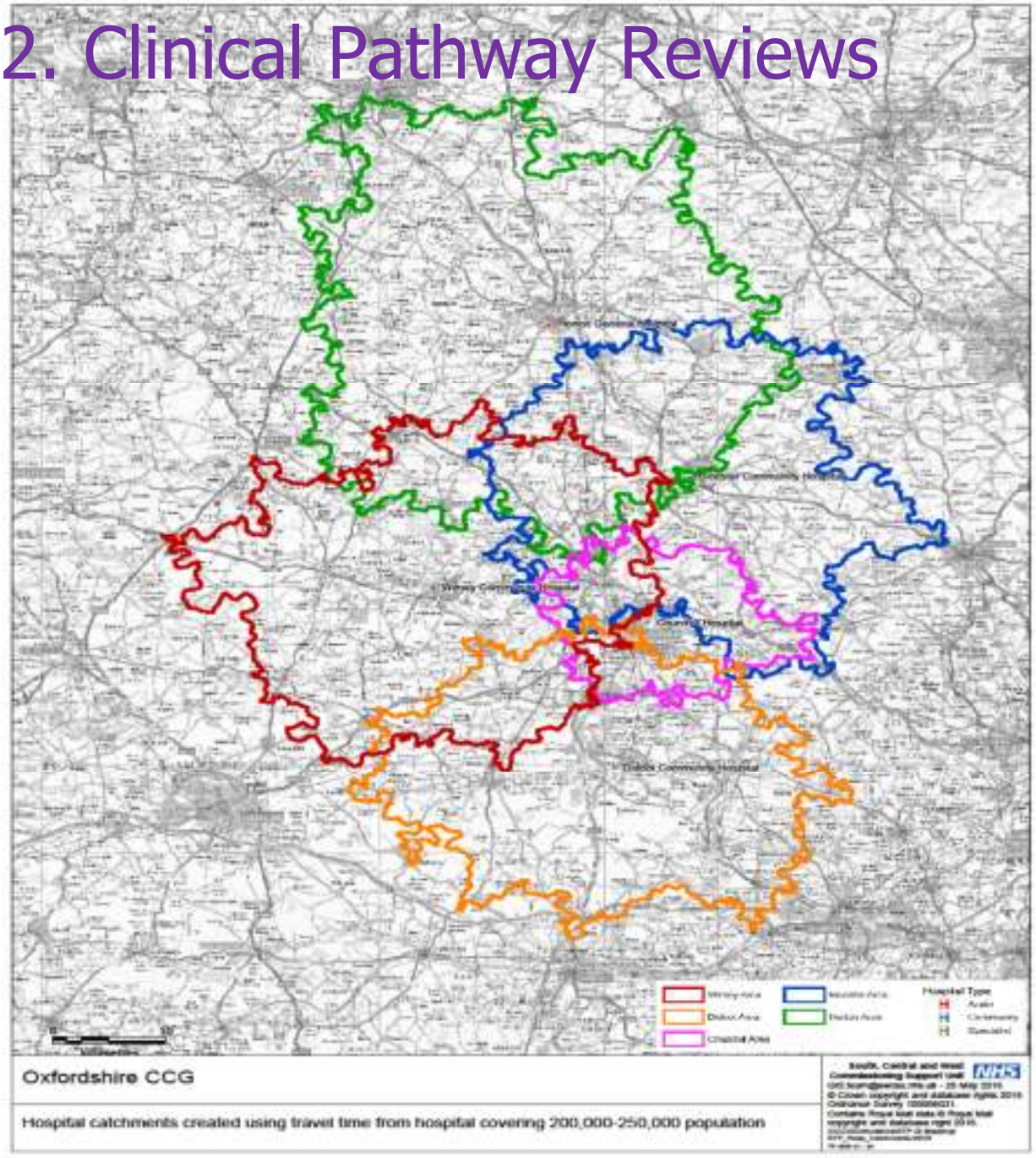
2. Clinical Pathway Reviews

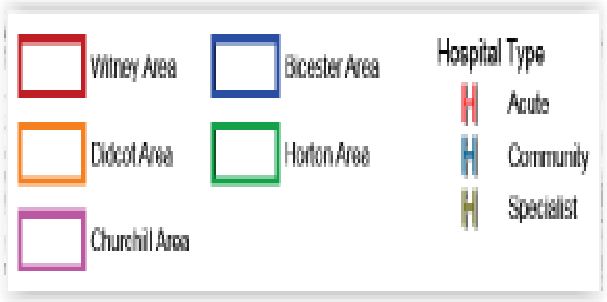


Population growth in Oxfordshire

Expected numbers of new houses
over the next 15 years
(2.7 people per home = **141,080** new population)

2. Clinical Pathway Reviews

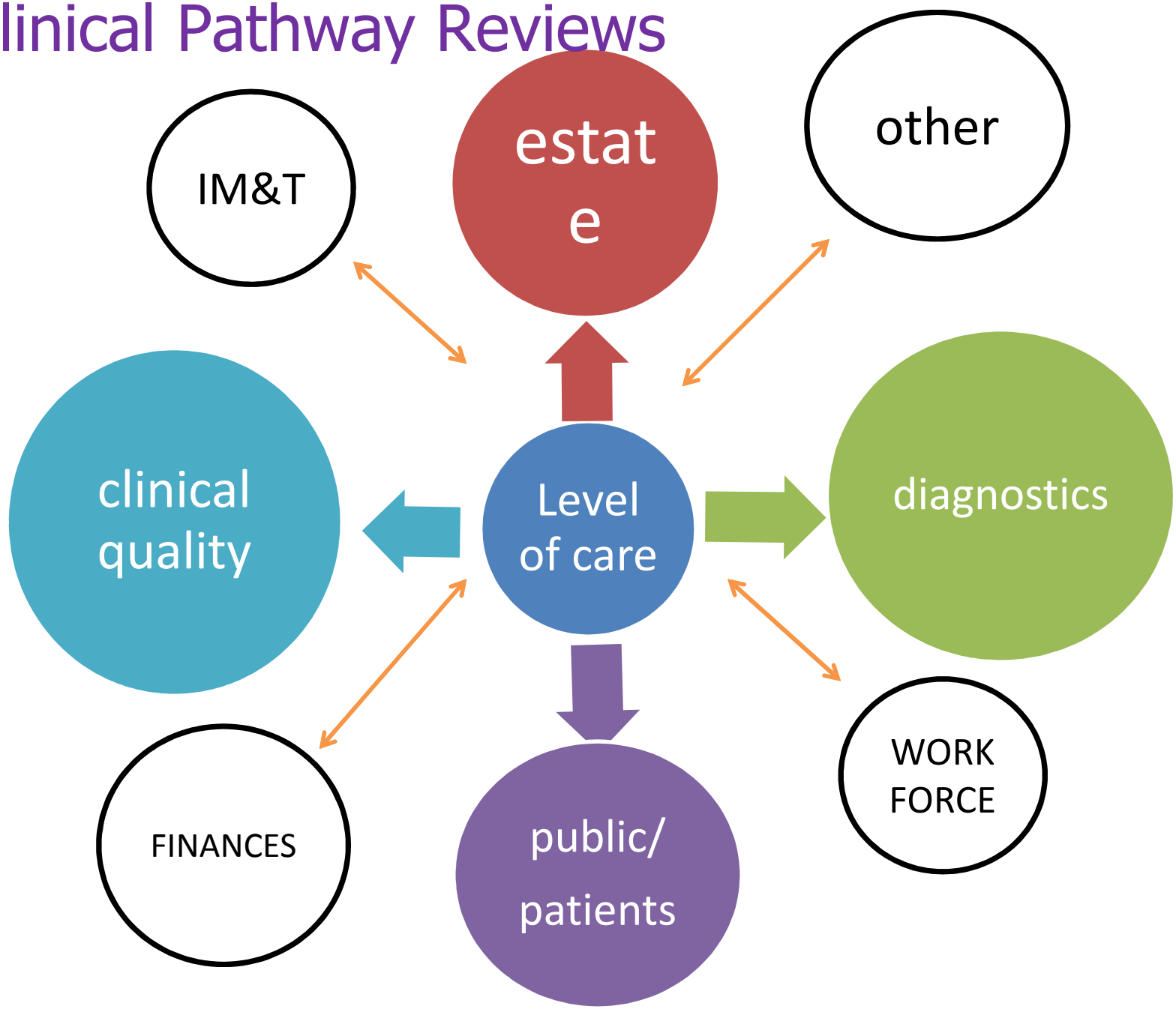




Site catchment areas created using travel time from hospital covering 200,000-250,000 population

Catchments

2. Clinical Pathway Reviews



2. Clinical Pathway Reviews

Planned Care and Diagnostics

Dr Shelley Hayles


North


North East


Oxford City


South East


South West


West

2. Clinical Pathway Reviews

CASE FOR CHANGE

2. Clinical Pathway Reviews

Health and Wellbeing Gap

- **Ageing population** with increasing demand for elective services as a result e.g. Ophthalmology; cataracts, Orthopaedics ; hip and knee replacement etc.
- Oxfordshire growth in over 65s is **greater than national average** with predicted increase 28% by 2026.
- Growing population predicted increase by 2026 13%; increasing demand as a result across all age groups **outpatient referrals up** approximately 8% in 15/16

2. Clinical Pathway Reviews

- Changes in **patient expectations**
- Increasing **mental health issues** with LTC's, cancer etc.
- **Increasing incidence of cancer** due to older population.
  - Cancer prevalence is predicted to rise by more than 3% a year, as more people are either living with or surviving cancer.
  - There is an increasing incidence with age (>50% in over 70's) due to demographic changes, with a predicted 1 in 2 people being diagnosed with cancer by 2030

2. Clinical Pathway Reviews

Quality Gap

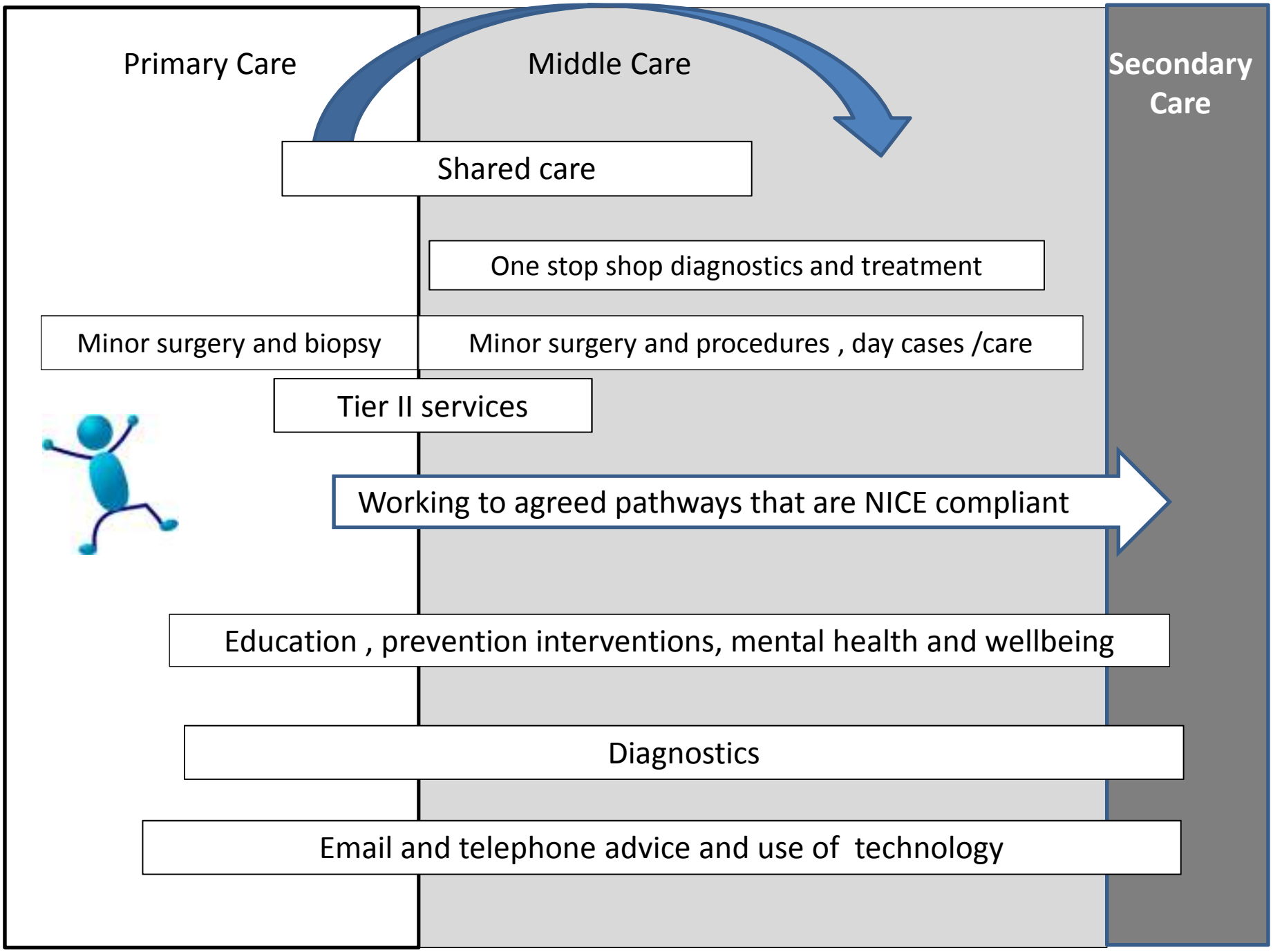
- Workforce, particularly primary care, under **pressure** so making more referrals
- **Availability of workforce** to deliver; specialist nurses, physio, GPs and Drs in specific areas.
- Constitution **standards** not met in some specialities (Non-admitted and admitted); ENT, Ophthalmology, T&O, Gynaecology, Cardiology, Cancer (inconsistent)
- **Access** to outpatients and surgery needs to be sooner particularly after waits for diagnostics

2. Clinical Pathway Reviews

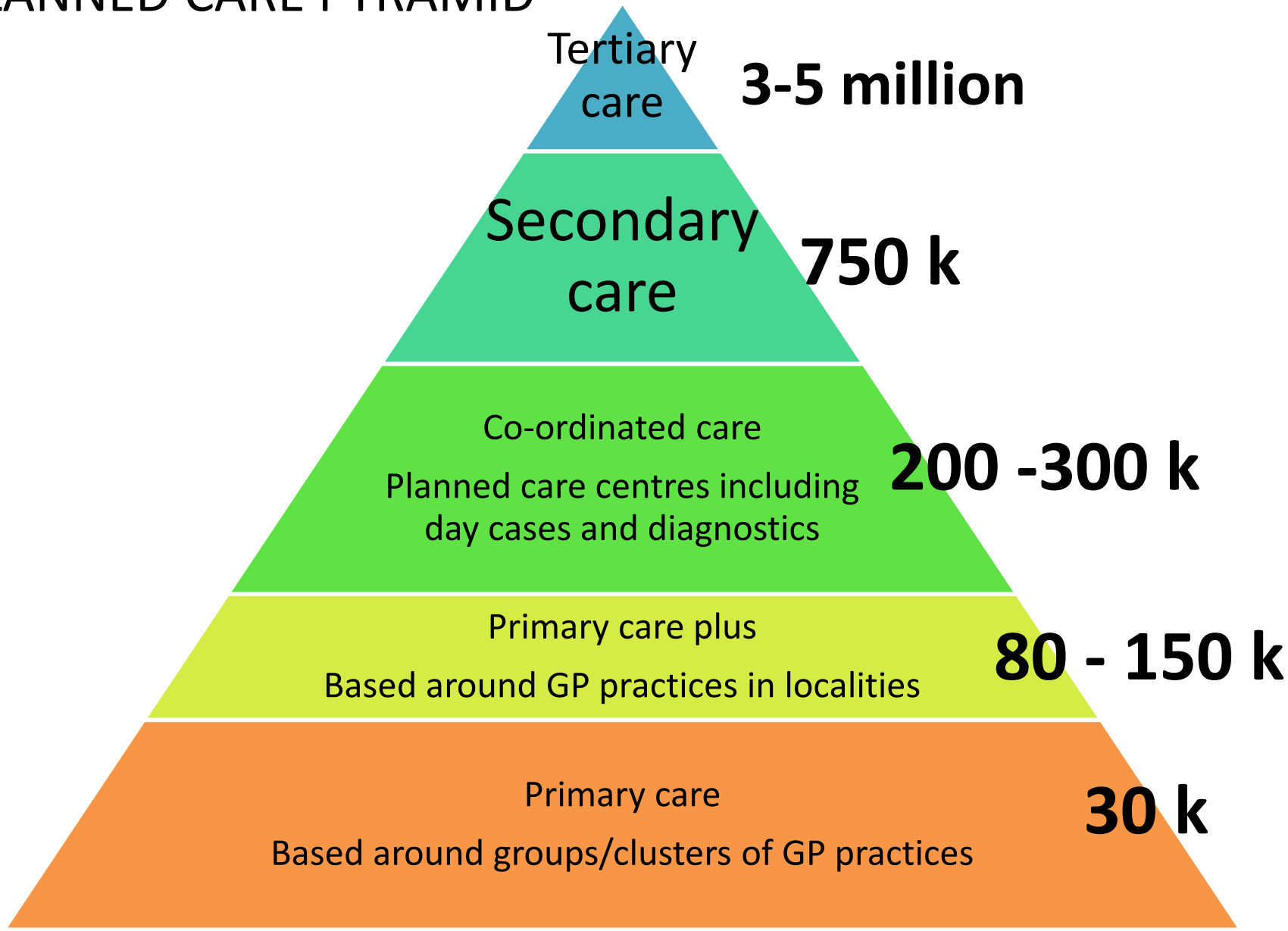
- **Estate** not fit for purpose and requires repair and upgrading
- **Patient experience**; parking, processes, communication
- **IT issues**
  - No **shared patient record a**cross the system leading to fragmented communication between professionals
  - **Development** of IM & T solutions not keeping pace with developments in technology
- **Late diagnosis of cancer** meaning treatment prolonged and more expensive.
- **Best practice** pathways not available in some areas leading to variation

2. Clinical Pathway Reviews

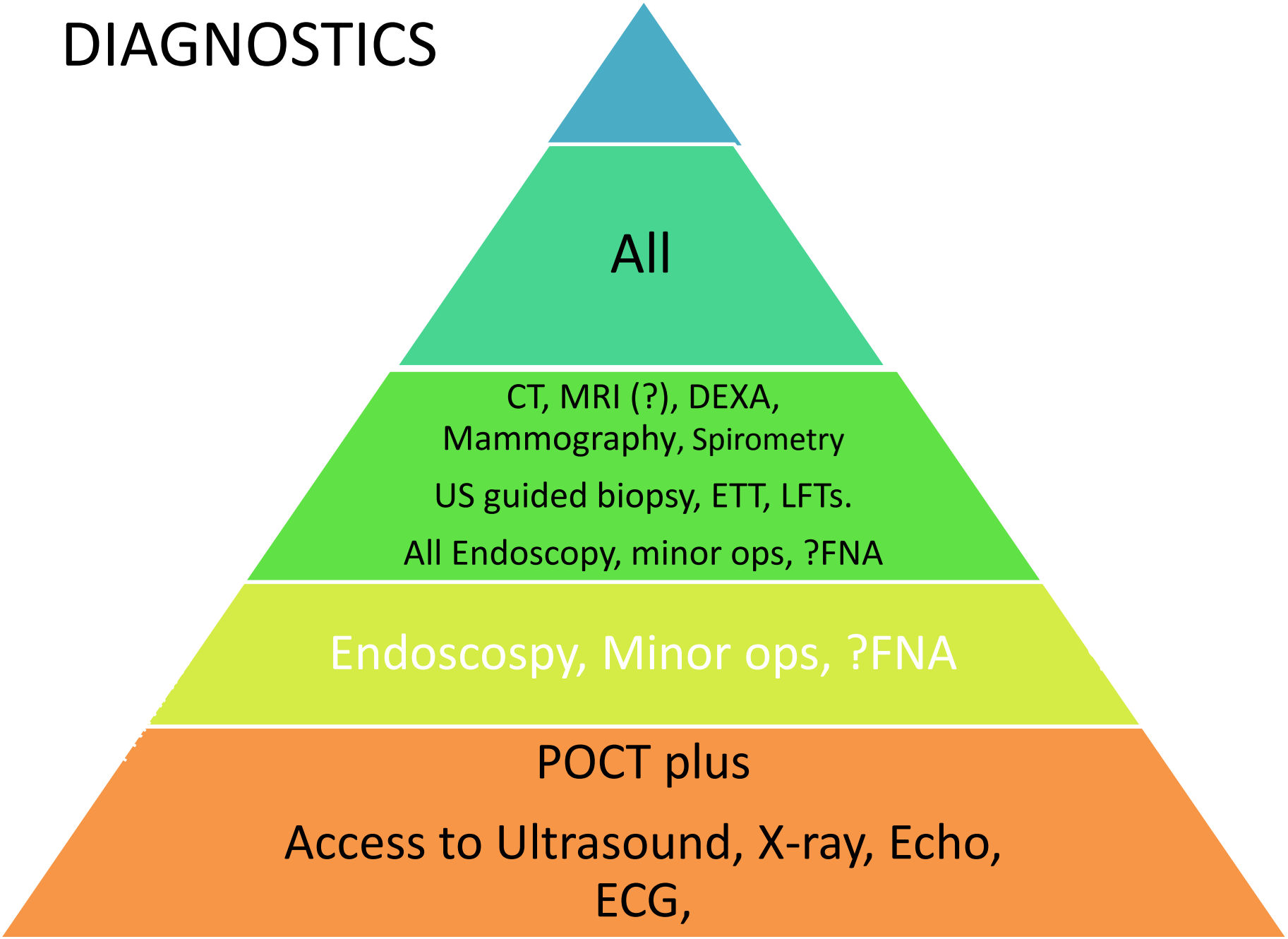
WHAT MIGHT GOOD LOOK LIKE?


Primary Care
Middle Care
Secondary Care
Shared care
One stop shop diagnostics and treatment
Minor surgery and biopsy
Minor surgery and procedures , day cases /care
Tier II services
Working to agreed pathways that are NICE compliant
Education , prevention interventions, mental health and wellbeing
Diagnostics
Email and telephone advice and use of technology

PLANNED CARE PYRAMID



DIAGNOSTICS



Urgent and emergency care

Dr Barbara Batty


North


North East


Oxford City

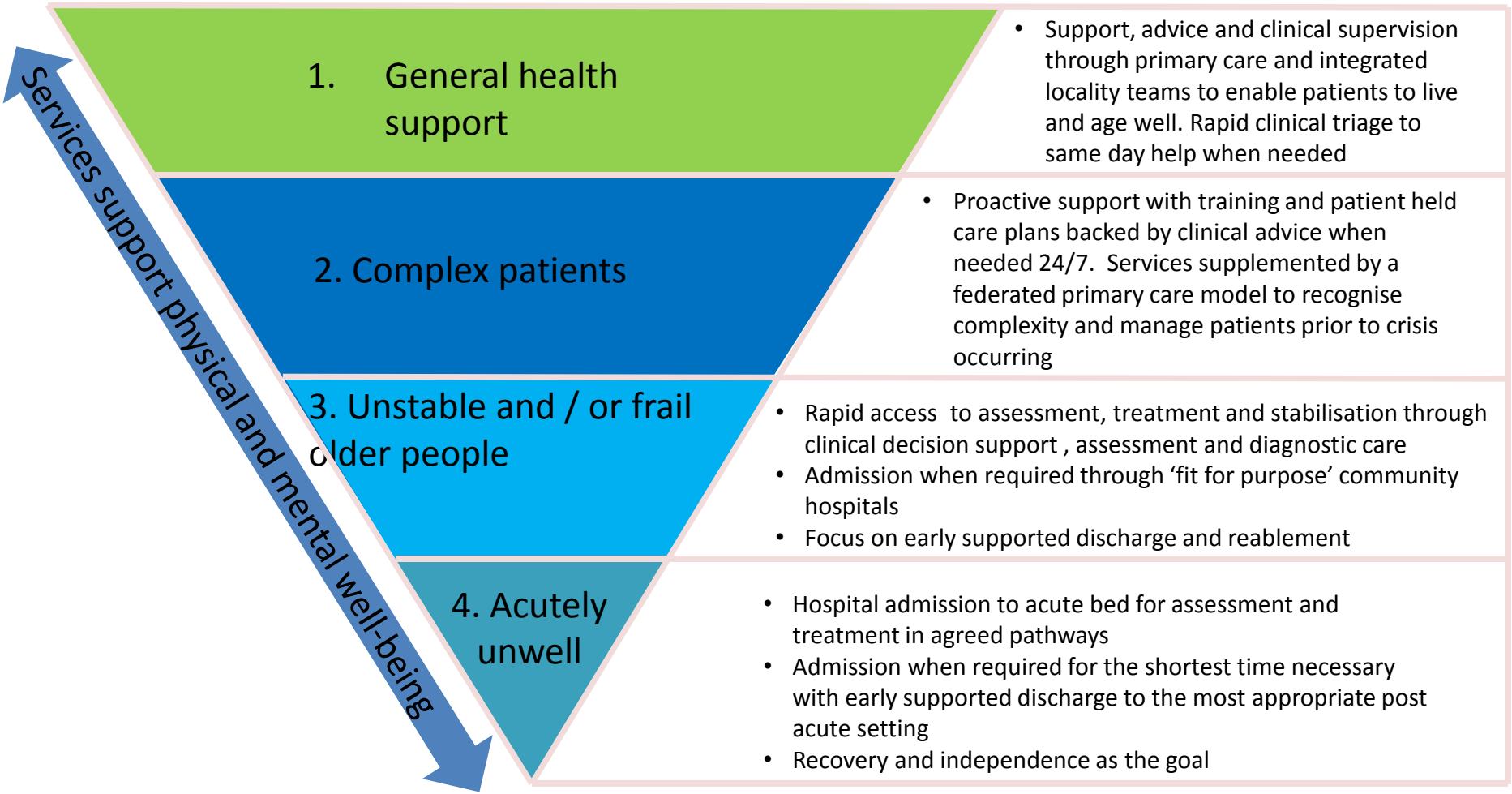

South East


South West


West

2. Clinical Pathway Reviews

Urgent & emergency care - vision



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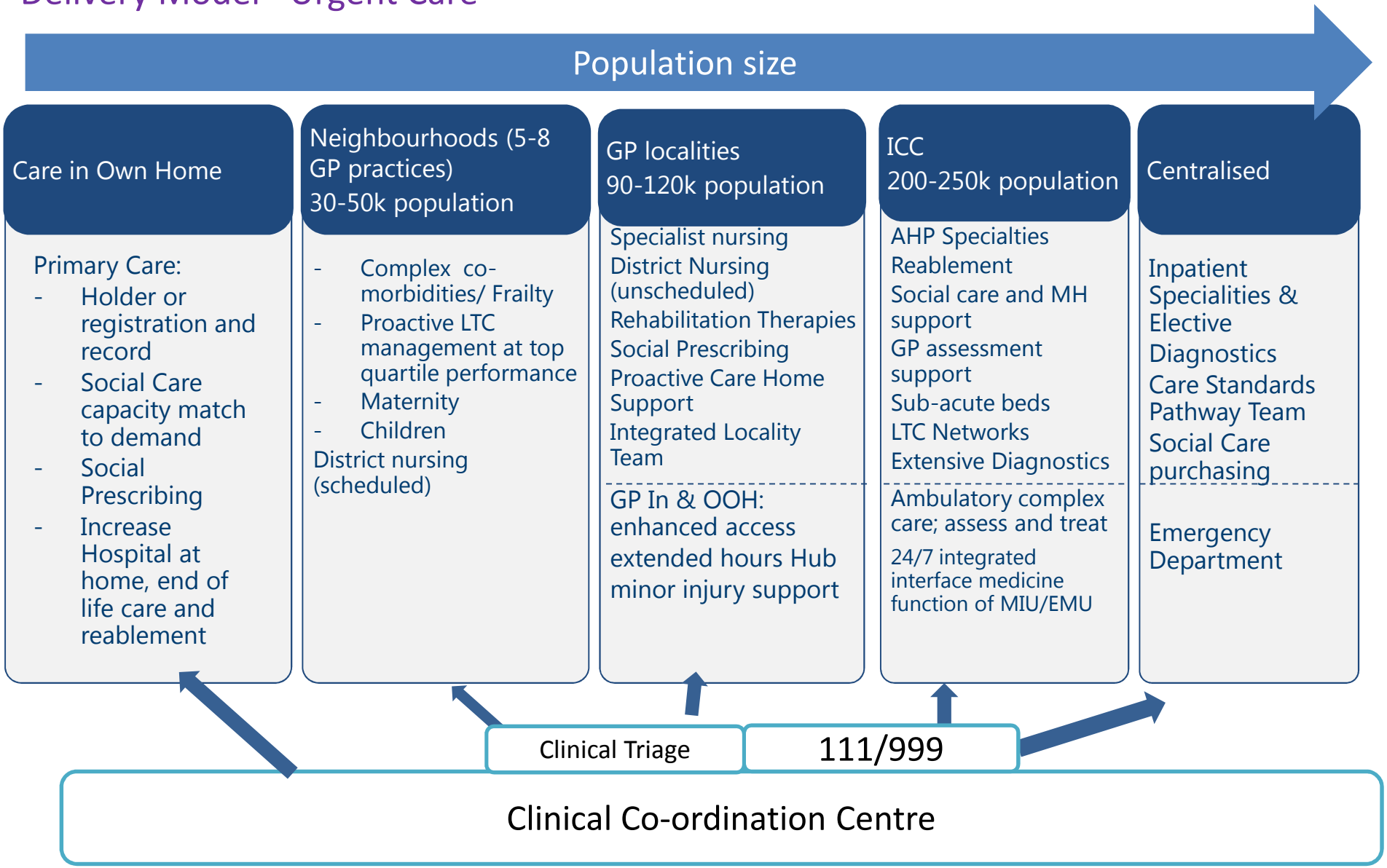
Delivery Model - Urgent Care



Integrated Care Centres

Essential components

'Front door'

- Integrated functions
- 7 day
- senior MDT including medical

Clinical coordination centre

Diagnostics
CT XR PoCT

>60-80 acute/subacute inpatients

Possible co-located functions
Specialist inpatient care
Diagnostic centre
Locality Hub
Maternity MLU
'Mental Health'
Child Health

Three hub option

Hub 1

Integrated UCC including
•A&E, MIU
•GP walk-in, GP out-of-hours
•EAU/EMU
Level 2 HDU

Hub 2

Major A&E with MIU
•EAU/EMU
•All specialties
•Level 2+3 HDU+ICU

Separate UCC with MIU
•expanded capability primary care at scale, 24-7

Hub 3

Integrated UCC including
•MIU
•GP walk-in, GP out-of-hours
•EAU/EMU

NHS
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Mental Health, Learning Disability and Autism STP


North


North East


Oxford City


South East


South West


West

Scope of this STP

- Outcomes focussed
- Seeks to meet the needs of all people with mental health needs, learning disability and autism
- The following groups are not in scope:

Cohort	**STP**
MH needs of people with physical health presentations	Urgent & Planned Care
Perinatal mental health	Maternity
MH needs of older people with frailty	Urgent Care
Dementia (not diagnosis)	Urgent Care

Outcomes that will be delivered

1. All age access to MH, LD and ASC triage within one week of planned referral
2. A dedicated 24/7 MH urgent care pathway for those in distress or at risk
3. A system wide approach to managing risks around MH, LD and ASC
4. Patient level outcomes that deliver and evidence resilience and the ability to self-care
5. Better physical health outcomes for people covered by the STP
6. System level outcomes that reduce in-patient beds, repatriate out of area patients and support safe and effective discharge from secondary community services
7. Management of demand through new models of care

A draft MH Urgent care pathway –All age

All age. … MH presentations wherever they present to the system:
GP in hours and OOH, SCAS (111, 999, crew on scene), TYP (999 or on street) , OUH ED & acute wards, Fire Service, at home, schools, OCC emergency …

'System' access to 24/7 Central MH Urgent care telephone triage facility
and
On site integrated MH psychiatric triage and /or assessment teams in:

- Emergency Dept. (SMI and psychological medical assessment) (24/7)
- Thames Valley Police on street (7 day 1800-0600)
- South Central Ambulance Service control room (7 day 1800-0600)

Triage/Assessment outcome

Emergency

- CAMHS Crisis or AMHT crisis team contacted
- **Referral to urgent care pathway where indicated (physical health)**

Admission (for CYP acute or MH) or Crisis Home response team

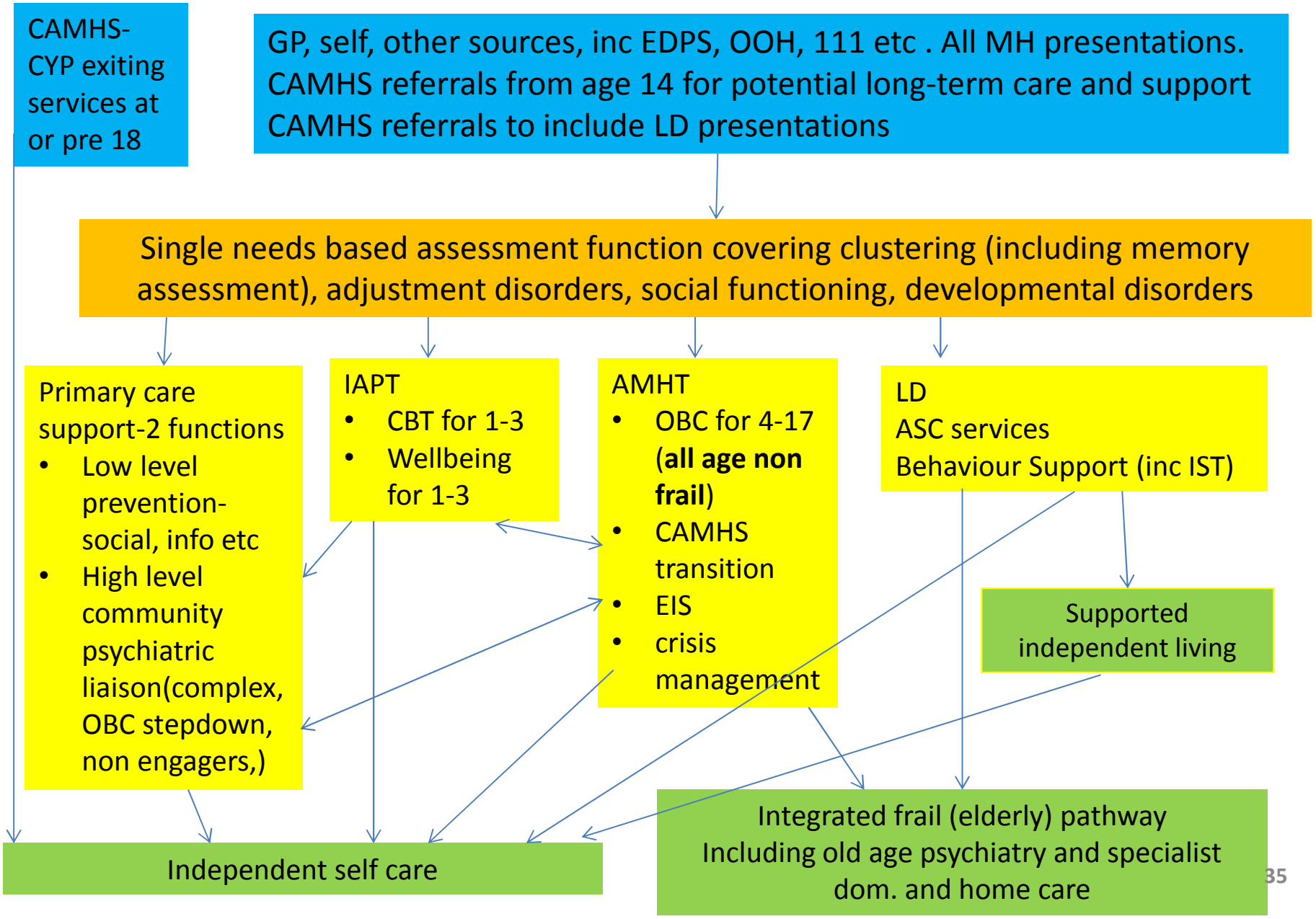
MHA83 deployment

Non -emergency

If known:
- Refer CAMHS or AMHT team f/u

If unknown:
- Refer CAMHS or AMHT assessment
- Information/signposting to other support
- Refer back to GP/letter to GP

Future MH planned care pathway



Options for service reconfiguration

- New model of CAMHS to deliver Future in Mind
- New model of intervention that divides our population:
  - At age 25
  - If / when people move into frailty pathways
- All adult approach to severe mental illness - extending OBC to older adults
- Integration of assessment functions and approaches across MH/LD/ASC for planned and urgent presentations
- Integration of physical health care into specialist MH/LD/ASC services

Options continued…

- System-wide behaviour management services across MH/LD/ASC, based on intensive support models
- A new primary care MH function:
  - social support to address health inequalities
  - community psychological medicine for MUS or complex MH-PH
- BOB level initiatives: MH and LD secure in-patient and community forensic pathways that release resources to support prevention and step down
- Integration of substance misuse and MH services

Implications: Financial & Estates

- Financial: managing demand within existing 5 year contracts
- Potential impact of urgent care hubs on ED support to mental health assessment and care
- Potential re-siting of the Warneford to meet CQC and other requirements - outcome not known
- Need to develop local LD beds and / or step down or crisis provision
- Further extension of non-acute beds in supported living

Implications: Workforce

- Training for all health & social care staff: MH, LD & ASC awareness, recognition and reasonable adjustments
- Development of expertise in behaviour management
- Development of a workforce (skill mix) that can deliver recovery and well-being
- General recruitment challenge
- Increased resilience of third sector workforce

Implications: System

- System-wide touch points for MH identification and referral
- Integrated MH/PH assessment and treatment in planned and urgent
- Adjustments to health care provision for people with LD that provide equality of access and equity of outcome
- System wide approaches to managing risk around MH and behaviour
- Integration of IT and case management systems
- Expansion of use of technology to support self-care
- Change to 999/111 DoS to route into MH urgent care triage
- Impact of social care budget pressures re living well services
- EMI housing and other needed supported living

2. Clinical Pathway Reviews

Maternity

Dr Kiren Collison


North


North East


Oxford City


South East


South West


West

2. Clinical Pathway Reviews

Background

- Approximately 7400 births in OUH by women registered with an Oxfordshire GP last year. Another 400 Oxfordshire women delivered outside of the OUH.

- Current places to give birth:
  - Home (current level about 2%)
  - 3 Midwife led units: Chipping Norton, Wantage, Wallingford
  - 1 Alongside midwife led unit: The Spires at the John Radcliffe
  - 2 Obstetric units: The John Radcliffe and The Horton

- 1400 births at The Horton, 300 from outside of Oxfordshire

2. Clinical Pathway Reviews

It's not just about the birth…Quality gap

- Preconception care – consistency of provision
- Role of GP unclear previously
- Perinatal mental health provision
- Continuity of care
- Informed choice – balanced with clinical safety and capacity
- Staffing – RCOG standards for obstetric units, midwife to birth ratios
- Estates – some not fit for purpose, some under-utilised, others need more capacity
- Technology – community based diagnostics, care records
- Postnatal – continuity, breastfeeding support, parenting advice, clear medical advice for more complex patients

2. Clinical Pathway Reviews

POSSIBLE MATERNITY PATHWAY

PRECONCEPTION

Universal:

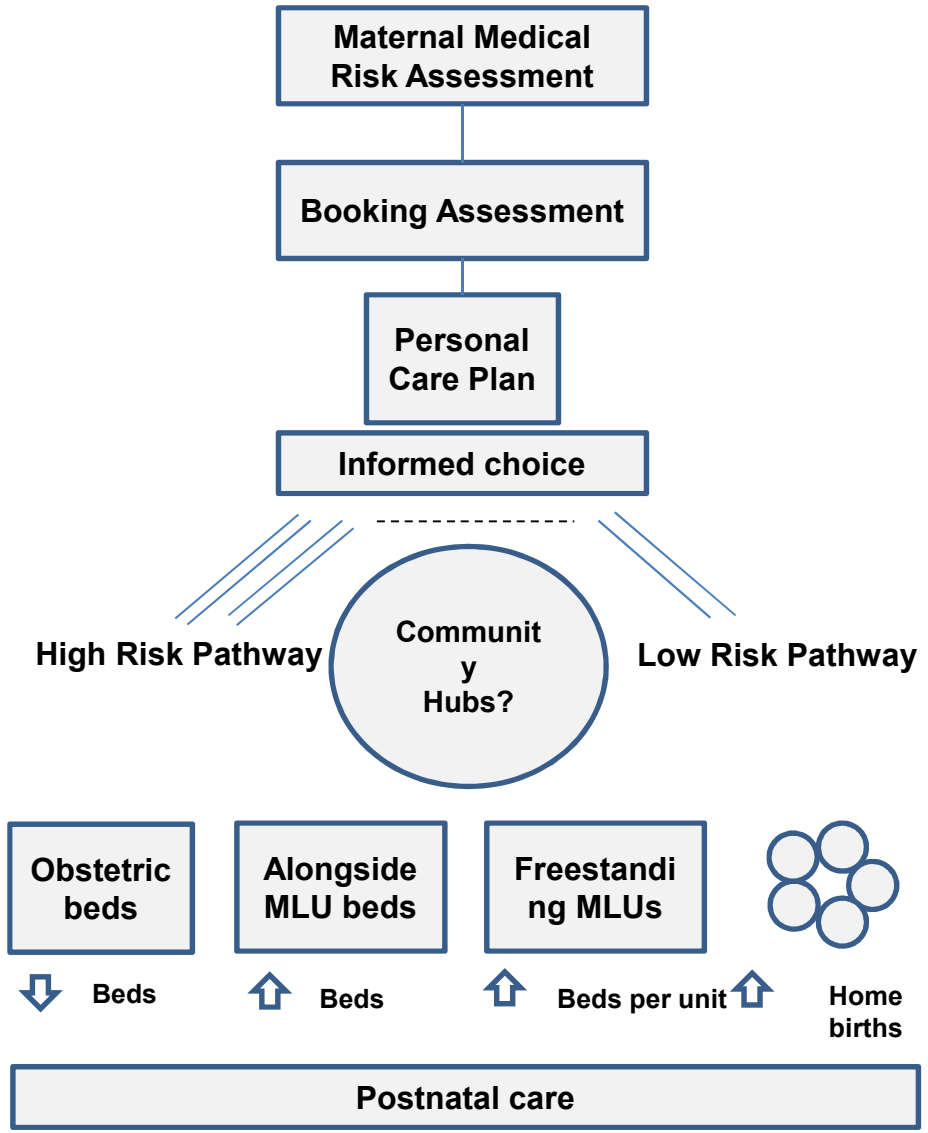
- Healthy weight
- Exercise
- Smoking
- Self – esteem and resilience

Targeted:

- Pre-existing conditions
  - BMI
- Previous serious mental illness
- Substance misuse

Specialist:

- Long-term conditions
- Previous stillbirth
- Current mental illness



PRINCIPLES

- Personalised care
- Continuity of care
- Safer care
- Postnatal and perinatal mental health
- Multi – professional
- Working across boundaries

2. Clinical Pathway Reviews

POSSIBLE NEW MODEL OF MATERNITY UNITS

Number of women with low obstetric risk at booking based on choosing to go to the nearest unit Oxfordshire CCG population 2015/16.

WITHOUT WEST MLU
Banbury 808
Oxford 2257
Wallingford 826

WITH WEST MLU
Banbury 754
Oxford 1753
Wallingford 826
Witney 541

WEST MLU?

3 *LDRPs

North MLU?

- High risk clinics
- Midwife base
- Ultrasound
- Postnatal groups
- Antenatal clinics
- Antenatal classes
- 7 *LDRP rooms

SPIRES INTEGRATED MLU

- 5 Labour rooms (pool)
- 5 Postnatal rooms (or 10 *LDRPs)
- Ultrasound
- 12 labour rooms
- 20 postnatal beds
- 10 antenatal beds
- Midwife base

e.g.
- ✓ Florence Park
- ✓ Rose Hill
- ✓ Antenatal clinics
- ✓ Antenatal classes
- ✓ Postnatal classes

HDU AREA | OBSTETRIC UNIT | NICU

COMMUNITY BASE(S)

SOUTH MLU

- Antenatal clinics
- Antenatal classes
- Ultrasound
- Postnatal classes
- Postnatal groups
- Midwife base
- 2 labour rooms with pool
- 1 postnatal room (or 3 *LDRPs)

* Labour, delivery, recovery, postnatal rooms with birthing pool

2. Clinical Pathway Reviews

Children

Dr Miles Carter


North


North East

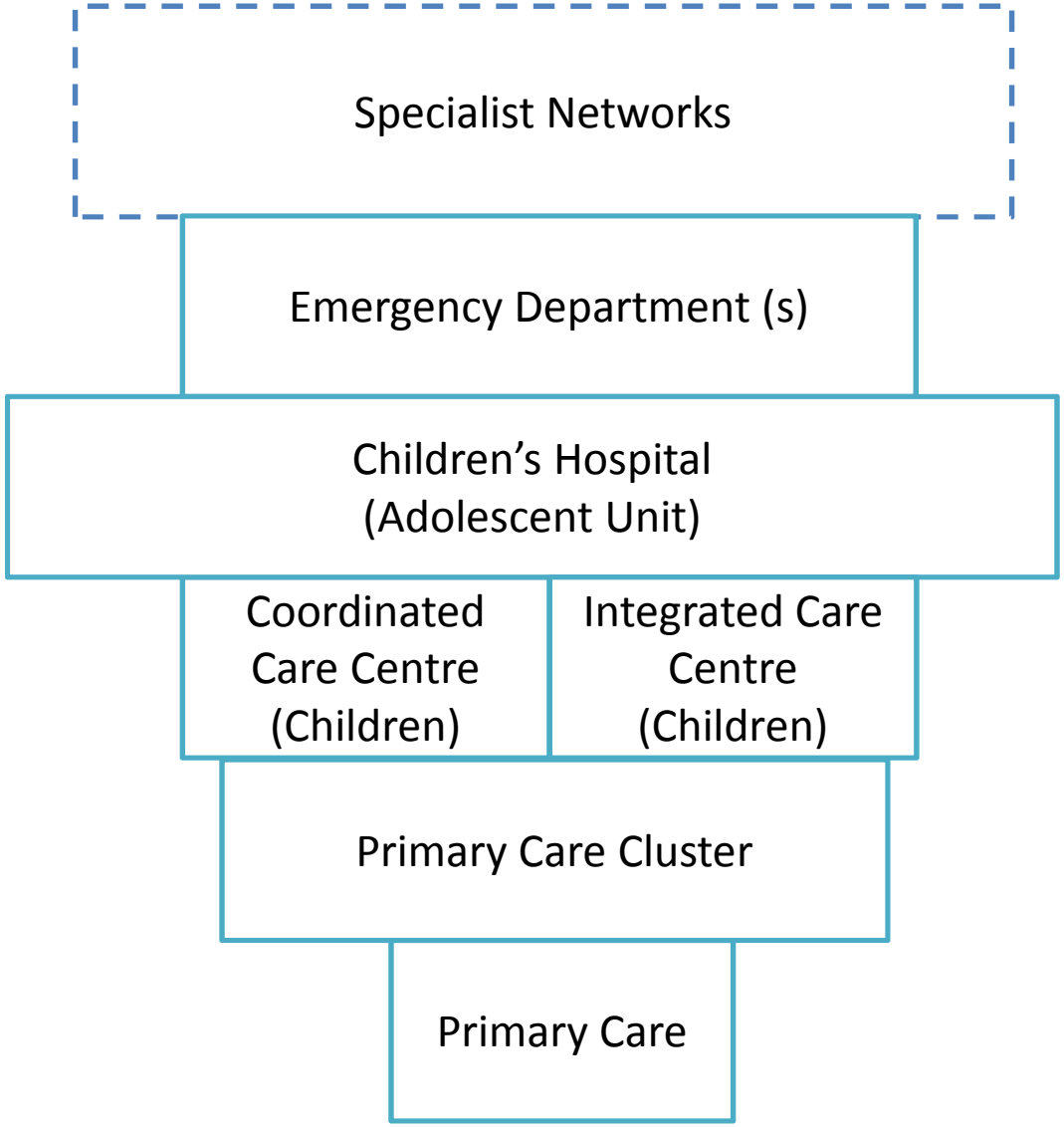

Oxford City


South East


South West


West

Core Offer for Children



2. Clinical Pathway Reviews

Core model – Primary Care cluster

- GP access/same day booked
- Integrated child health clinics – CC4C model
  - Paediatricians working alongside GPs.
  - Specialist joint clinics.
  - Multi-disciplinary team meetings for case management and learning.
  - Community practice champions.
  - Cluster 3 or 4 practices across child population of 4-5,000.
  - Headline: Up to 40% reduction in outpatient activity.
  - Pilot in Oxford City (and Banbury?)

2. Clinical Pathway Reviews

Integrated Care Centre

- North, Mid Oxfordshire and South
- Diagnostics
  - Paediatric phlebotomy
  - X-ray (access to paediatric radiology)
- Central reception for triage but separate waiting and play areas
  - Very young children
  - Adolescents
- Hours of operation – different
  - 15.00 – 22.00 as peak time

2. Clinical Pathway Reviews

Coordinated Care Centre

- **CCC based teams in each**
  - Community Paediatrics, Children's Therapies, Children's Community Nurses, Disability Teams, (CAMHS and Social Care).
  - Also deliver into other settings e.g. Special Schools.
- **CCC delivery teams based in one hub and delivering across all three**
  - Paediatric diabetes
  - CAMHS/LD team
- **CCC outpatient, diagnostic and daycase activity via general paediatrics**
- **Hours of operation – after school and/or weekend working**

2. Clinical Pathway Reviews

Children's Hospital

- All inpatient beds including expanded Adolescent Unit
- HDU and PICU
- Specialist diagnostics and access to paediatric diagnostic workforce
- Paediatric sub-specialties
  - Telemedicine link to CCCs
  - Skype into consultations
- Psychological medicine base for access to wards
  - Clinics in CCCs
- Acute safeguarding by Community Paediatricians
  - Security
  - Medical photography

2. Clinical Pathway Reviews

Primary Care

Dr Joe McManners


North


North East


Oxford City


South East


South West


West

Solution 5: Primary and integrated Care

Ambition for reducing the gaps and making improvements in ….

Health outcomes:

- Reduced inequalities
- Reduced lives lost and illness due to preventable disease

Quality

- Faster access to clinicians
- Increased independence as more people remaining at home
- Sustainability of primary care
- Better mental wellbeing, more economically productive population

Finance

- Optimum use of MDT to a) improve efficiency of primary care b) improve efficiency of locality teams reducing need for more GPs.
- Reduced hospital admissions – Particularly LTC and frail elderly
- Primary care at scale efficiencies and productivity (higher percentage clinical contact)
- Reduced length of hospital stay
- Less clinician time spent with chronic poor health

Critical decisions

Engagement with patents and particularly with clinicians to achieve changes in working practices is crucial but there is a very good start across the STP footprint with support from practices and emerging federations.

Solution 5: Primary and integrated Care

BOB wide principles:

The problems are widely recognised, the principles are being developed by CCGs, working with their stakeholders and patients. The specifics will vary from place to place and the implementation will be at GP locality level. However the workforce, the shift to prevention and the model of care is being developed 'BOB' wide.

Changes planned

1. Improve recruitment and retention by developing attractive careers in primary care which support portfolio working, and different options for GPs, with new and different roles (enhanced clinical, managerial, senior GPs, sessional GPs). Developing new roles to support primary care teams and making sure professionals working at 'top of pay grade'. Getting the right balance between quick access and continuity of care. Patients will see the right professional at the right time and be treated by a happier workforce.

   Delivered by;

   - Training new workforce; pharmacists in practice, care navigators, nurse practitioners, emergency medical practitioners; physicians assistants; mental wellbeing practitioners. Aspiration is 50 WTE of each across BOB (1 per 40k patient neighborhood)
   - Skilling up existing workforce; GPs fellows with portfolio of practice work, special interest and leadership roles; enhanced roles for nurses, receptionists, and health care assistants; developing and supporting role of senior 'list holding' GPs who lead multi-disciplinary teams.
   - Improving retention by 'at scale' hub admin support and large shift away from 'box ticking' for GPs. Supporting federation development to manage some of this.

2. Supporting practices with quality improvement, efficiency and increased capacity – both longer term and in short term teams to help in unstable situations. This should improve access and longer term health outcomes for patients as well as reducing the disruption to services.

   Delivered by:

   - Significant and strategic investment in infrastructure, not just buildings but also IMT and capability.
   - Robust planning of infrastructure and growth with local authorities
   - CCG /federation teams to support quality improvement; diagnostics and 'fire fighting' short term capacity problems. 'Quality and Support teams'
   - Investment in extra capacity of GPs and other professionals across BOB (as above) to improve access and free up time for responsible GP to spend with complex patients
   - Developing best practice, evidence based toolkit for better access and pathways.

Solution 5: Primary and integrated Care

3. To set out our vision for primary care – to build a 21st century modernised model based around the best of NHS General Practice. Working across neighbourhoods and localities to provide extended primary care teams, enhanced primary care, and more specialised care closer to home, integrated with primary care. The patient 'offer' will be better coordinated, more personalised care closer to home.

Delivered by:

- Strengthened practice teams, GP led
- Multi-disciplinary professional teams (see above) supporting GP teams working across populations of neighborhoods/clusters of 30-50k; improving population management and urgent access. Teams working under single leadership and management.
- Specialists, including urgent care, planned care and diagnostics working in locality basis (80-150k) integrated with primary care.
- Hospital outreach using new ways of working, better technology and better use of population data and targeting (e.g. improving diabetic outcomes), to support primary care to manage populations of patients
- Shared/single records
- Access managed over locality 'network', using clinical hubs via 111/secondary care, some delivered locality wide via federations, some cluster level, some practice level. Details implemented locally.

4. To work with patients and local populations for a paradigm shift in prevention and self care, to level health inequalities and reduce demand for downstream care.

Delivered by:

- Practical data analysis and practitioners who can work with primary care and patient groups, to target and improve people's health proactively.
- Working with patients as partners in the way that works for them
- Scaled up use of social prescribing to unlock potential in voluntary sector and communities
- Genuine partnership with local authorities on the determinants of poor health; specifically housing, obesity, low income, poor start to life, poor mental health.
- Significant investment in evidence based measures, using innovation and technology to help self care, self management and preventative measures (such as better mental well being, earlier targeting of high risk patients, exercise etc).

Questions?

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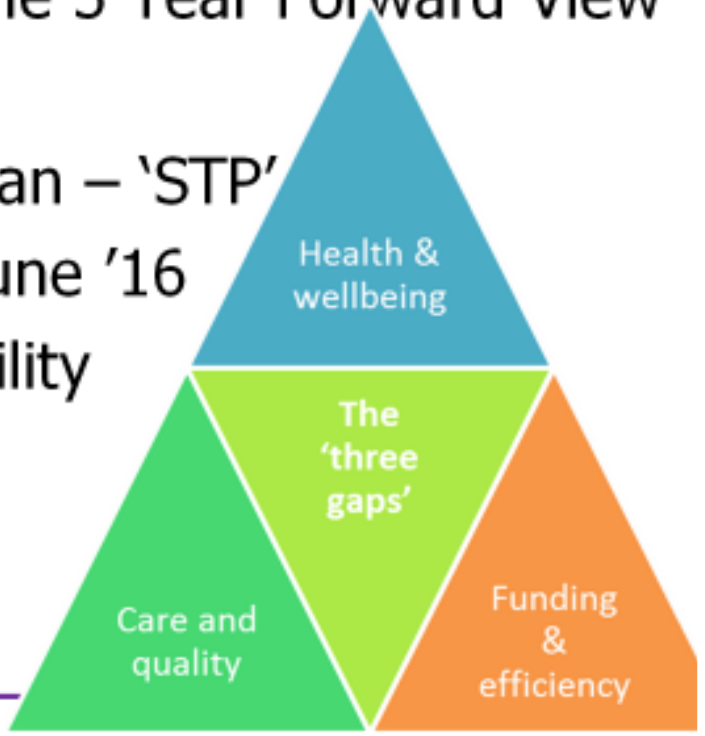
- Public consultation in Autumn 2016
- Key next steps (what, when and who)
- Next Steps - for you to understand how to get involved in the development of new emerging models of care

3. Plans for 2016/17

Key Messages

- THERE IS NO STP FOR OXFORDSHIRE – IT IS FOR BOB!
- BOB - an Alliance with West Berkshire & Buckinghamshire
- To work together to develop a STP
- STP responds to the 3 challenges in the 5 Year Forward View

- 5yr Sustainability & Transformation Plan – 'STP'
- Draft BOB STP Submission due 30th June '16
- Focus on financial & clinical sustainability
- Resources allocated at BOB level
- **David Smith BOB STP SRO**



3. Plans for 2016/17

Key Messages

Consultation

- Business as usual not an option – Case for Change
- Develop Pre Consultation Business Case
  - Key Messages:
    - Clinically Driven
    - Improving Quality 7 Reducing Inequalities
    - Opportunity to Get Involved
- Scheduled for Autumn 2016
- Requires:
  - NHS England Approval
  - Thames Valley Clinical Senate Approval

3. Plans for 2016/17

STP for Buckinghamshire, Oxfordshire & Berkshire West

Opportunities for scale, value & impact:

- Scaled Public & Population health
- Mental Health care services
- U&E Care, Cancer & Maternity
- Workforce
- Primary Care sustainability
- Reducing/avoiding variation

BOB STP – An Alliance with Bucks & Berkshire

:

Key Facts:

- 1.8m population
- £2.5bn place based allocation
- Circa £510m funding pressure
- 7 CCGs
- 6 Foundation and NHS Trusts
- 14 local authorities
- STP Lead SRO David Smith OCCG

3. Plans for 2016/17

STP for Buckinghamshire, Oxfordshire & Berkshire West

- Simon Stevens meets all STP leads early June
- CEx meet 20th June to discuss June submission
- Submit draft in June – not signed off by CCG Board
- Won't be published until later in the year
- Key messages shared with HOSC 30th June '16
- Review by NHS England during summer/Autumn
- BOB STP 'low risk'
- Update to Board

Extract June submission guidance: 'we do not anticipate the requirement for formal approval from your boards and/or consultation at this early stage.'

3. Plans for 2016/17

STP for Buckinghamshire, Oxfordshire & Berkshire West

- Sets out key areas for public consultation & major service change
- Sets out areas of political risk and controversy
- NHS England national oversight of local transformation & scale of change
- NHS England opportunity to shape national conversation about need for change
- NHS England opportunity to review local Service Redesign Assurance Framework

3. Plans for 2016/17

Oxfordshire Narrative contribution to BOB STP

- Develop Oxfordshire narrative 30th June '16
- Public facing document & will be widely shared
- Co-produced with patients & Healthwatch
- Set out:
  - Key messages
  - Case for change
  - Service Redesign & emerging models
  - Next steps for public consultation and how to get involved
- Share draft with Transformation board 14th June
- Share draft at HOSC pre-meet 20th June
- Share with HOSC 30th June

3. Plans for 2016/17

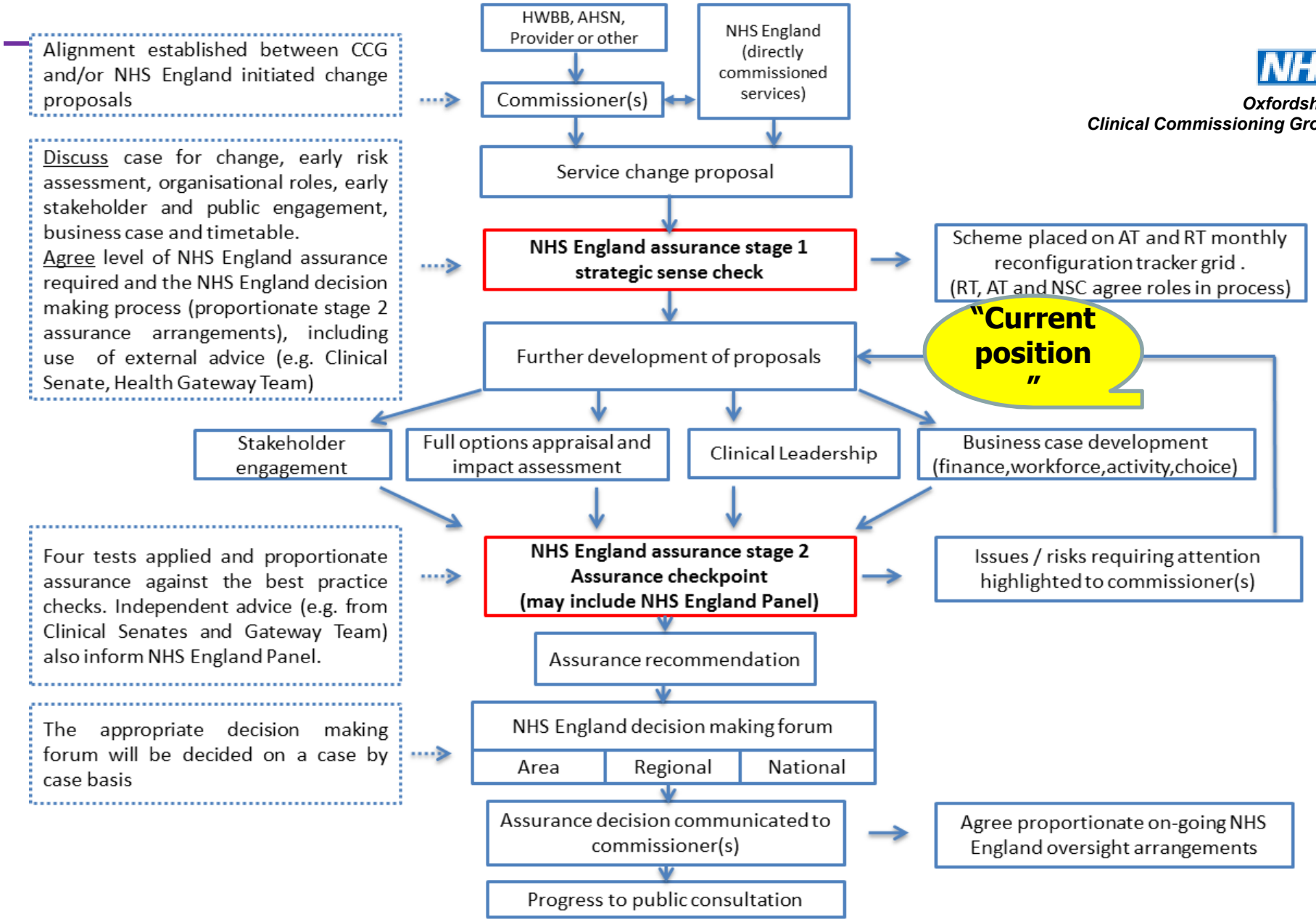
Pre Consultation Business Case

- Requires HOSC Approval of Case for Change
- Must demonstrate passing 4 key tests:

1. Patient & public involvement
2. Commissioner ownership
3. Compelling Clinical Case for Change
4. Maintains NHS Constitution standards for Choice

- Will be 'approved' by NHS England (Gateway 2 review)
- Will be approved by the TV Clinical Senate
- Avoid Judicial Review-Independent Review Panel
- Signed off by Transformation Board & individual boards
- **Owned by Oxfordshire CCG**

3. Pre Consultation Business Case

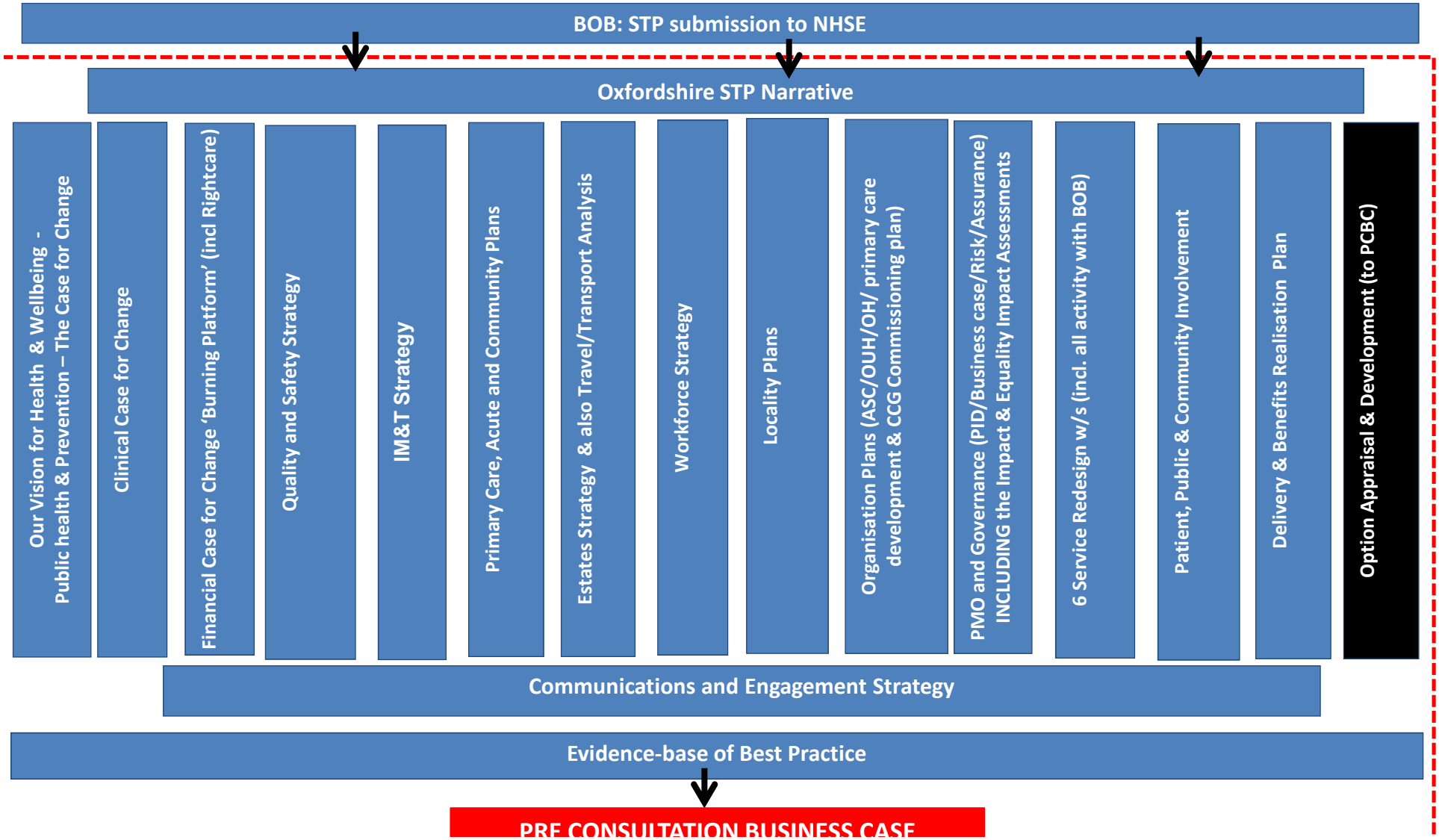


NHS
Oxfordshire Clinical Commissioning Group

3. Pre Consultation Business Case

Oxfordshire
Clinical Commissioning Group

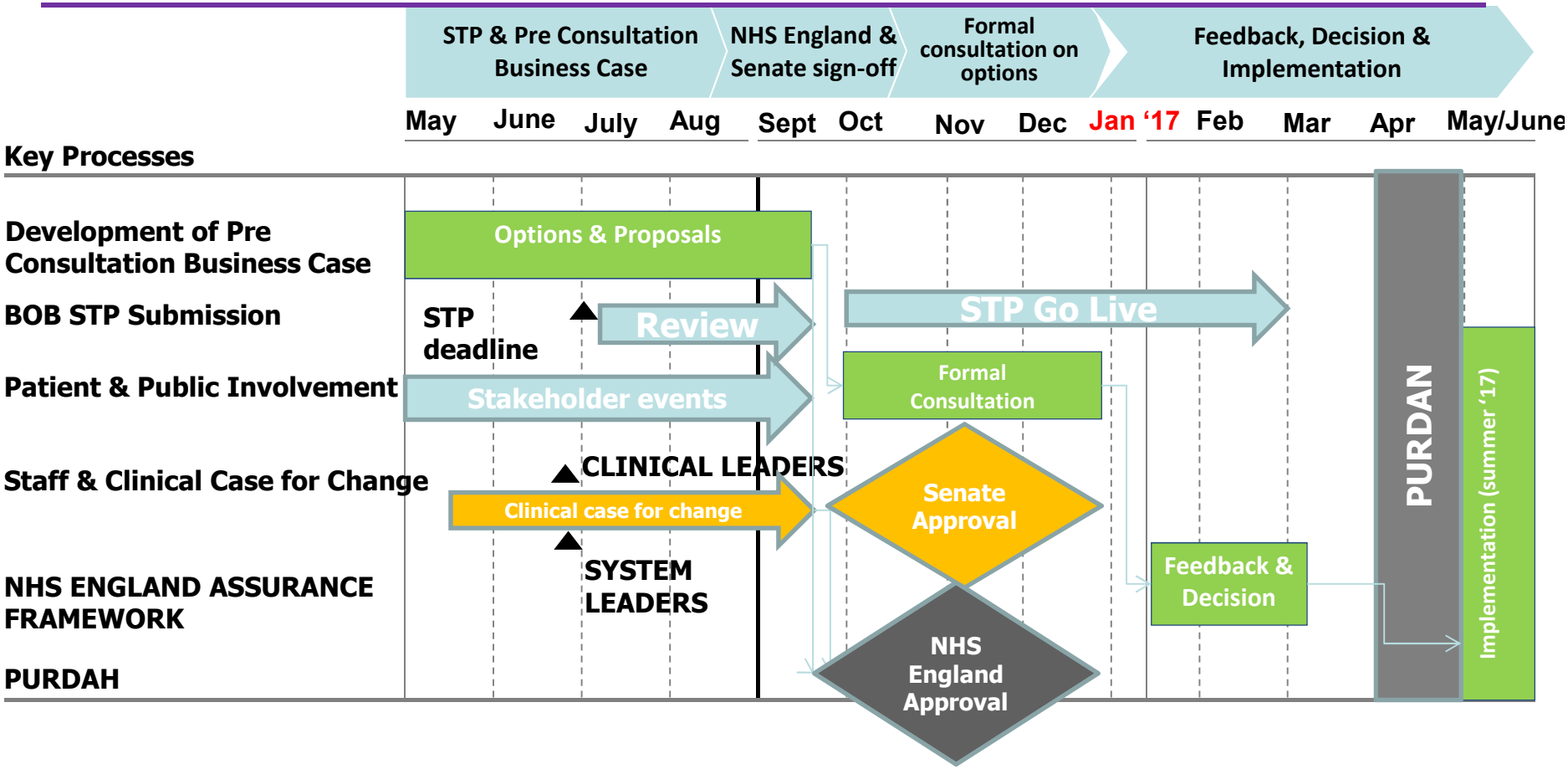
NHS England Assurance Framework – Evidence Library post Oxfordshire STP launch



3. Plans for 2016/17

High level summary of the process for developing the STP and consulting on the options

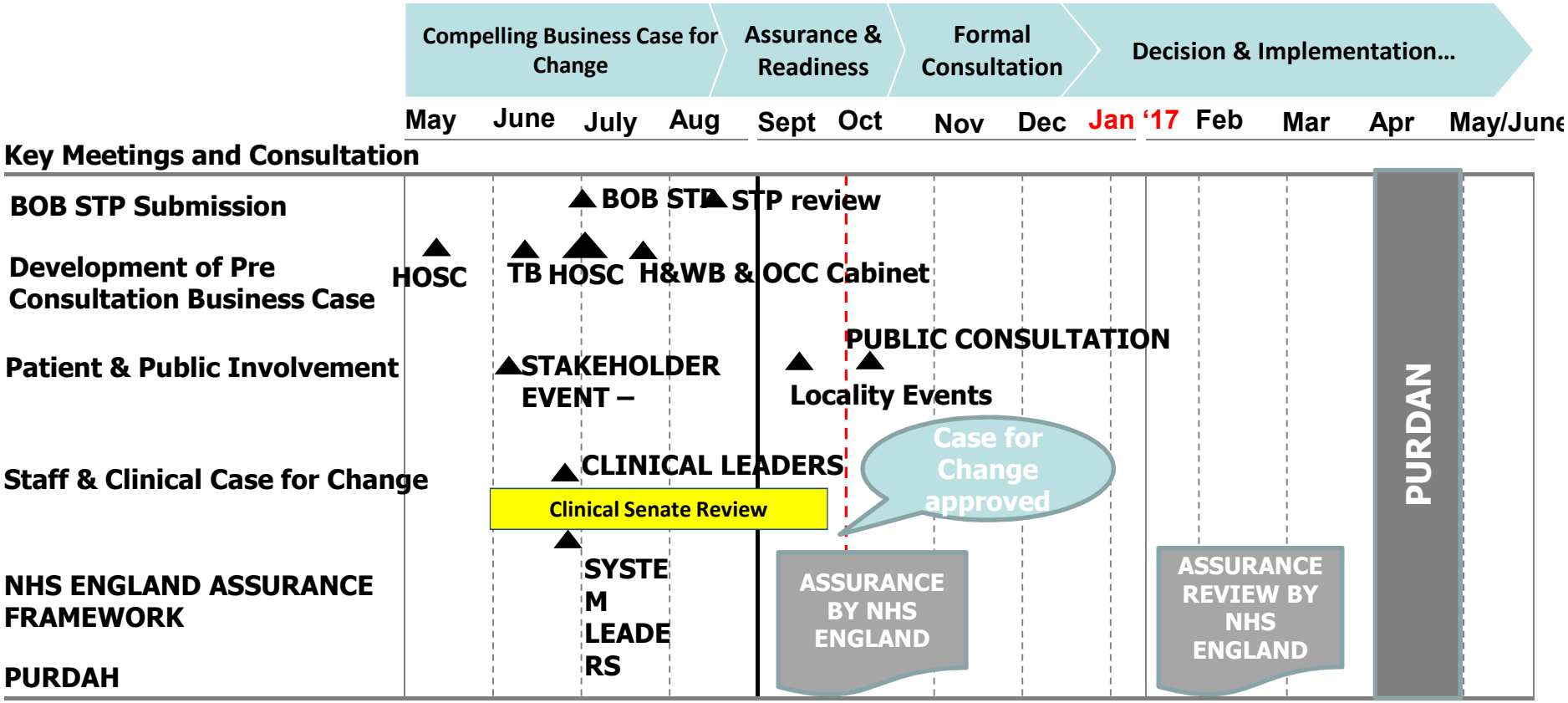
Oxfordshire Clinical Commissioning Group



3. Plans for 2016/17

High level summary of the process for developing the STP and consulting on the options

NHS
Oxfordshire
Clinical Commissioning Group



3. Consultation – anticipated scope

NHS Oxfordshire Clinical Commissioning Group

The scope of the anticipated consultation includes the following:

1. Service change in acute service provision including:

- Increasing elective and outpatient provision at sites
- Changes to stroke services
- Changes to obstetric and paediatric services
- Changes to critical care

2. Service change in community services across Oxfordshire including:

- Inpatient beds and the supporting services– both in terms of overall numbers, and in terms of service locations
- Enhanced diagnostic and outpatient services in the community
- The number and location of intermediate care beds provided by OCC
- The number and location of community hospitals/hubs (essentially following on from the above)
- Midwife led maternity units location and number, in the context of other changes in community hospital based services

3. Consultation – appraisal criteria?

What criteria should we use to Evaluate the Options & Proposals

Oxfordshire
Clinical Commissioning Group

Activity data
How many patients move?
How does this compare between options?

Quality and Safety
Are the standards achieved?
What is the patient experience?
How does this compare between options?

Public / Stakeholder consultation feedback
What does public feedback say?
What do stakeholders say?

Integrated Impact Assessment
What is the impact on protected groups?
How does this compare between options?

Workforce
How many more consultants do we need?
How does this compare between options?

Oxfordshire Coherence
Does the option 'work' at a r level?
Oxfordshire

Estates
Do we need additional estate?
How does this compare between options?

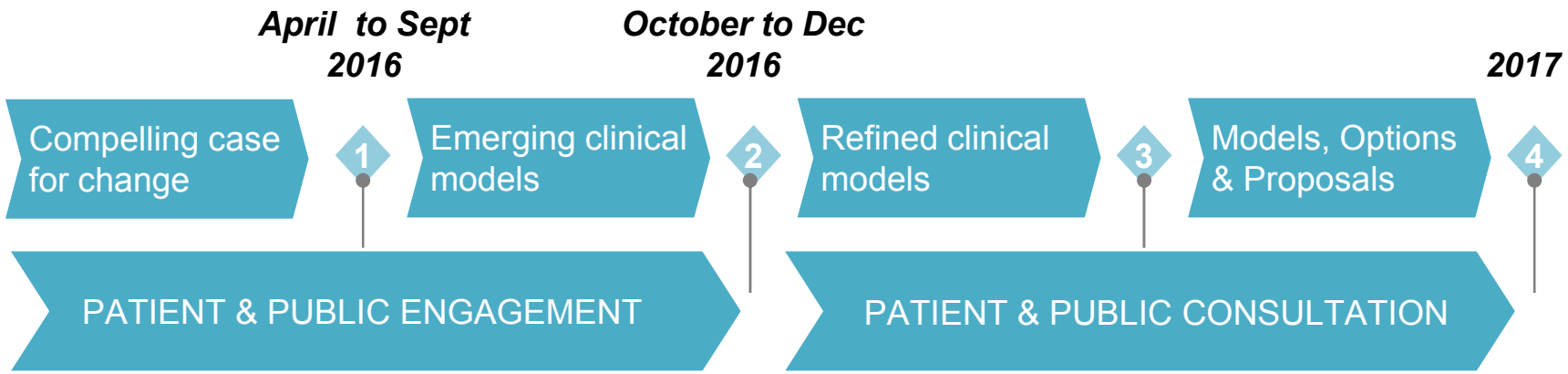
Capital
How much does new estate cost? Is any existing estate released?
How does this compare between options?

Finance
How much does each option cost?
How does this compare between options?

Travel and Access
Can the population access specialist services?
How is patient choice affected? How does this compare between options?

Transition
How much will it cost, what are **the workforce challenges**, how long will it take? How does this compare between options?

Next Steps



- Agree the Case for Change, focusing on trends & challenges in current health care services
- Review best practices on models of care and discuss potential implications for Oxfordshire
- **Publish STP**

- Input into emerging views on best practice care models
- Clinically driven discussions and engagement
- **Agree models and options for consultation**

- Launch public consultation on new care models options & proposals
- Review models of care based on feedback
- **Begin delivery of the 5-Year STP**

- Consult on options and proposals for the new care models
- Seek public feedback on models and options
- Refine options and proposals
- **Implement new care models as appropriate**

4. Next Steps

1. Case for Change
2. Plans for 2016/17
3. Clinically driven focused on improving quality
4. Getting involved

We want to continue the conversation . . .

There is a range of communications and engagement activities which will take place during the pre-consultation period and will include:

- Six patient and public engagement events throughout the summer
- Presentation and discussion at meetings of key community and voluntary sector groups
- Briefings for the County Council and District Councils
- Briefings for Oxfordshire MPs
- Updates and reports to Oxfordshire's Joint Health Overview and Scrutiny Committee, including a discussion at the June meeting about the plans for pre-consultation engagement planned for the summer period
- Updates to Oxfordshire's Health and Wellbeing Board
- Online information on the Transformation Programme website which we hope to launch next week.