Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 26 January 2017	**Paper No: 17/05a**

Title of Presentation: Final OCCG Operational Plan 2017/18 – 2018/19 and OCCG Priorities

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

Purpose and Executive Summary (if paper longer than 3 pages):
The national planning guidance requires the development of an Operational Plan which covers a two year period; 2017/18 – 2018/19. This was successfully submitted on 23 December 2016. The Board approved the first draft at its meeting in November and the attached plan is the final draft.

The Operational Plan reflects the commitments outlined in the Buckinghamshire, Oxfordshire and Berkshire West Sustainability & Transformation Plan (BOB STP), the commissioning intentions that have been agreed for 2017/18 – 2018/19 and the Oxfordshire Transformation programme.

NHS England is currently considering our plans and we expect feedback in the week ending 20 January 2017.

Financial Implications of Paper:
The final Operational Plan submission includes a financial plan for 2017/18 – 2018/19.

Action Required:
The Board is asked to

i. approve the CCG's 2017/18-2018/19 Operational Plan narrative
ii. approve the OCCG priorities for 2017/18 - 2018/19;
iii. note the operational priorities outlined for the next 6 months (a subset of ii)

NHS Outcomes Framework Domains Supported	
✓	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 ✓

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1. Introduction

This paper provides an update for the Board on the submission, on the 23 December 2016, of the final draft of Oxfordshire CCG's 2017/18–2018/19 Operational Plan, attached as appendix 1.

2. Oxfordshire CCG Priorities and Key Operational Plan Deliverables

The 2017/18 – 2018/19 Operational Plan is set in the context of delivering the next 2 years of the Five Year Forward View, Oxfordshire's share of the BOB STP and delivery of Oxfordshire's Transformation Programme.

The Operational Plan aims to show how, over the next two years, we intend to reduce the health, quality and finance gaps and address the nine national 'must do's.

Also attached is an updated copy of the CCG's priorities for the next 2 years, appendix 2. However the focus for the next 6 months will be:

- 2016/17 operational performance
    - Delivering our financial plan
    - Delivering our improvement trajectories for A&E 4 hour performance, cancer targets and 18 week referral to treatment time
- Continuing to work on Oxfordshire's Transformation Programme:
    - Consulting on Phase One January-March 2017 with a Board decision in May or June 2017
    - Undertaking the ground work for Phase Two February- April 2017 and launch of consultation later in 2017
    - Engaging with practices and the public on the Primary Care Framework
- 2017/18 Operational Plan and contracts
    - Achieving assurance of 2017/18 operational plan by end March
    - Sign all contracts and budgets and agree all trajectories by end March 2017
- Agree whole system approach to new models of care delivery and how we will support this work
- Ensure that OCCG plans continue to reflect the BOB STP and continue to review how we work in the light of the STP

3. Operational Plan submission

The final draft of the 2017/18 – 2018/19 Operational Plan was submitted to NHS England on 23 December and included:

- Final draft of the Operational Plan narrative
- Finance template
- Activity template

In addition to the narrative and templates detailed above, we also submitted:

- The draft Oxfordshire Framework for Primary Care
- Oxfordshire's GP Forward View Investment Plan

- A range of strategies and documents as supporting evidence
- A key lines of enquiry (KLOE) document; and
- A signpost document showing how we will be delivering the '9 Must Do's'

4. Next steps

Our plans are currently being considered by NHS England and we expect to get feedback in the week ending 20 January 2017.

5. Recommendation

The Board is asked to consider and approve:

i. OCCG's final 2017/18 – 2018/18 Operational Plan narrative
ii. OCCG's Priorities for 2017/18 – 2018/19
iii. Note the operational priorities for the next 6 months (January to June 2017) which are subset of ii.

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group

Operational Plan 2017/18 – 2018/19

v6.2
Final Draft Submission
(23 December 2016)

Introduction from the Chief Executive

This document details the Operational Plan for the next two years 2017/18 and 2018/19. We describe how we will meet the national policy objectives as set out in the 5 Year Forward View; deliver on the NHS Constitution Standards; and continue to maintain our financial position.

Key to our success is the transformation of our system of care delivery. In order to meet rising demand and financial pressures due to population growth, inflation, technological advances and new standards, we cannot continue to provide care in the way we have done in the past. We will be embarking on a number of public consultations during 2017/18 as we endeavour to rebalance our system.

We will also be working with our NHS and local authority partners to tackle the challenges that exist across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Plan (STP) footprint and contribute to the delivery of the vision for the BOB area.

The level of funding provided by the Government is increasing so we will receive an additional 2% in 2017/18 and a further 2% in 2018/19. However, this will only cover the inflationary increases which apply to the services we commission and therefore we have to find savings to fund all other cost pressures.

We know that 90% of the care our population receives is provided in primary care, however only 10% of our funding is spent on the services provided by GPs. It is critical that we shift resources from hospital care to primary care; and from treatment of patients when they are ill into disease prevention. To achieve this, we have to change our hospital services, reducing the reliance on bed based care and treating more patients on an outpatient and day care basis closer to their own homes. Unless we grasp this nettle now, we will see increasing numbers of GP practices closing which will cause even greater financial pressures for the system.

However, if we take some difficult decisions and rebalance our care system, we will be able to prioritise higher standards of care for our growing and ageing population. The actions we take in the next two years as set out in this Operational Plan are critical to the sustainability of care in Oxfordshire over the next five to ten years.

This is the final draft of our Operational Plan 2017/18 – 2018/19, for submission to NHS England on 23 December 2016. It will be circulated for comments before being taken to the CCG Board for sign-off on 26 January 2017.

David Smith
Chief Executive

1. Oxfordshire's Strategic Priorities

The Oxfordshire Clinical Commissioning Group (OCCG) Board has agreed six priorities for 2017/18 – 2018/19 which will support improvement in our health outcomes, quality and financial position; and respond to the nine national 'must do's'.

The 'What'	1. Operational Delivery 2. Transforming Health and Care 3. Integration
The 'How' (enabling)	4. Empowering patients 5. Engaging communities 6. System leadership

Further detail of these priorities can be seen in supporting document 1.

Through the implementation of the programmes outlined within this Operational Plan, Oxfordshire strives to deliver the nine must do's for 2017/18 and 2018/19. Appendix 1 cross references the sections of this Plan with the must do's.

This Operational Plan details the challenging agenda that will be pursued in Oxfordshire in 2017/18 – 2018/19. There are however four main areas of focus which will help to make the system more sustainable and also contribute in a very significant part to the delivery of the BOB STP:

- Consultation on and delivery of the Oxfordshire Transformation Programme
- Working to ensure the sustainability of Primary Care
- Delivery on operational performance
- Delivery of financial control totals

This Operational Plan has been developed through a shared and open book process to deliver performance and improvements.

2. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability & Transformation Plan (STP)

2.1 BOB: A High Performing System

Across our STP we have a proven track record of implementing innovation and excellence in clinical practice to deliver high quality patient care. This has led to us being a highly cost effective system, which we will build on as part of the BOB STP. This also provides assurance that we have the collective capability and capacity to deliver an ambitious plan to overcome our health, quality and financial gaps.

Further detail can be found in section 5 of the BOB STP (supporting document 2).

2.2 Key Challenges

- Health and Wellbeing
  Buckinghamshire, Oxfordshire and Berkshire West residents generally enjoy good health and access to high quality health and care services relative to the rest of England. However, the overall health profile for the footprint masks very localised variation in deprivation and poor health.

  Life expectancy is better than the England average, but we also have significant challenges across the BOB footprint:
  - Areas of deprivation with some people suffering poorer health outcomes than those in more affluent areas.
  - Two thirds of our adult population are either overweight or obese and in the 3 Place Based Health and Care systems across BOB has doubled in recent years.
  - 2.2% of our population is over 85 and this is set to increase by 22% by 2020 to approximately 49,000 people.
  - Our overall population is increasing by 3% by 2020, with additional growth driven by significant new housing development.

  Further detail can be found in section 4.2 of the BOB STP (supporting document 2).

- Care and Quality
  Detail of the care and quality gaps can be found in section 6.2 of the BOB STP (supporting document 2).

- Funding and Efficiency
  Collective commissioner resource for purchasing health services across BOB totals £2.55bn in 2016/17 and will increase to £2.87bn by 2020/21 (including Primary Care and Specialist Services), a composite increase of 12%. This uplift is to pay for increases in costs as a result of population growth, inflation and technological advances, together with funding for elements of new national initiatives, such as implementing 7 day working across the NHS, implementing the GP and Mental Health 5 Year Forward View objectives locally, some funding for these initiatives has been retained centrally.

  However our expenditure is growing at a faster rate than the increase in our funding and there is a growing financial gap, driven to a great extent by increased demand and complexity. We have calculated that if we do nothing, by 2020/21, we would have a financial gap of £479m. The proposals we are developing demonstrate how we can offset this cost through a combination of efficiency savings; delivering services in different and more cost effective ways (productivity); and tackling areas of current service provision which deliver poor value for patients and taxpayers.

  Further detail can be found in section 6.1 of the BOB STP (supporting document 2).

2.3 Our Vision and Ambition

Our vision is to improve health outcomes and add value by working together to close the health and wellbeing, care and quality and financial gaps.

By this, we mean:

- providing the best quality care for patients as close to their homes as possible
- healthcare professionals working with patients and carers to ensure quick access to diagnostic tests and expert advice so that the right decision about treatment and care is made first time
- ensuring, as modern healthcare develops, our local hospitals keep pace by using innovation to provide high quality services to meet the changing needs of our patients
- preventing people being unnecessarily admitted to acute hospital or using A&E services because we can't offer a better alternative
- caring for people in their own homes where possible
- spending funding wisely to ensure the provision of consistently high quality care that supports improved health outcomes

Further detail can be found in sections 7 and 8 of the BOB STP (supporting document 2).

2.4 Intended Benefits for Local Communities within BOB

Implementing our proposals will have major benefits for patients and drive efficiencies as we deliver better health outcomes by improving population health, access to services and care and quality.

Further detail can be found in section 11 of the BOB STP (supporting document 2).

2.5 BOB STP wide programmes

For each of these proposed programmes where working at STP scale adds value Project Charters have been developed with clear leadership, milestones and descriptions of benefits.

1. Prevention
2. Urgent Care
3. Acute Services including
    a. Clinical Variation
    b. Maternity
    c. Paediatric admissions
    d. Pathology
    e. Procurement
    f. Specialist paediatrics
4. Mental Health
5. Specialised Commissioning
6. Workforce including
    a. Support workforce
    b. Leadership and OD
    c. Value Improvement
7. Digital Interoperability
8. Primary Care at Scale

The Project Charters can be found at Appendix C of the BOB STP (supporting document 2).

2.6 Local Population Working

The great majority of work being undertaken is being progressed through strong local partnership working within our three place-based health and care systems. This work is summarised in section 15.1 and in the Project Charters (Appendix C) in the BOB STP (supporting document 2), with more detail provided in section 3 of this Operational Plan.

2.7 Summary of STP wide and local programmes and how they address BOB wide gaps

The high level summary, shown in section 9.1 of the BOB STP (supporting document 2), demonstrates how BOB STP wide programmes and the transformational plans in each of the three local systems contribute towards improvements in our health and wellbeing, care and

quality and financial gaps. It can be seen how we are working at scale where this adds value, while working with local partners for the majority of initiatives as this is the optimum way in which to get changes at the local level that are required to realise the full benefits. Detailed information describing the full extent of local working is provided in section 3 of this Operational Plan.

2.8 BOB Governance

System wide governance arrangements (figure 1) have been developed to maintain a strong grip on delivery to ensure benefits are realised.

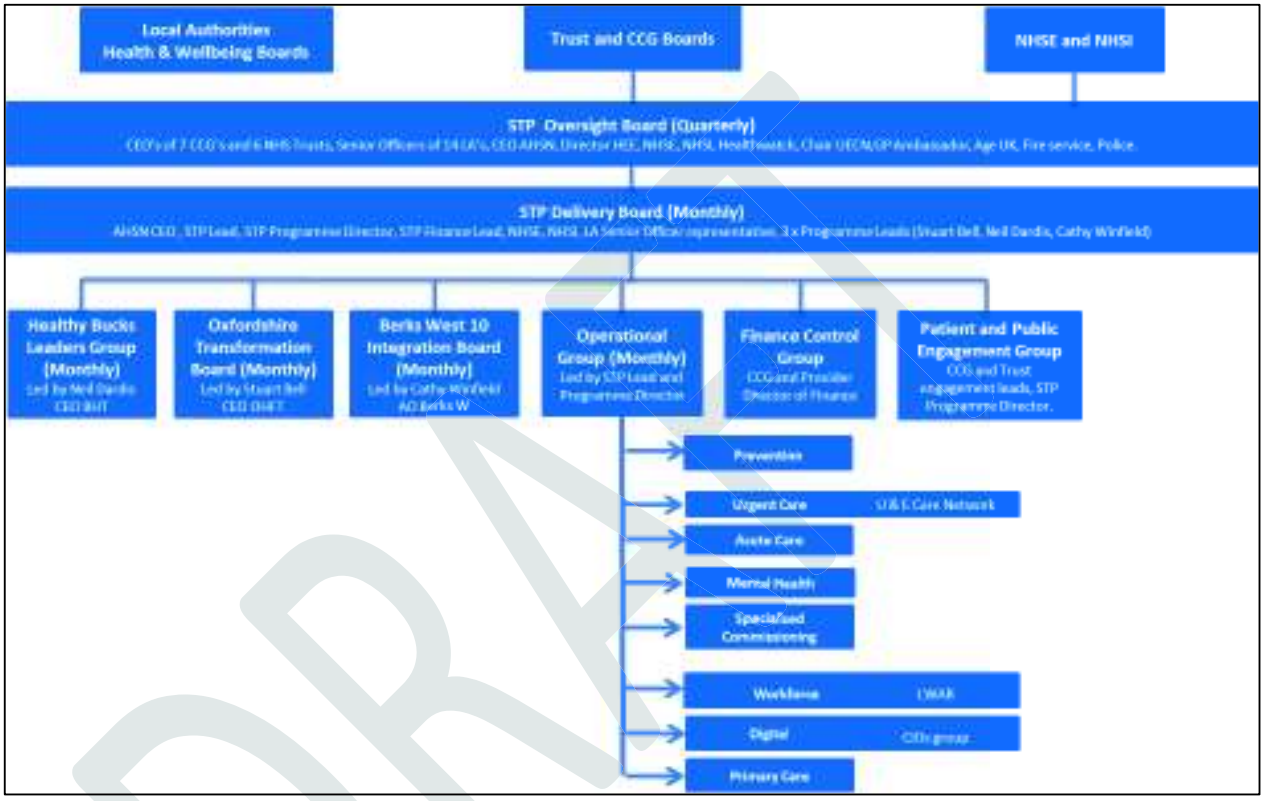


Figure 1: STP Governance Structure

2.9 Financial Plan

This section should be read together with Section 6.1 of the BOB STP (supporting document 2).

Although significant progress has been made since June and September 2016 in developing the STP there is recognition that there is still work to be done in ensuring the plan is sufficiently developed and deliverable. The Sustainability and Transformation Funds (STF) supporting providers totalling £41m have been included in the 'Do Something' template for 2017/18 and 2018/19, while nothing has been assumed in 2019/20 and the entire £106m allocation included in 2020/21. Our plan at the end of year 5 (2020/21) shows a surplus position of £11m.

BOB STP SUMMARY YEAR 5				
		£m	£m	£m
Do nothing position				-479
Do something solutions				384
Deficit				-95
STF funding				106
Year 5 position				11
Do something				
BAU CIPs	2.00%		213	
BAU QIPP	0.70%		63	
		72%		276
BOB Schemes				
Prevention			3	
Urgent Care			2	
Acute			7	
Mental Health			4	
Workforce			34	
Specialist			60	
Digital			-27	
		22%		83
Local Schemes				
Oxfordshire			8	
Berkshire West			5	
Buckinghamshire			12	
		7%		25
Total				384

Table 1: Year 5 Summary Position (from BOB STP templates)

3. The Oxfordshire Local Health Economy

3.1 Systems Leadership

The Chief Executives meeting has been developed to be a CEO System Delivery Board; this now includes GP Federation and Healthwatch representatives in addition to the CEOs of Oxfordshire Clinical Commissioning Group (OCCG), Oxford University Hospitals Foundation Trust (OUHFT) and Oxford Health Foundation Trust (OHFT). The purpose of the group is to deliver change in the operation and budgetary approach for the Oxfordshire health system through more joined up delivery, single budget management and a joint organisational form that drives up performance, drives up quality and makes sure Oxfordshire's finances balance. This is not just about the operational management of services or management of the financial risk, but it is also about creating the "delivery vehicle" for the Oxfordshire Transformation Programme. The main areas of focus are:

- Implementation of integrated locality teams across the whole area; single management of our bed base, rather than being split between OUHFT and OHFT; new outcome based models for long term condition management in diabetes, Chronic Obstructive Pulmonary Disease (COPD), heart failure
- a single contract between the CCG and OUHFT/OHFT/federations for the next two years for these services
- the involvement of primary care in any new organisational and contractual models developed
- resources moved from secondary care into primary care, with a specific plan for this agreed with primary care
- an improved system for mana ing financial risk
- delivery of NHS Constitution targets

This joint working has underpinned our approach to agreeing contracts for 2017/18-2018/19 as outlined in section 3.2.

3.2 Contracting

In managing delivery of our financial control total and securing quality services we have worked collaboratively with our main partners, Oxford University Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust, to agree affordable contracts for 2017-19 which support in-year delivery of all constitutional standards and investment in mental health for parity of esteem. The contract agreements reached are supported by a system risk management agreement that requires the three organisations to work together in order to reduce activity and cost pressures within the two contracts.

The 2017/18 contract values are as follows:

- Oxford University Hospitals NHS Foundation Trust - £331m
- Oxford Health NHS Foundation Trust - £89.3m

Collectively mitigations have been identified to reduce activity and cost pressures during the term of the contracts. Delivery of the mitigations will be overseen and managed via a system governance arrangement with each organisation represented. This will report directly to Chief Executives.

Engagement with primary care to support delivery of the mitigations will be key and the CCG will continue to work with practices and GP Federations to manage the pressures identified.

As part of the risk management agreement, the CCG has committed to undertaking a review of both mental health services and spend and primary care capacity in 2017/18 to inform funding priorities for 18/19. 2018/19 Contracts will be varied as required to reflect the outcome of these reviews and any changes resulting from phase one and/or phase two of the public consultation exercises planned for 17/18.

Lead Provider Framework: there is a national requirement to re-procure the Commissioning Support Services across the Thames Valley. Oxfordshire, together with Thames Valley Partners, are maximising this unique opportunity to deliver efficiencies whilst sourcing top quality services to support transformation across the area. The Thames Valley CCGs are setting out to procure services provided by a lean, highly efficient, effective and competitive commissioning support services. Such a service will distinguish between the heavily transactional where standardisation and automation yields efficiency savings, and the non-transactional where different sets of tools and skills need to be deployed to maximise the value adding end of the service to commissioning organisations.

The new service is expected to be operational from October 2017, thereby delivering enhanced commissioning support for a reduced and reducing cost envelope.

3.3 Performance

3.3.1 Operational Delivery

During 2016/17 we have delivered on the majority of our constitutional targets except:

- Accident and Emergency four hour wait
- Referral to Treatment Incomplete 18 week
- 62 Day Cancer GP Referral

We have built additional activity into Q1 and Q2 in order to recover RTT and 62 day by the end of Q2. We will monitor activity to ensure that we deliver on these targets through to March 2018.

We anticipate Accident and Emergency four hour wait to not consistently meet targets over the two years of planning. A Remedial Action Plan (supporting document 3) outlines milestones relating to reducing '999 calls and conveyance' and sustained recovery of response times including increased 'hear and treat' and 'see and treat'. The action plan has details of care plans for patients at high risk of admission. This will help us facilitate improved performance of the A&E 4 hour wait target.

Our activity template shows that we aim to deliver on all other constitutional targets through 2017/18.

Our activity submission will show a 1.14% reduction in elective in year 1 and a 1.26% growth for FU in year 1. This is because of the Day Case to OPROC scheme agreed as part of the OUHFT contract which will meant that a number of procedures will be done on an outpatient

bases as opposed to inpatient basis. The equivalent for year 2 is Elective -2% and OPFU +0.28%.

3.4 The Oxfordshire Transformation Programme

The Oxfordshire Transformation Programme (*'the Transformation Programme'*) has taken a collaborative 'whole system' approach which recognises the interdependencies between primary, community and acute care. The Programme has been developed through joint working across the system, involving all relevant partners.

Figure 2: Whole system scope of the Transformation Programme

3.4.1 Oxfordshire's Case for Change

The population of Oxfordshire currently enjoys good overall health but access and outcomes are not consistent across the county. The health needs of the population are also changing, driven by increasing chronic disease and ageing and births from the growing populations of Bicester and Didcot. This is exacerbated by workforce shortages and the financial challenges facing all public sector organisations.

The report of the Health Inequalities Commission has recently been published and will be used to set our priorities for addressing the inequalities that exist across Oxfordshire. There is a need to take time to consider its recommendations and identify which actions will have the biggest impact on reducing health inequalities. A Health Inequalities Commission Implementation Group will be established and meet in early 2017, with partners from the organisations listed in the report, to develop a forward plan. The recommendations were considered at a CCG Board workshop to highlight initial priorities and the outcome of these discussions will be taken to the Implementation Group.

Copies of the main report and headline report, which include more detail on the recommendations, are included as supporting documents 4 and 5. There are 58 recommendations which have been grouped as follows:

- Recommendations 1-11 focus on the common principles which emerged during the process of the Commission. The Commission recommend that these principles should inform all policy, resource allocations and practice across the county to ensure health inequalities do not become further entrenched or grow.

- Recommendations 12-40 focus on common themes across the lifecourse; these take into account not only geographic communities but also communities of common interest, particularly vulnerable groups most likely to suffer from health inequalities.
- Recommendations 41-58 focus on stages of the life course
    - Beginning well: pre-pregnancy, the antenatal and perinatal period and childhood
    - Living well: the middle years
    - Ageing well: the latter years of life

-

The overarching case for change in Oxfordshire has seven elements and is summarised below.

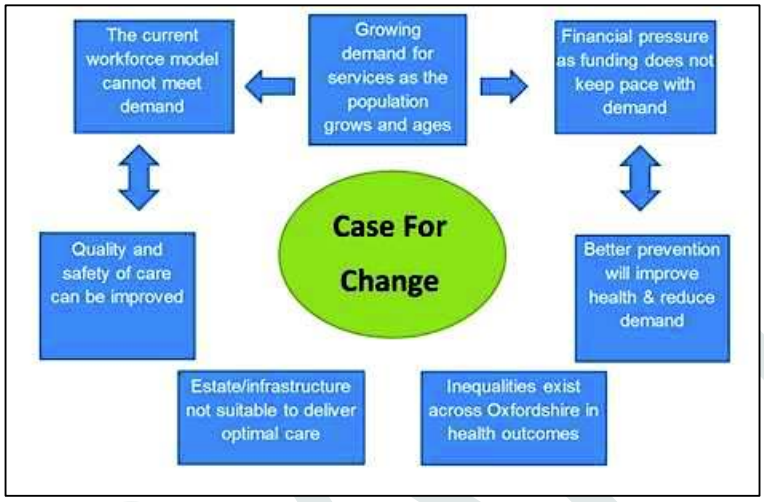


Figure 3: Overarching Case for Change for the Transformation Programme

The Oxfordshire system has a shared ambition and commitment to deliver transformational change to:

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

Further detail on the case for change can be found in the Oxfordshire Transformation Programme Pre Consultation Business Case (supporting document 6).

3.4.2 Our Approach

With regard to the areas of the Transformation Programme which require consultation, we are taking a phased approach to change. This is outlined in table 2 below.

Phase One
Acute Hospital Services: 1. Elements of Urgent and Emergency Care 2. Planned Care (diagnostics, outpatients, Elective Care) 3. Maternity Services
Phase Two
Community and Acute Services

1. Primary and Community Services including Community Hospitals 2. Children's hospital services 3. Accident and Emergency

Table 2: Phasing of Transformation Programme

Further information on the scope and phasing of the programme is included in supporting document 6, including an implementation plan (chapter 11).

We will be developing and agreeing how we track progress and monitor both financial benefits and patient benefits resulting from our transformation plans.

There is a high level of complexity to work through to ensure that the financial benefits at STP, Oxfordshire system and individual organisation level are clearly identified and that we have robust monitoring systems in place. This work will be driven by the new Transformation Finance Working Group which includes commissioner and provider Directors of Finance.

Patient benefits will be identified through the new Transformation Clinical Working Group. Recommendations will be made by these two new groups to the new Transformation Programme Executive who will achieve sign off from the CCG Board for the recommendations and who will oversee and monitor progress and benefit realisation.

3.4.3 Consultation and Engagement Plans

The Transformation Programme is committed to engaging with all relevant stakeholders and specific proposals, once assured, will also be subjected to formal public consultation. Consultation on Phase One of the Transformation Programme is expected to take place between January and March 2017, with consultation on Phase Two planned for Summer/Autumn 2017.

Our consultation plan is set out in chapter 12 of the Pre Consultation Business Case (supporting document 6), including detail on phasing, stakeholders and key messages.

3.4.4 New Service Delivery Models

The new service delivery models which form the Transformation Programme are outlined below. It is not possible to model the impact of the change into the Operational Plan activity template and finance plan which are being submitted alongside this Operational Plan until we have been able to consult on Phase One of the Transformation Programme.

3.4.4.1 Primary Care

Historically Oxfordshire has benefitted from a reasonably funded, high-quality general practice system. However, the issues that are impacting on general practice elsewhere in the UK are creating similar pressures in Oxfordshire. The most common cause of the stress felt in general practice that is causing vulnerability is workforce. This is made worse by the declining state of GP premises, the decline in GP funding, and the escalating challenge of providing good quality care to a growing number of ageing and more complex patients.

To address these issues and deliver our vision for the future of Primary Care locally, we have developed the Oxfordshire Framework for Primary Care (supporting document 7). This clearly lays out the new model of care for Primary Care and identifies which services would be better provided at scale sharing the burden of care but also supporting the shift of care

from acute hospitals, wherever possible, to a community setting. The Framework will be implemented across all of Oxfordshire but localities will apply the Framework in a way that meets the needs of their population and will start to shape the things that make a difference locally.

The Framework will be supported by the GP Forward View Investment Plan for Primary Care (supporting document 8). Together these changes will be used to transform primary care from a predominantly reactive health system, which responds to people when they become ill, to significantly build on and increase proactive support for people to improve their health and remain well. This change is essential for the sustainability of both primary care and the wider health service and the health and wellbeing of people living and working in Oxfordshire.

This population based approach is outlined in the diagram below:

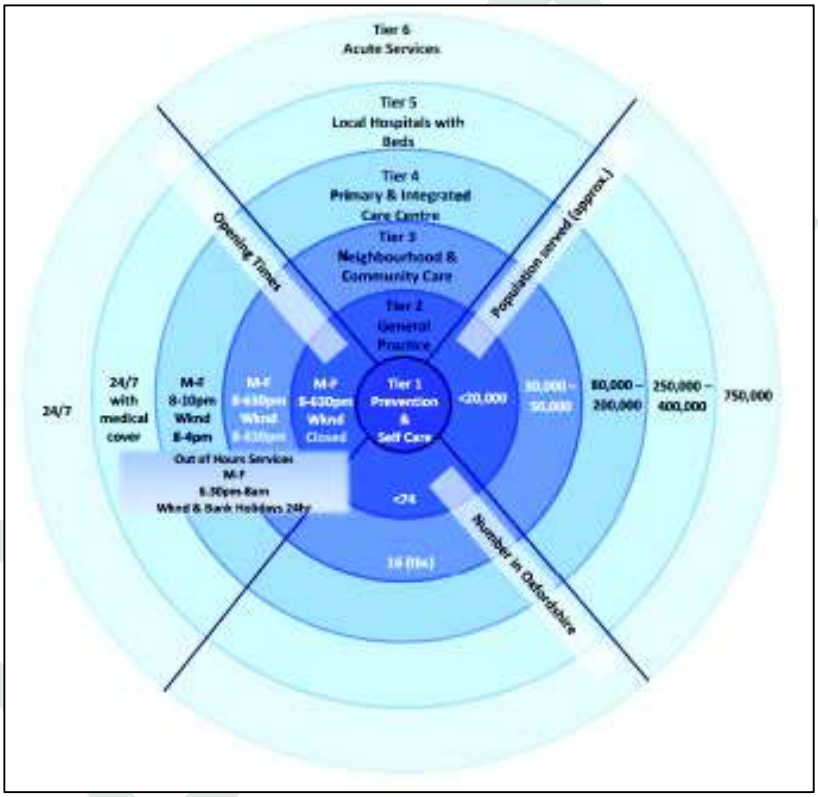


Figure 4: Population Based Approach

Further detail can be found in draft supporting documents 7 and 8.

3.4.4.2 Urgent and Emergency Care, including stroke care and critical care

Proposals for accident and emergency will be developed in Phase Two of the Transformation Programme. In Phase One it is proposed that the current Critical Care Centre at the Horton General would be changed from a Level 3 (support of at least two organ systems) to a Level 2 Centre (more detailed observation or support of a single failing organ system only – other than advanced respiratory support).

In Phase One of the Transformation Programme, we are also proposing to make changes to stroke services within Oxfordshire with the aim of ensuring that all stroke patients receive the

best quality care and support through the stroke pathway. The proposal aims to ensure that all elements of the pathway are compliant with the latest NICE guidance and that the most effective treatments and procedures are used to improve outcomes. We aim to reconfigure services with a view to increasing the capacity of the Hyper Acute Stroke Unit at the John Radcliffe and ceasing acute stroke care on the Horton General Hospital site.

We also believe that the best place to receive your rehabilitation following a stroke is in your own home and your own bed wherever possible. We currently have a service that supports early discharge for eligible patients for part of the county and linked to the proposal for stroke services want to expand this service to cover the whole of Oxfordshire.

As part of our Phase One transformation plans, our intention is to reduce the number of Delayed Transfers of Care (DTOC) in Oxfordshire. Linked to this, we are proposing to make permanent the current realignment of 194 acute beds (a reduction of 76 beds in Phase One and then 118 beds in Phase Two of the changes), subject to public consultation. This would formalise the temporary changes made as part of the 'Rebalancing the System' delayed transfer project that has been running since November 2015. This project has enabled patients who no longer need acute medical care to move from a hospital setting into an intermediate care bed in a nursing home, allowing patient needs to be met more appropriately while they wait either to be transferred home with community-based support or to a permanent care home placement.

The Thames Valley Emergency Care Network Urgent and Emergency Care Review has been used as the foundation for the work within Oxfordshire's Urgent and Emergency Care Clinical Workstream and has informed our transformation plans. As active participants we share lessons learnt with the Network, including those relating to 7 day services and actively track against the Urgent and Emergency Care Route Map which is monitored via our Urgent Care Programme Board and the A&E Delivery Board.

Further detail on the future service delivery model for urgent and emergency care, including the stroke service, can be found in supporting document 6.

OUHFT is an early adopter of 7 day services and consistently ranks in the top quartile on the 7 day service measure. OCCG are monitoring this via the A&E delivery board.

3.4.4.3 Planned Care (elective care, diagnostics and outpatients)

Proposed changes to planned care are part of Phase One transformation plans and include a new community based service model in the North of the county, which would feature:

- Primary Care access to local diagnostics including a full diagnostic suite in Banbury facilitating high quality diagnostics and improved diagnostic procedures that will increase access for patients and reduce travel time for routine diagnostic procedures and the need for consultations in secondary care
- Effective triage of outpatient referrals to manage demand and ensure "right care first time", re-directing care from an acute provider to care closer to home as appropriate.
- Moving to an integrated partnership model of care with shared ownership of outcomes to deliver a population-based approach for long term conditions, starting with diabetes. This will enable improved care planning and help patients manage their own conditions. An initial pilot in one locality starts in January 2017 with a second planned for April 2017.

- Outpatients delivered locally with diagnostic to support using a “one stop” approach where possible. The proposals include an expanded facility at the Horton General Hospital.
- An advanced risk stratified approach to pre-operative assessment to facilitate the smooth running of elective interventional services and reduce cancellations in the community.
- A co-ordinated elective theatre complex in Banbury to improve surgical throughput and improved productivity in line with “Four Eyes” report.
- Elective theatres ring fenced, where possible, to ensure best use of time and support for the achievement of national standards.
- Increased capacity for direct access diagnostics across the localities to support delivery of the 2 week wait cancer pathway, where possible.

Improvements to Planned Care in the South of the county will be part of Phase Two transformation plans and will inform proposals for the use of Community Hospitals.

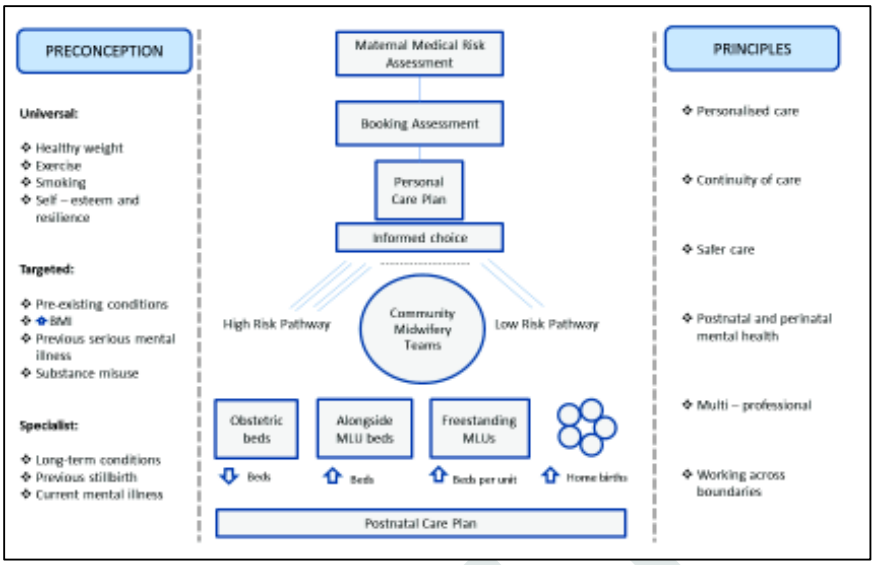
Further detail can be found in supporting document 6.

Other key areas for development are:

- Improved access to advice and guidance via email and telephone for GPs to reduce the need for referral where possible.
- Improved quality and access to a wide range of End of Life Care services as detailed in the OCCG End of Life Strategy (supporting document 9). The vision for End of Life Care in Oxfordshire is about a personalised; simple enough for anyone (patient and professional) to navigate, co-ordinated to ensure that all services work together to deliver seamless care.

3.4.4.4 Maternity Services

The vision for maternity services in Oxfordshire is for the ‘right woman, to get into the right part of the maternity service, cared for by the right professional’. The aim of the new service model is that every woman will experience personalised care from early medical risk assessment through to birth and into the postnatal period. The proposed new service would deliver real choice and continuity of care throughout the pregnancy, birth and postnatal period.



*(*MLU – Maternity Led Unit)*

Figure 5: Proposed Maternity Service Delivery Model

Proposed changes to the delivery of maternity services will be part of the Phase One consultation.

Further detail can be found in the supporting document 6.

3.4.4.5 Children's Services

The vision for Children's Services is that Oxfordshire should be the best place in England for children and young people to grow up in. We want to work with every child and young person to give them the best start in life and support them to develop the skills, confidence and opportunities they need to achieve their full potential.

A new model of care to deliver this vision is being developed and, subject to assurance, will be consulted on in Phase Two of the Transformation Programme. The model will include:

- A core offer for all children and young people
- Early help and speedy access
- Published pathways and waiting times
- A revised offer in primary care to enable more children to be treated in neighbourhood settings
- Integrated teams with easier access to community diagnostics;
- Equitable access to paediatric assessment units with ambulatory support,
- 7 days a week; specialist outreach clinics with paediatricians and integrated teams for children with disabilities and/or socially complex children.

A redesigned Children and Adolescent Mental Health service (CAMHS) is outlined in the section below.

3.4.4.6 Mental Health, Learning Disabilities and Autism

The transformation plan for mental health, learning disability and/or Autism is an all age plan that addresses national priorities and responds to local issues identified through the Transformation Programme. The plan will be delivered partly by new initiatives and partly

through the implementation of current agreed initiatives. The CCG has commissioned two Outcome Based contracts (OBC) that incentivises providers to support people with severe mental illness (HoNOS PbR clusters 4-17) and people with mild to moderate depression who need psychological therapy and preventative wellbeing services (HoNOS PbR clusters 1-3). These contracts are set to run to 2022 and 2021 respectively and are designed to meet the requirements in the *Five Year Forward View* for mental health.

Children and Adolescent Mental Health Services (CAMHS)

The CAMHS Transformation Plan (supporting document 10) is being taken forward through the procurement of a redesigned children and adolescent mental health service. OCCG is currently evaluating a bid to deliver these new services using the most capable provider process. The new services are due to commence April 2017 and will deliver information, advice and consultation, assessment and treatment services for children aged 0-18 with mental health problems and learning disability (and for children and young people in transition, up to the age 25).

Through the most capable provider process we will be able to evaluate a new provider's ability to deliver

- Evidence-based treatment, including availability of Improving Access to Psychological Therapies (IAPT)
- Access to eating disorder services for 95% of children in 4 weeks (or 1 week for urgent cases)
- 24/7 access to urgent response care in the community
- Support for survivors of childhood abuse
- Support for children and young people as they transition to adult services

The focus of the incentivised contract for children and adolescent mental health and learning disability is to deliver:

- Improved access
- Achievement of personalised outcomes
- Reduced use of in-patient services
- Increased school attendance and reduction in number so children who are 'not in Education, Employment or Training' (NEET)
- A greater focus on recovery planning, wellbeing and resilience
- Reduction of self-harm
- An extra 700 young people, over the 2014/15 national baseline, able to access treatment by 2020 (our 1% share of the national trajectory as set out in *'Implementing the Five Year Forward View for Mental Health*)

We also intend to review the age boundary between children and adult services. The outcome might lead to contractual variations in 2018/19 if the 'age boundary changes'.

Improving access and outcomes for people with learning disabilities and/or Autism

The Oxfordshire Transforming Care Plan (supporting document 11) sets out Oxfordshire's ambition to improve access to services, provide better quality and more personalised services with improved clinical and life outcomes for people of all ages with learning disability and/or autistic spectrum conditions.

Implementation of the Plan will

- Integrate specialist learning disability health services with Oxfordshire's mental health and community services through a planned transfer to mainstream providers in 2017/18. We are assessing the capability of our provider of mental health services to take on the provision of specialist health services for people with learning disability. This most capable provider assessment will be concluded in January 2017 and it is planned that the new service should be implemented during 2017/18.
- Provide support for Primary Care enabling them to increase the number of GP health checks to 75% during 2017/18 (from 2014/15 baseline of 41%)
- Improve health outcomes for people with learning disability and/or autistic spectrum disorders through increased GP health checks, improved reasonable adjustments in contracts for community and acute services and an integrated approach to NHS continuing healthcare.
- Redesign service pathways for autism, across learning disability and mental health services during 207/18, to reduce the numbers of people inappropriately detained in secure mental health beds by increasing access to community support and appropriate accommodation
- Reduce reliance on in-patient Learning Disability beds through
    - A step up model of intensive community-based support and community care and treatment reviews for those at risk of admission
    - Development of personal health budgets to support early intervention for those at risk of admission
    - Access to alternative forms of housing and support for those at risk of admission or to provide support to facilitate discharge

Together these measures aim to reduce the number of people in in-patient beds during 2017/18 and 2018/19 and are being included in 2017/18 contracts.

Perinatal Mental Health

The CCG has worked with partners in primary care, mental health and obstetric services to design a new perinatal pathway. A multidisciplinary specialist Perinatal Mental Health Service will be developed and led by a dedicated psychiatrist with specialist knowledge of Perinatal Mental Health. The Clinical Lead will oversee and support the pathway to deliver a NICE compliant service across a number of service areas. The team will ensure all women can access timely evidence-based specialist perinatal mental health care locally throughout the ante and postnatal period. The service will act as a signpost to other services including Psychological Services, Infant Perinatal Service (IPPS) and Adult Mental Health Teams (AMHT) to support mental health needs of the perinatal population.

This service model will be refined to take into account the feedback on the Oxfordshire bid for dedicated funding. A new bid will be made to support implementation from 2017/18.

Improving access to mental health services for adults

In 2015/16 to deliver the access requirements of Five Year Forward View we have commissioned:

- A new IAPT service (TalkingSpacePlus) increasing access for an additional 17% (10,320 people) this has subsequently been extended to 19% (11,534 people). We have done this as part of a successful bid for pathway funding to expand the service to people with long-

term conditions. We aim to deliver the Five Year Forward View 2017/19 access and waiting times through our current contracts. We have submitted a bid for additional funding to support people into work and have agreed a contract to improve access to psychological therapies for people with severe mental illness.

- We have contract arrangements in place to meet national deliverables for access to NICE compliant Early Intervention in Psychosis services and will meet the 53% expectation by 2019.
- Crisis Response and Home Treatment services that will deliver national targets in terms of responsiveness to people in acute psychotic crisis. We will be leading a system wide bid in January 2017 for funding, under the Urgent & Emergency Mental Health Liaison Values Based Transformation Funding stream, which will build on the current Crisis, Early Intervention in Psychosis (EIP), Ambulance and Street Triage services and psychiatric liaison services. The bid will be used to develop an integrated pathway for people in acute psychotic crisis that ensures access to NICE-approved services no matter where people enter the health or social care system in an emergency
- A memory assessment service that provides assessment within 6 weeks. In 2017/18 we aim to review the pathway to improve access to dementia diagnosis and agree a 5% improvement in 6 week wait performance.

In addition we are:

- Leading a review of the post diagnostic pathway for people living with dementia to inform a redesign of the service from October 2017, in line with our intention to remove the upper age limit within the contract.
- Working with local authority partners to develop a home care and nursing home sector that can respond to the needs of people with the more complex dementias.

We have redesigned acute and emergency liaison services and commissioned:

- 24/7 1 hour access to psychiatric assessment at the main acute site in Oxford and 1.5 hour access in Banbury.
- Street Triage services that work with the police 1800-0200 7 days a week
- Mental Health triage services that works with ambulance dispatch 1800-0400 7 days a week to help avoid inappropriate conveyance to emergency departments

We have identified the need to bring these initiatives together around urgent access to care, for people of all ages with mental health presentations (including those without formal mental illness) to create a new integrated urgent mental health pathway in 2017/18.

As this work impacts on the OBC the new service will be in introduced from October 2017. This new service will focus on the reduction in suicide rates through a dedicated hub for people in mental and emotional distress, a risk management and care planning approach for people with identified needs and training and support for staff in all urgent-care outward facing services, including primary care

This work will be developed within the scope of the Oxfordshire Mental Health Crisis Concordat and will be used to model the development of a bid for funding to support Core 24 services in the acute sector plus psychological medicine support into community and primary care.

Improving outcomes from mental health services

Since 2015 we have contracted on an outcomes basis for people with severe mental illness who fall within HoNOS PbR clusters 4-17 (moderate to severe depression, personality disorder and psychosis, including first onset of psychosis). The service has an open door for referral and assessment, taking people either into treatment or referring people to appropriate alternative treatment (IAPT, drug and alcohol services and wellbeing). The outcomes based contract is incentivised and we agreed 20% of the value to be at risk contingent on delivery of the outcomes. For most measures 2015/16 has been a baseline year with improvements delivered from October 2016. The outcomes will be extended to people living with learning disabilities and/or Autism.

A list of the outcomes commissioned by OCCG is included as supporting document 12.

The Outcomes Based contract is held by Oxford Health NHS Foundation Trust and is delivered by the Oxford Mental Health Partnership which includes the Foundation Trust and voluntary sector organisations that deliver housing, employment, wellbeing and recovery services. The contract runs until September 2022 and is designed to offer flexibility in terms of scope, inputs and term that will support the transformational change needed to deliver recovery and well-being to people living with severe mental illness. The contract is flat cash and was agreed with the provider to meet national expectations, within current value.

The Mental Health Investment standard has been met in the 2017-18 plan, but not in 2018-19. This reflects the fact that the CCG has let a five year outcome based contract for Mental Health services at a fixed price for the life of the contract. The CCG has been notified of further allocations for Mental Health in future years which are not yet reflected in the plan and which will help move the CCG plan closer to the standard.

The outcomes based approach has been used in the new contract for IAPT, in the current procurement of children's services and is included as part of the Transforming Care Plan for people with learning disability and/or Autism. For people with learning disability and/or Autism we anticipate that we will baseline measures in the period to September 2017 with improvements being delivered from October 2017.

The provider partnership is incentivised to minimise the use of out of area treatments and to develop housing solutions that improve patient outcomes and release resources back to the partnership through the use of less restrictive, less expensive options. We will be monitoring the use of out of area placements during 2017/18.

Within the OBC the provider holds the Individual Placement Service (IPS) that is integrated within the partnership. We monitor the impact of employment services based on the number of people that are in work, whether assisted to retain or to gain jobs rather than the inputs necessary to deliver this outcome.

Through the Oxfordshire Transformation Programme we will be driving further key outcome initiatives including:

- Extending the outcomes delivered to adults with severe mental illness to include older adults with functional mental illness. Reviewing older adult services with our partners to extend the upper age limit of the OBC from October 2017.

- Improving post diagnostic dementia care, particularly in relation to avoiding unnecessary admissions to hospital and improving the management of people with significant behavioural challenges in the community rather than in secure units. This will be reviewed and will inform commissioning intentions for 2017/18
- Developing a support service for people with emotional distress, behavioural challenges or medically unexplained symptoms in primary care settings. This will be developed through existing services in 2017/18; a key dependency will be the acute liaison services that work into and out of hospital (and which will be built into a bid under Core 24).

Improving the quality of care for people with mental health needs, learning disability and/or Autism

To improve the quality of services we will:

- Ensure that compliance with national dataset reporting is written into TalkingSpacePlus and the OBC and evaluate it as part of the capable provider process for both children and adolescent and learning disability services
- Require providers through their contracts make more use of user feedback and co-produced models of care using partnership approaches in service developments
- Make greater use of serious incident reports and learning from national programmes such as the Learning Disability Mortality Review. We review serious incidents in contract Quality Review Meetings, but will also use case studies to explore potential improvements in care pathways (e.g. by the Mental Health Crisis Concordat).

Further detail on the Mental Health and Learning Disability Transformation plans can be found in supporting document 6.

3.5.5 Enabling Programmes

3.5.5.1 Prevention

Primary Care delivers both primary and secondary programmes of prevention as outlined below. Many of these programmes are commissioned for Oxfordshire patients by Oxfordshire County Council (OCC) through their Public Health team who work closely with the CCG.

Managing Long Term Conditions

Using technology such as email consultations and skype consultations is an increasingly acceptable way for people to access health care. People are becoming more used to contacting the practice for advice and having the range of self-help facilities easily available would support patients to care for themselves. We will be promoting this approach through 2017/19.

Long term conditions lend themselves to a model of partnership care that is identified in the 10 high impact changes. We already promote the use of technology, through apps such as True Colours, and this alongside programmes such as the expert patient programme in diabetes helps people to self manage and experience better outcomes. People live with their long term condition 24/7 and are best placed to manage their condition if they have the right knowledge and support. It is recognised that this model will not suit all people but where it does it has the capacity to release pressure and time in primary care.

Diabetes

As noted in Appendix B of the BOB STP, OCCG will be participating in Wave 2 of the NHS Diabetes Prevention Programme (NDPP) in partnership with Buckinghamshire CCG. Implementation will commence from April 2017. This includes participating in the NDPP Digital pilot, referring 250 patients (across Buckinghamshire and Oxfordshire) to a digital behavioural intervention in the first year. The NDPP will provide behavioural interventions for non-diabetic hyperglycaemic patients to achieve weight loss, improved diet and improved physical activity, with the aim of preventing or delaying the onset of Type 2 diabetes.

The main referral pathways for NDPP will be through NHS Health Checks and GP referral (both proactive and opportunistic). Oxfordshire will use the learning from East and West Berkshire colleagues (NDPP Wave 1) and the Thames Valley SCN to implement NDPP effectively and efficiently.

Weight Management

Local GPs and Primary Care staff regularly identify and offer advice to patients who are overweight or obese.

Oxfordshire County Council commissions a range of weight management services up to Tier 2+ for our local population. A BOB STP obesity prevention working group has been established that will review obesity prevention and weight management services across the BOB footprint (STP Appendix B action plan). This will improve and standardise the commissioning of obesity prevention/weight management services (inclusive of Tier 3) across the STP footprint and potentially enable single point of referral to weight management services across the area as currently happens in Buckinghamshire making it easier for patients to access these services and receive an equitable service..

Self-Care Technology

Initial presentations of educational and self-care technologies have been received for diabetes, COPD and asthma patients. A review of these technologies and others, involving patients, is planned in February 2017. The review will inform the decision about which technologies are best placed to facilitate more informed patients, better self-care and prevention of admissions. The outcome of the review will inform our commissioning plans in 2017/18.

Respiratory

There will be full implementation of all standard Primary Care COPD and Asthma preventative interventions in 2017. These include:

- Smoking cessation advice (Appendix B of STP)
- Inhaler technique advice and training
- Flu and Pneumococcal vaccination
- Pulmonary rehabilitation advice and referral
- Written COPD and Asthma management plans
- Prescription of ‘Just In Case’ medication
- Identification of End of Life patients who would prefer an alternative pathway of care

An audit identified that some practices were not implementing these preventative interventions in full, the main limiting factor being time. In 2015/16 just under 600 patients were admitted, non-electively, more than 800 times for COPD at a total cost of £1.5m.

A project is looking into how these preventative interventions can be standardised and fully implemented across all Oxfordshire practices to prevent and reduce the number of COPD and Asthma admissions, particularly through A&E. We will also be promoting the British Lung Foundation's Patient Passport to better inform and educate COPD patients about the care they should expect.

Staff smoking cessation and physical activity requirements are being built into the Oxfordshire providers' contracts to ensure better preventative outcomes in line with the Health Workplace programmes outlined in Appendix B of the STP.

NHS Health Checks

The OCC Public Health team is currently meeting with all of our GP practices that are commissioned to deliver NHS Health Checks as part of an annual quality assurance (QA) process. They will use this opportunity to ensure that the healthcare professional completing the risk assessment (usually a nurse or HCA) is following best practice guidelines to identify atrial fibrillation, high cholesterol, pre-diabetes, diabetes, hypertension and chronic kidney disease.

3.5.5.2 Workforce

The Oxfordshire Transformation Workforce Workstream has used the Transformation Programme's financial modelling, to model future workforce needs. This analysis suggests that, assuming no changes in productivity, but assuming that everyone who is 'released' across the system (e.g. due to reductions in activity in acute settings) is redeployed elsewhere, an additional c.80 FTE will be needed over the next 5 years. This picture is set against the backdrop of a prevailing 7% gap to establishment demonstrating the challenge we face in ensuring we have the right level of skilled workforce to deliver future needs and new ways of working.

Recruitment and Retention

Recruitment and retention is a particular problem for Oxfordshire given the high cost of living and the number of GPs reaching retirement age and seeking to retire early. We also have difficulty in recruiting to certain roles and specialities as highlighted in our transformation plans. Alongside this OCC also have difficulty in recruiting and retaining care staff to deliver packages of social care. However we are working with BOB STP partners on a joint strategy for recruiting, retaining and developing the workforce.

Where we can recruit we need to ensure that those recruited share the right values base to deliver inclusive high quality care. Values based recruitment is becoming the norm across health and social care and all providers are building it into their appraisal and organisation development as a means of retaining and developing the values at all levels of the workforce. Through our transformation plans we will be ensuring that the skills within the workforce are used to maximum effect and that all staff/practitioners are working at the top of their skill set.

We will also be working closely with Health Education England's Local Workforce Action Board (LWAB) on a workforce strategy to address the workforce implications of our transformation plans, including workforce type, numbers, skills and leadership development, both at a BOB and Oxfordshire level.

Through BOB we hope to establish a joint workforce across organisations and lead on identifying new combined health and care roles across sectors, underpinned by integrated education and training. We will also be exploring the feasibility and opportunities for sharing a flexible workforce via a joint staff bank.

Further detail can be found in supporting document 6 (Oxfordshire Transformation: Pre Consultation Business Case).

Leadership

Leadership and organisational development are key priorities both at BOB and at local level as it will be an enabler for the 'systems' thinking, collaboration and behaviour change needed for transforming our systems of care. Oxfordshire is a partner in the BOB Workforce Action Group through which we can identify and implement best practice system leadership behaviours at a local level.

Developing a Workforce fit for the Future

Working at BOB level with providers of care we need to influence curriculum development and signal the change in health and social care provision that is required so that it is incorporated within undergraduate level education. Our transformation plans are predicated on a step change from an illness, dependent model to a wellness, empowerment model and prevention and self-care needs to play a greater role in the day to day delivery of health and social care making the most of initiatives such as 'making every contact count'.

At a local level we need to ensure all health and care staff are trained and supported to make prevention as much of a priority as managing day to day care needs. Existing workforce will require programmes of work in harmony with NHSI and the Leadership academy. An approach to continuous quality improvement (QI) also needs further development so that quality improvement is the norm rather than an additional function for practitioners, this approach needs support from all levels of leadership. Tools such as national benchmarking and RightCare provide the standards to aspire to in the delivery of the highest quality care.

3.5.5.3 Estates

In order to deliver the Transformation Programme a number of changes are required to be made to the existing estate provision.

Primary Care is a clear example where GPs are trying to deliver 21st century care in very poor quality estate. The CCG submitted 21 bids at a total cost of just over £50m to NHS England for funding from the Estates and Technology Transformation Fund, a three year programme of investment. The CCG received funding of just under £2m and whilst it was not expected that we would receive the full £50m, we were disappointed that there was such a difference between bids submitted and bids funded.

Unfortunately this has led to many practices having high expectations of receiving funding who are now disappointed and there remains active pressure to fund infrastructure.

Further detail can be found in supporting document 6.

3.5.5.4 Digital Transformation – the Local Digital Road Map

The Local Digital Roadmap is focused on supporting direct patient care and has been developed in partnership with local providers. The aim is to digitally enabling people as a means of supporting their care, providing support for staff in the adoption of new technologies, utilisation of data for commissioning and working towards becoming a paper free NHS by 2020.

As a system we have driven the successful delivery of the Oxfordshire Care Summary (OCS), a shared electronic health record which currently combines real-time hospital and GP patient information on a single online platform. The OCS is used by GPs (both in and out of hours) and Oxford University Hospitals Foundation Trust (OUHFT) hospital staff (especially emergency department teams and pharmacists). We will be developing the OCS to enable patient access to their own records and to provide access to the OCS by caregivers across Oxfordshire.

Working with the Academic Health Sciences Network (AHSN) plans are being developed for an eHealth Informatics Platform that will enable digital health, store data and ultimately enable real time analytics to improve the quality of clinical decision making. We are committed to using technology to support more efficient working, encouraging and educating our workforce and citizens, thereby improving digital literacy to increase utilisation and take up of services.

We have established an Oxfordshire Informatics Delivery Group to take this work forward and develop the LDR roadmap/strategy further.

The OCS is our short/medium term tool but will need to be replaced over time. Therefore over the next two years we will:

- Continue to deliver enhancements to Oxfordshire Care Summary (OCS) including:
  - Safeguarding information
  - Alerts and flags
  - Caseload management tools
  - Diabetes views
- Defining the approach to interoperability across the BOB STP footprint and improving the utilisation of both the SCR and OCS across trusts within the health community, implementing tools to facilitate the timely access of up-to-date care plan information for SCAS and Out of Hours.
- Development of a business case for the procurement and replacement of the OCS infrastructure and tools for the digital platform i.e. Patient Portal and alignment of interoperability solutions across the BOB STP footprint.
- Continuing to work towards becoming a paper free NHS through the use of national systems, increasing utilisation levels to achieve each of the Universal Capabilities
- Introducing the 111 mobile directory of service and enabling all services to access the Directory of Services used by the 111 service to manage the demand across urgent care

- Provision of whole system analytics derived from patient records sharing/ interoperability to support the care of patients
- Upgrade the expansion and sharing of infrastructure, including continued development of solutions, to support mobile working
- Working with our providers to improve our measures on the new digital maturity index
- Supporting GP practices to offer patient facing digital services and e-consultations
- Working at a BOB level to agree a common set of data sharing agreements to support direct patient care
- Working with providers and social care to improve use of NHS numbers.

Plans for delivery of schemes which support the BOB STP are highlighted in the LDR (supporting document 13) and the programme plan (supporting document 18). Funding requirements to deliver the LDR are outlined in the LDR and along with the risks and issues will be reviewed as part of the joint STP LDR submission. The Oxfordshire Digital Programme governance structure is outlined in supporting document 19, with the latest monthly programme report included as supporting document 20.

For further detail see draft supporting documents 13 to 20.

The reprocurement of commissioning support services as part of the Lead Provider Framework (see section 3.1) will ensure the development of analytics (approaches and tools) to support the system transformation agenda across the Thames Valley footprint.

3.6 Business as Usual Programme of Work

In 2017/18 and 2018/19 alongside the STP and the Oxfordshire Transformation Programme we will be implementing a number of other service changes. Further information can be found in the OCCG Commissioning, Contracting and Procurement Intentions for 2017/18 and 2018/19 (supporting document 21).

3.6.1 RightCare

Oxfordshire has been part of the first 'Wave' of clinical commissioning groups using the RightCare benchmarking data and approach for service redesign to identify and deliver high-value opportunities, our partners across the STP footprint are now joining the programme. Working with our clinicians and partners, we are pursuing a number of opportunities at STP, CCG, service and locality/practice level as shown below:

STP/CCG - level

- Identifying the Care and Quality Gap and the means of closing it (STP)
- Identifying the Finance Gap and the means of closing it (STP)
- Understanding and evaluating the relationship between spend and outcomes (STP)
- Strategically realigning resources (STP/strategic contract negotiations)

Service-level

- Agreed programme of service redesign

Locality/Practice-level

- Identifying and understanding variation
- Performance managing and supporting practices

We will pursue these opportunities in partnership across the STP footprint. RightCare (clinical variation) is a feature of the BOB STP with a distinct workstream led by the Academic Health Science Network (AHSN) on behalf of the Buckinghamshire, Oxfordshire and Berkshire West Health Economies.

Locally the RightCare packs have been used to identify opportunities for improvement in areas of long term conditions such as osteoporosis and rheumatoid arthritis. This will largely be addressed through the new musculoskeletal (MSK) service but we will be undertaking an audit of the rheumatoid arthritis procedures of limited clinical value (PLCV) as well as ensuring cardiovascular risk assessments are being undertaken within secondary care.

We will work closely with secondary care colleagues in rheumatology to improve the areas identified in the RightCare analysis. Work is also being progressed around 'risk of fracture' rates, early identification of patients with osteoporosis and the use of bone sparing agents in primary care.

RightCare projects once that have been developed and agreed will form part of the CCG's savings plans and will be monitored to ensure delivery and release of savings. Where possible the impact of these schemes on activity and finance have been assimilated into the templates submitted alongside this plan.

3.6.2 Cardiology

We are working closely with OUH and primary care to implement an integrated community service for patients with cardiac issues that could be seen more appropriately in the community. A GP-Cardiologist (GP-C), with training from a consultant cardiologist, will triage referrals from GPs and consultants and will 'see and treat' patients with symptoms such as arrhythmia and chest pain. An audit of 60 referrals completed at the beginning of 2016 by a cardiology consultant and the GP with Special Interest showed that 50% of referrals to OUHFT General Cardiology and Arrhythmia clinics could be managed elsewhere.

This clinic will be supported by consultant cardiologists and a community cardiology diagnostic service. Discussions are on-going to finalise the model of delivery, with the first clinics due to begin in April 2017. There is scope to roll out the clinics to each of the six localities through the period 2018/20. This additional clinical capacity will improve patient access to the service, improve patient outcomes, reduce inequalities and reduce referrals to hospital. It will alleviate some of the pressure on the hospital outpatient department and reduce RTT waiting times.

Psychological support from OHFT will be offered in cardiac rehabilitation clinics and the new integrated pathway. It will ensure access to a new psychological therapies service specifically for long term conditions and prevention services such as stop smoking, weight management and exercise, through a single point of access. There is a risk around appointment of GP cardiologists to run the 10 clinics, however significant interest has already been received regarding these positions.

3.6.3 Medicines Optimisation

We will be engaging in a programme of work that will improve the transfer of information about medicines across all care settings to reduce incidents of avoidable harm to patients,

improve patient safety and contribute to a reduction in avoidable medicines related admissions and readmissions. We will also be considering further opportunities to improve cost effectiveness in the prescribing of high cost drugs and the efficient use of resources.

3.6.4 Cancer

Suspected Cancer Pathway (SCAN) Pilot

The proposed diagnostic pathway will replicate the Danish pathway for patients with non-specific symptoms and signs of cancer (NSSC-CPP) (Ingeman 2015, Vedsted 2015). It will be available for Oxfordshire registered patients who are over 40, suffering from "vague" or "non-specific" symptoms and clinical signs which could represent cancer or serious disease, but do not already have a designated pathway for urgent investigation or referral. The pathway focuses on ensuring the patient is seen by an appropriate clinician in the maximum timeframe of 14 days following initial diagnostic testing. The pilot is scheduled to go live in the last quarter of 2016/17.

We are also working on:

- An on-going review of mandatory GP to provider referral pro-formas to help to facilitate triage of patients straight to test, shortening time on the pathway. Phase 3 of this will be rolled out in December 2016.
- Reducing the time to test to 4 days and reporting to 3 days (7 days in total).
- Exploration of rapid access clinics (as an alternative to 2 week wait appointments) for underperforming specialities and where waits for routine appointments are long,
- Educational events for GPs and other primary care professionals. This is an annual programme that includes cancer sessions.
- Increasing cervical screening uptake to ensure all Oxfordshire GPs are in-line with or better than the England average. (For 25-49 year olds the England average is 71.2%. Overall Oxfordshire against the target is good but some localities are only just reaching this or are below. For 50-64 year olds the England average is 78.4%, Oxfordshire's average is 79.2% but not all localities are achieving the England average and need to improve)
- Improving services for survivorship patients (through the Macmillan HOPE programme, which will be in place by March 2017) and supporting providers to carry out electronic holistic needs assessments and treatment summaries for each tumour site sharing the information with the patient's GP.
- Improving the quality of data for on-going performance management, review and improvement of the patient satisfaction and quality of care as identified in the national cancer patient experience survey.
- Improving the uptake of other screening programmes such as bowel and breast in partnership with PHE

3.6.5 Musculoskeletal (MSK) Services

We will be implementing the recommendations of the whole service review of MSK to ensure that the most effective and efficient pathway is delivered in the most appropriate setting. The aim of the new service is to provide a fully integrated, patient centred, goal focused, locally based, de-medicalised model of care. It will offer signposting, triage, referral, assessment, treatment as well as advice for the referrer. The new service will be implemented by September 2017. It will deliver:

- A single standardised, transparent and coordinated patient pathway for MSK eliminating inefficiencies and inconsistencies. The pathway has been co-designed by patients and clinicians.
- Care provided by appropriate clinicians in the right place, first time.
- Improved quality and patient access and co-design of patient treatment plans.
- Cost-effective service delivery through a reduction in secondary care interventions.
- Shared decision making.
- Evidence based pain management.
- Group work in the community to promote wellbeing.

The patient will be given advice on self-management in the event of recurrence of their symptoms and 90% of patients with a long term MSK condition will receive a patient centred Care and Support Plan (C&SP) with the ability to access mental health services if this is required.

Implementation of the service will ensure that:

- 50% of patients migrate in the first year from GP to self-referral with no net increase in activity/ costs
- No GP referrals will go directly for urgent secondary care opinion
- Secondary care clinicians attend virtual primary/secondary care interface meetings
- Secondary Care will refer to the Musculoskeletal Assessment, Triage and Treatment (MATT) for appropriate elective non-surgical or post-operative Lower Back Pain follow-ups and consultant to consultant referrals.
- 2017/18 activity is based on current activity with additional 20% for self-referral and population growth (as suggested by published evidence and NICE)

Proposed Savings:

- 10% savings on costs of physiotherapy (currently GP Direct Access Physiotherapy) due to self-management
- Reduction in GP visits for MSK problems (20-30%)
- 10% reduction in cost of diagnostics
- 5% reduction in cost of appointments in community services
- 8% efficiency savings on costs of community services (HUB review found rate referred back with same problem NOC data 6% South East data 10%)
- 5% substitution saving at 50% tariff
- 5% reduction in elective surgical procedures

3.6.6 Diabetes

During 2017/19 we intend to develop an outcome based partnership contracting approach (primary, community and secondary care) and introduce a GP/Multi-Disciplinary Team dashboard for care processes which use accessible integrated care records to identify high risk patients. Primary Care and the Federations are agreeing the model of delivery.

Fundamental to the partnership is a defined ‘house of care’ model for diabetes patients in Oxfordshire. The new approach will be piloted in the North East Locality from April 2017 and evaluated over the year to inform the development and implementation of this approach to diabetes across Oxfordshire from through 2017/18. This will include:

- A Care and Support planning approach to diabetes across the partnership with improved access to tailored management and self-management advice to empower patients to improve diabetes control. Both Buckinghamshire and West Berkshire have implemented the Care and Support Planning and will work with us to enable successful training and implementation of Care and Support Planning in Oxfordshire. The training and implementation will commence in April 2017 in a single locality before roll out across Oxfordshire through 2017/18.
- Integration of dietetics, podiatry, psychology and nursing care to support shared responsibility for patient care.
- The set up in March 2017 of virtual advice and clinics between GPs and consultants
- Implementation of a diabetes data dashboard showing aggregated diabetes data across GP practices to highlight areas of excellence and highlight where improvement is required.
- Implementation of an integrated diabetes care record during 2018 to enable clinicians across organisations to view the latest clinical updates for Oxfordshire diabetes patients.
- Training for all primary care and community staff in the delivery of the new diabetes services and 'what good looks like'.

The implementation of Care and Support planning for diabetes patients will inform how this approach can be extended and implemented across Oxfordshire for other long term conditions from 2018 onwards.

The main risks to implementation of integrated diabetes care is that the North East locality pilot phase does not provide the expected level of positive outcomes, potential financial savings and the potential failure of partner providers to agree an appropriate partnership and governance model. However, effective partner leadership and engagement is in place across OCCG, Oxfordshire providers and the Thames Valley SCN to mitigate these risks.

3.6.7 Neurology

We propose to implement a new Community Headache Clinic service to reduce footfall in the OUH Neurology Outpatient Department for patients with primary headache symptoms. Following a triage of 130 referrals in 2016, by three neurology consultants, it was identified that up to 50% of headache referrals could be seen in the community, with a further 16% of appointments avoided by sending advice to the GP or expediting an MRI without an appointment. At full capacity, this would mean 550 patients seen in the Community Headache Clinic, with a further 180 new appointments avoided.

A consultant neurologist will triage referrals to a GP with Special Interest and will have an ongoing role in supporting the clinics. The first clinic will start in April 2017, with a further two in other localities to provide an equitable service for patients. This capacity in the community will improve patient outcomes, reduce inequalities and reduce referrals to hospital. It will alleviate some of the pressure on the hospital outpatient department, reducing RTT waiting times.

A risk to delivery is the employment of a Consultant Neurologist with dedicated time for the new headache pathway, however OUHFT are confident of making this appointment.

The services for Parkinson's disease and Epilepsy will be reviewed in the coming year in line with TVSCN RightCare policies and the Mental Health, Dementia and Neurology network.

3.6.8 Bladder and Bowel

We are currently commissioning a Bladder and Bowel Service (BABS) for patients with continence problems (urinary and faecal incontinence) who are registered with a GP in Oxfordshire. The service will assess, diagnose and treat people with continence problems and provide ongoing support to people with long term incontinence so that they can lead fulfilling and independent lives. It will also provide post-operative support to patients who have had continence surgery, including patients who require support with intermittent self-catheterisation and trial without catheter. This new service will be available by March 2017.

3.6.9 Ear Nose and Throat (ENT)

We are not currently delivering on 18 weeks for referral and capacity does not match demand for adult routine ENT appointments. This has an impact on provision for paediatrics, referral, follow-up rates show a steady increase and capacity is restricted at the John Radcliffe and Churchill Hospitals.

To address this we plan to implement a new community ENT clinic service that will reduce footfall in the OUHFT ENT outpatient department and increase community based provision. It will reduce waiting times, DNA rates and improve the provision of audiology services. Some GPs will be trained to run ENT clinics at a reduced local tariff, reducing the average cost of the service. The business case will be completed in December 2016 and if the case is successful, we aim to implement the new service from April 2017.

3.6.10 End of Life (EoL)

The vision for End of Life Care in Oxfordshire is for co-ordinated, personalised care that is simple enough for anyone (patient and professional) to navigate. It needs to be co-ordinated with all services working together to deliver seamless personalised care that meets the needs of the individual patient. We are continuing to work on delivering the End of Life Strategy across Oxfordshire to ensure the best possible quality of end of life care for patients and families, regardless of diagnosis or where they are cared for.

The EoL care work stream spans primary, community and secondary care. A well-attended, multiagency reference group is pursuing the following priority areas:

- Increasing palliative care education across Oxfordshire for all health and social care staff with dedicated group established to support this work (Oxfordshire Palliative Education Group).
- Increasing the numbers of patients on Palliative care registers held in GP practices.
- Conducting consultant led 7 day palliative care reviews of patients via Emergency Departments and the Emergency Assessment Unit within OUH, with a proactive approach to the swan scheme.
- Increasing access, awareness and use of the electronic advanced care planning (dPCPs) - an online digital solution available via the Oxfordshire Care Summary
- Increasing access to 24/7 services.
- Promotion of the ‘message in a bottle’ scheme through all operational staff within SCAS. .
- Participating in the Thames Valley Strategic Network (TVSCN) to collaborate with other CCGs and share best practice.

- Ongoing review and use of guidance from TVSCN website, EoL Commissioner Guidance, End of Life Care Intelligence website, NICE Quality Standards, National Strategy for End of Life and other relevant documents.

We intend to implement an Oxfordshire Palliative Advice Line (OPAL) in early 2017 providing the OCCG is successful in a bid for Macmillan funding for the first two years of the pilot. OPAL will provide a 24 hour helpline to co-ordinate EoL and palliative care services for people in their last year of life (including those in care homes), their carers and health professionals.

The helpline will be staffed by nurses with EoL experience providing advice or signposting to other services as needed. This advice line should reduce avoidable emergency admissions and support patients and carers to self-care. By enabling more end of life patients to be cared for in their home their quality of life will be improved and personal wishes for end of life care can be met (currently 46% of Oxfordshire people needing end of life care die in hospital, we intend to reduce this figure below 15% to more closely reflect their wishes).

The OPAL pilot will identify areas where patients continue to be admitted to hospital because of shortfalls in the current provision of community services.

It has also been identified that there are significant synergies between the OPAL service and the provision of a Telemedicine support service to care homes. This mirrors a model of care that has been demonstrated to work effectively in other areas of the country (Airedale). It is envisioned that the OPAL and Telemedicine support to care homes services will be provided by one provider and launched in conjunction with each other. The objective of the Telemedicine support service for care homes is to provide timely advice to help residents remain active and independent and as a result reduce hospital admissions, A&E attendances and GP visits.

Further details of OCCG intentions regarding End of Life Care can be found within the EoL Strategy (supporting document 9).

3.6.11 Pathology – Point of Care Testing

In 2017 we will be piloting Point of Care testing in Primary Care. Point of Care testing is currently only available in urgent care settings but we want to create access for GPs to the service as it will shorten the time to diagnosis as well as reducing pressure in pathology. By February 2017 we hope to have worked with GPs in all localities to identify pathways where tests or groups of tests would improve diagnosis, referrals and patient outcomes.

3.7 Improving Quality in 2017/18 – 2018/19

We use our clinical assurance framework (supporting document 22) 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 that action is taken to address identified issues.

In seeking to establish quality, OCCG utilises ISO 9000 quality management methodology to monitor and improve the quality of services provided to the patients of Oxfordshire. This

process is explained in figure 6 below. The Quality Committee, a subcommittee of the OCCG Board, reviews and acts on findings to improve the quality of services.

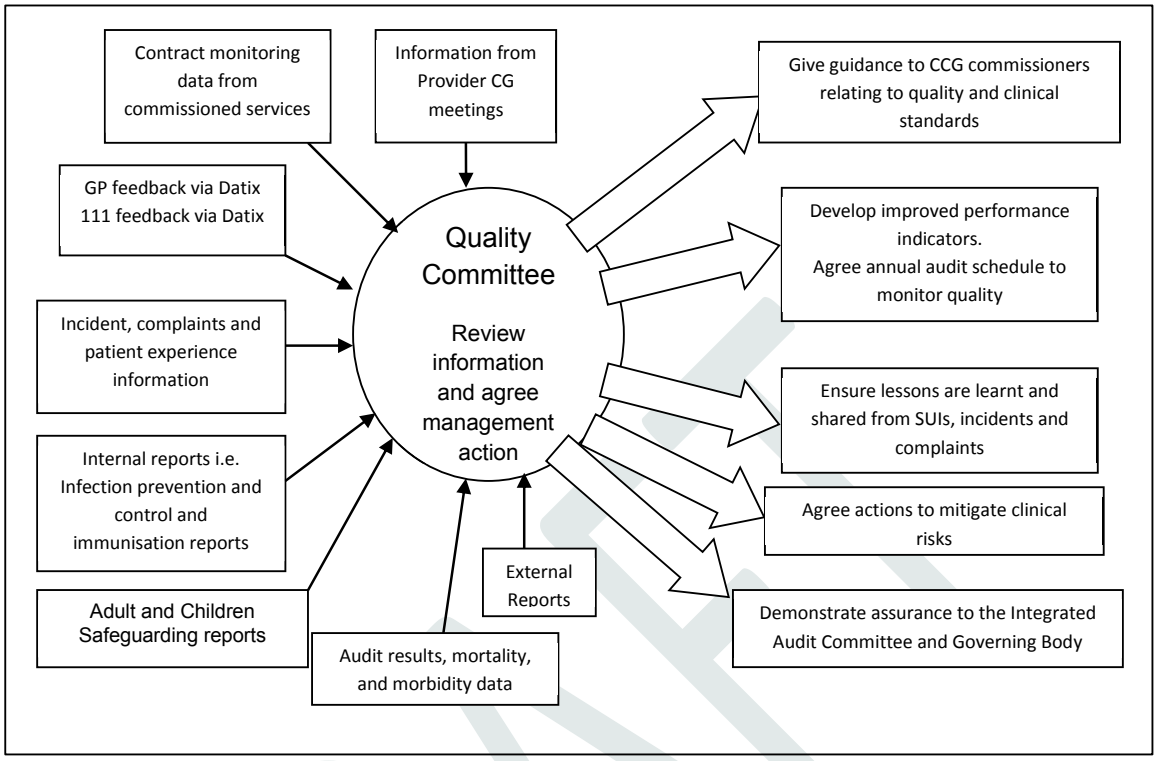


Figure 6: Quality Management Methodology

Triangulation of information is used to monitor the quality of services. All incidents, complaints, PALS comments and GP feedback is recorded in the Datix Risk Management system to allow swift analysis. The Safeguarding team is integrated within the Quality function to ensure good communication and the Medicines Optimisation team is represented by the Operations and Delivery Directorate on the Quality Committee.

3.7.1 Redesign of services

The CCG Quality and Delivery teams work closely together to ensure all potential risks relating to patient safety, clinical effectiveness and patient experience are identified and mitigated prior to the commencement of any service change. We use a Quality Impact Assessment tool and all significant clinical risks are reported to and scrutinised by the Quality Committee.

3.7.2 Improving Clinical Outcomes

Our plans for 2017/19 for improving clinical outcomes following national and local audit findings and include:

- Ensuring Providers comply with national and local Commissioning for Quality and Innovation (CQUINs)
- Ensuring OCCG meets Quality Premium targets
- Improving The Sentinel Stroke National Audit Programme (SSNAP) performance as part of the redesign of the stroke pathway, to reach A standard in all domains

- Continuing to work with the OUHFT and community partners to improve nutrition and hydration for patients
- Supporting OUHFT to improve performance on the national diabetes inpatient audit
- Ensuring significant improvements in OUHFT's treatment of hip fractures, with 80% of patients being operated on with 24 hours and 98% within 36 hours
- Driving up the quality of rehabilitation and recovery in community hospitals, and improving clinical assessment of progress in recovery across all community services
- Improving the clarity of clinical responsibility, recording and follow up of physical health issues for those with mental health problems

3.7.3 Improving safety

Our plans to improve safety following Datix feedback, serious incidents, incidents and complaints include:

- Improving electronic endorsement of test results within 7 days at the OUHFT from 80 - 98%
- Improving the number of discharge summaries going to GPs within 24 hours from the OUHFT from 80 – 98%
- Improving the number of outpatient letters going to GPs within 14 days from the OUHFT from 80 – 98%
- Improving the management of cancer MDT meetings to ensure safe follow up of patients within the OUHFT
- Continuing to work with Providers to undertake mortality reviews in Mental Health and Learning Disabilities services
- Working with Acute and Community providers to eliminate avoidable pressure ulcers
- Improving the way our mental health services support carers of people with mental health

3.7.4 Improving infection prevention and control

Our plans to improve infection prevention and control include:

- Reducing the number of Healthcare associated infection (HCAI) including MRSA bacteraemias, C.difficile and Ecoli.
- Implementing the SEPSIS CQUIN in acute provider trust
- Developing and implementing a coherent approach to assessment and treatment of SEPSIS in primary and community care
- Commencing a comprehensive surgical site infection surveillance system within the OUHFT
- Promoting influenza vaccination throughout Oxfordshire and improving upon 2016/17 uptake figures by 5% in all groups
- Promoting prudent antimicrobial prescribing and minimise resistance

3.7.5 Patient Experience

The CCG will continue to monitor and act on patient experience and respond to individual concerns from patients, clinicians and the public about incidents related to poor patient experience. Individual cases are carefully scrutinised in order to establish whether there may be a trend in a particular area. We collect a more general view of patients' experience of services through patient surveys, Friends and Family Test, feedback from CCG locality groups and mystery shopper feedback.

3.7.6 Regulatory inspection

Our plans to improve quality because of Regulatory inspection include:

- Ensuring all 72 GP practices within Oxfordshire are rated "Good" or above
- Ensuring all Acute, Community and AQP services are rated "Good" or above

3.7.7 Safeguarding

OCCG has comprehensive Safeguarding arrangements and fully complies with all statutory requirements, and has excellent relationships across the system. Annual reports are presented to the Board relating to both adult and children's safeguarding including progress regarding Child Sex Exploitation (CSE), Female Genital Mutilation (FGM), Mental Capacity Act (MCA) compliance, PREVENT, modern day slavery and Looked After Children (LAC).

3.8 Financial Plan

3.8.1 Context

In 2016/17 the CCG allocation was increased by 7.3% (£49.5m) as part of NHS England's commitment to move all CCGs to within 5% of their target allocation. This took the CCG to 4.8% below its target allocation. However, in 2017/18 and 2018/19 the CCG will only receive the minimum level of growth of 2% which has put pressure on contract negotiations and savings schemes required in order to deliver the financial targets set for the CCG.

The plan reflects the contract agreement between the CCG and its two main providers – The Oxford University NHS Foundation Trust and Oxford Health Foundation Trust signed on 21st December. The terms of this agreement are set out in section 3.2 of this Operational Plan and include a risk sharing arrangement in order to manage the financial risks across the three organisations in a co-ordinated and collaborative way.

3.8.2 The Financial Plan

The two year financial plan for 2017/18 and 2018/19 complies with the business rules and control totals expected by NHS E. The plan assumes use of £1.142m from the cumulative surplus generated by the CCG in previous years. In accordance with requirements, 0.5% contingency has been built into the plan and half of the 1% non- recurrent requirement is un-committed at plan stage.

The Mental Health Investment standard has been met in the 2017-18 plan, but not in 2018-19. This reflects the fact that the CCG has let a five year outcome based contract for Mental Health services at a fixed price for the life of the contract. The CCG has been notified of further allocations for Mental Health in future years which are not yet reflected in the plan and which will help move the CCG plan closer to the standard.

Growth and planning assumptions reflect the STP for the wider BOB footprint as far as is possible although some of the Solutions proposed in the STP are now being further developed and/or refined.

The plan assumes net savings targets of £20m for 2017/18 and £19m for 2018/19.

The summary plan is shown below:

£ 000	2016/17	2017/18	2018/19
Income and Expenditure			
Acute	398,866	416,426	424,527
Mental Health	68,874	71,132	71,872
Community	71,411	71,724	70,723
Continuing Care	63,282	65,403	69,502
Primary Care	99,823	104,620	107,116
Other Programme	26,341	21,405	21,709
Primary Care Co-Commissioning	89,011	90,982	92,799
Total Programme Costs	**817,608**	**841,692**	**858,249**
Running Costs	14,624	14,609	14,595
Contingency	-	4,304	4,459
Total Costs	**832,232**	**860,605**	**877,303**

£ 000	2016/17	2017/18	2018/19
Underspend/(Deficit) In-Year Movement	0	0	0
In-Year (RAG)	GREEN	GREEN	GREEN

Table 3: Summary Financial Plan

3.8.3 Risk

The financial risk facing the CCG and its two main providers is forecast at a worst case of £18m. The contract agreement sets out how the three organisations plan to manage this risk and to ensure that all are incentivised to collaboratively manage demand within the Oxfordshire system.

In addition, the CCG faces financial risks in relation to Continuing Care, Primary care prescribing, and in ensuring that the services provided for people with a Learning Disability match those provided for the rest of the population.

Delivery of savings targets are challenging in a system that generally benchmarks well against other areas; therefore this will be particular focus in 2017/18 led by the CCG Savings Task Force. The early agreement of contracts for the next two years should provide space for the CCG and its main providers to refine and implement the agreed schemes which aim to further improve efficiency within the system.

4. Draft Summary of Deliverables

2017/18 Draft Deliverables

Transformation (including Oxfordshire BOB STP Deliverables			
Q4 2016/17	**Q1**	**Q2**	**Q3**
January – March/April – Public Consultation on	Analysis of consultation and review of proposed service changes.	Clinical Senate and NHSE Assurance of Phase Two Pre-Consultation	Consultation on Phase Two Transformation plans

Phase One – Acute Services Scoping and development of Phase Two – Community Services including community hospitals, Children's hospital services and accident and emergency	May 2017 OCCG Board decision re Phase One- acute services changes Public and stakeholder engagement on Phase Two – Community Services including community hospitals, Children's hospital services and accident and emergency	Business Case Preparation for public consultation on Phase Two Transformation plans Implementation and monitoring of Phase One Transformation changes	
Contracting and Performance			
Q1	**Q2**	**Q3**	**Q4**
Recovery of A&E 4 hour target			
Delivery of all constitutional targets – whilst monitoring A&E performance			
Business as Usual			
Cardiology			
Q1	**Q2**	**Q3**	**Q4**
First Integrated Primary and Community Cardiology Clinics to commence – including psychological support in cardiac rehabilitation clinics			
Cancer			
Q1	**Q2**	**Q3**	**Q4**
Improved services for survivorship patents implemented including holistic needs assessment and treatment summaries for each tumour site			
Musculoskeletal Services (MSK)			
Q1	**Q2**	**Q3**	**Q4**
	New MSK service implemented		
Diabetes			
Q1	**Q2**	**Q3**	**Q4**
Pilot of new approach to Diabetes in North East Locality			
Care and Support planning rolled out by March 2018			

Virtual advice clinic between GP's and Consultants up and running			
			Implementation of Diabetes Care record
			Extend and implement Care and Support approach for other Long Term Conditions
Neurology			
Q1	**Q2**	**Q3**	**Q4**
New Community Headache clinics to start			
Bladder and Bowel			
Q1	**Q2**	**Q3**	**Q4**
New Bladder and Bowel service implemented			
ENT			
Q1	**Q2**	**Q3**	**Q4**
New Community ENT clinic service implemented (subject to sign off of business case)			
End of Life (EoL)			
Q1	**Q2**	**Q3**	**Q4**
	Oxfordshire Palliative Care Advice Line (OPAL) implemented (subject a success bid for Macmillan funding)		
Point of Care Testing			
Q1	**Q2**	**Q3**	**Q4**
		Point of Care testing in Primary Care piloted	

5. Key Lines of Enquiry (KLOE)

The OCCG response to the Key Lines of Enquiry (KLOE) for the 2017/18 – 2018/19 Operational Plan are set out in Appendix 2.