

## NHS Oxfordshire Operational Plan 2010-11

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## 1.0 Executive Summary

This Operational Plan sets out what we will do to deliver the next year of Oxfordshire PCT's 5 year Strategy. This plan sets out, in detail, the changes the PCT expects to make in 2010/11. The scale of change, savings and investment being made by the PCT over the remaining life of the Strategy (2011/12-2013) is set out in that document.

The PCT has recently refreshed its strategy for the period to 2013. The fundamentals have not changed – the issues we needed to address in July 2008 are the same as the issues we need to address now. However, the PCT strategy has been revised to reflect the massive shift in expectations around the funding of the NHS over the last year that has resulted from the global recession.

Oxfordshire needs to address the issue of inflation only funding increases in the context that:

- Most services locally are already performing at or above the national average in terms of value for money
- Most opportunities for realising major new efficiencies as identified by the SHA Shaping the Future programme have already been factored into our plans
- As we have a healthy population our per capita funding for health services is one of the lowest in England (our per capita funding is 85% of the national average)
- Demand for health services continues to grow;
  - Our population is growing older and living longer
  - We are better at identifying patients who require interventions/care
  - Patients with LTC are more able to live with and manage their illness for longer
  - We know that the gap between those living in deprived and wealthier areas is growing and that services must be more equitably accessed
  - Giving children and young families a good head start in life is crucial if we are to break the cycle of deprivation.

In past years the risk around over-performance has been largely curtailed by negotiating price reductions or caps on activity between providers and commissioners, and successfully reducing GP referrals (from a starting point of being a relatively low referring PCT). However, given the severe financial restraints on the PCT and the demand on health services, we recognise that there now needs to be a step change in how we operate and manage these pressures, while at the same time ensuring the quality of services are not compromised.

Our strategy sets out how we will meet this challenge by:

- 1) Working with partners across Oxfordshire, through the joint Creating a Healthy Oxfordshire (CAHO) Programme Board, to deliver radical change in the way:
  - The PCT and Oxfordshire County Council (OCC) commission together
  - Patients are enabled to help themselves
  - Primary care is organised and delivered
  - Community services currently offered by a range of providers are better integrated

- Secondary care maximises efficiency, and only services that need to be provided in a hospital are.

CAHO will therefore deliver the big changes in what our delivery organisations look like, who does what and where – and a little more detail on how this will happen is set out in Chapter 3 of this plan

2) Delivering our 10 commissioning initiatives which will:

- Continue to drive efficiencies out of existing services while this transformational work takes effect
- Contribute to shifts in ways of working and mindsets that support the change CAHO seeks to deliver
- Deliver the efficiencies identified by Shaping the Future – all of which the PCT had already included in its plans.

Chapter 3 and Appendix A of this plan set out in detail the changes these programmes will deliver.

3) Exploiting the potential to realise efficiencies whilst improving quality through:

- Co-ordinated workforce planning and change management across the system
- Internal efficiencies in all organisations
- Improved contract management and contract challenge
- Exploiting the potential of collaboration with other PCTs to reduce costs and improve effectiveness
- Improved clinical engagement
- Improved patient and public engagement
- Exploiting the potential of technology
- Rationalising the use of estates

A summary of our planned approaches to these quality and productivity challenges are described in Chapter 4 and within Appendix A of this plan.

In writing this Operational Plan, the PCT has therefore embedded the principle of efficiency, effectiveness and value for money and has reflected the critical need to continue delivering improved patient outcomes against a background of profound financial challenges faced by the whole of the NHS and the wider economy.

## 2.0 Introduction

This chapter sets out the PCT's vision and strategic goals for 2008-13, and explains the purpose and content of this plan in more detail.

### 2.1 Vision

Oxfordshire PCT is ambitious about improving the health and wellbeing of local people. This year, working with partners, the PCT continues the process of transforming local health services so that, by 2013, the people of Oxfordshire will:

- Be healthier – particularly if they are vulnerable or live in our most deprived communities
- Be working with the PCT to promote physical and mental well being and prevent ill health
- Be actively supported to manage their own health and care needs at home, when this is appropriate
- Have access to high quality, personalised, safe and appropriate health services
- Get excellent value for money from their local health services
- Have a PCT which is a high performing organisation

This vision statement, first adopted in 2007, remains at the heart of what the PCT aims to achieve. It acts as the driver for change and captures the essential issues that the PCT needs to focus on to address local health needs. Both the PCT strategy and this Operational Plan also deliver the national and regional vision for healthcare set out in *“High Quality Care for All”* and *“Towards a Healthier Future”*.

### 2.2 Strategic Goals

In updating and refreshing its strategy in 2008, the PCT adopted a set of 5 strategic goals. We are committed to working in partnership to:

**A) Ensure that the core services purchased from Primary and Secondary Care providers continually improve to meet changing health needs, giving patients optimum access to satisfactory, timely, high quality care that also offers good value for money.**

Oxfordshire PCT must continue to focus on getting the basics right. If we do not manage the provider market in a way that enables us to continue to provide the right core services for our population, at a sufficiently high standard, within a controlled budget, we will not have the capacity to invest in and deliver other aspects of our strategy.

**B) Improve health outcomes and promote independence for the following key population groups:**

- **older people**
- **those with long term conditions**
- **people with mental health problems**

- **children and families living in areas of deprivation**

The PCT has identified these patient groups as priorities because of the projected increases in the elderly population, the numbers of people with long term conditions such as diabetes and mental health problems, and because of the persistent inequalities that impact on the health and well-being of children and families in Oxfordshire's most deprived areas. These priorities support the recommendations of the Director of Public Health's Annual Reports in 2007 and 2008 and of the county's Joint Strategic Needs Assessment (JSNA) 2008 and 2009.

**C) Improve access to health services by increasing the commissioning of integrated whole care pathways that create a proportionate and appropriate shift of activity from hospital into primary and community care settings.**

The PCT believes that a fundamental shift in the quality of care for its target groups can be achieved if it can begin to deliver the national and regional ambition of providing seamless, joined up care for patients, with as many elements of a care pathway as possible being provided close to where patients live.

**D) Help more local people of all ages to make sustainable healthy lifestyle choices.**

Our local demographic forecasting and disease modelling suggests that, in line with regional and national strategy, the local NHS must increase its efforts to reduce demand for health services by working to support people to stay well. In Oxfordshire we particularly need to focus on tackling obesity in adults and children, reducing smoking and managing alcohol misuse.

**E) Reduce health inequalities in Oxfordshire by improving health outcomes for people living in wards with the highest mortality rates at a greater rate than for the PCT population as a whole.**

Oxfordshire has a comparatively healthy population, but there are distinct geographical communities in Oxford and Banbury where life expectancy and health outcomes are markedly worse than both the local and national averages. The PCT therefore needs to focus investment and energy into these communities in partnership with other public sector bodies and with industries, in order to break the long term cycles of deprivation experienced by these populations.

## **2.3 The Purpose of the Operational Plan**

The Operational Plan sets out what the PCT will do to deliver its Strategic Plan in 2010-11 and how it will meet the requirements of PCTs set out in the NHS Operating Framework 2010-11.

This is an internal working document which will describe what we plan to do and how we plan to do it in 2010-11 and is in a format that is designed to be useful to operational managers, the PCT Board, the PCT Clinical Executive and the PCT's major partners.

The plan focuses on our strategic and operational priorities, as captured in the CAHO programme, our 10 strategic initiatives, and some of the key enabling work streams

that will underpin delivery. It does not - and cannot - cover every aspect of the “day job” of running the entire local health service. We will monitor our progress by ensuring delivery of CAHO and our initiatives and the extent to which they are having a positive impact on: the targets set for our 9 strategic outcome measures; the NHS Vital Signs; our own local delivery targets and adherence to the financial plans set out in our long term financial model (LTFM).

Our financial plans demonstrate the level of financial risk the PCT would incur if interventions are not successful. The financial risk management plan does not only represent traditional savings targets but clearly demonstrates the level of ambition in terms of service change, redesign and opportunities to make efficiency savings that the Trust aspires to in implementing its strategy. Financial planning takes into account the known totality of financial risk facing the organisation and demonstrates how managing this risk is embedded in the day to day management of the organisation.

Over the life of its strategy ( to 2013/14) Oxfordshire expects to have to find efficiency savings in the realm of £30m a year across the local healthcare system in addition to provider efficiency programmes as set out in core contracts . To achieve this, sustainable and wholesale change is required across the entire health economy to ensure that our population continues to receive quality services which are appropriate and effective, and which help them to remain as healthy as possible for as long as possible, The scale and pace of change and savings/efficiencies needed cannot be achieved by the PCT alone – either through its own work programme or by working separately to its other partners - and this is reflected in the emphasis we are placing on the Creating a Healthy Oxfordshire Programme, on improving provider efficiency, on exploiting the potential of collaboration with other PCTs and on initiatives that will reduce long term healthcare costs.

## **2.4 Operational Plan Content**

This plan therefore:

- Describes how, through CAHO and collaborative working, transformational change, savings and efficiencies will be implemented across the entire health economy in Oxfordshire. Critical to this will be ensuring strong clinical leadership and involvement throughout to enable and drive the scale of change needed.
- Sets out the strategic initiatives – or major work programmes - which will deliver strategic goals and outcomes in 2010/11
- Explains how we will make substantive improvements to the quality of services patients receive and the satisfaction of the public with the local NHS. Appendix A of this plan will describe the contribution each initiative will make to the Quality and Productivity agenda.
- Clearly demonstrates how, through delivery of its strategy, Oxfordshire PCT will deliver nationally and regionally agreed NHS priorities for its local population.
- Provides a robust foundation for the management and measurement of PCT performance over the next twelve months against an agreed range of indicators

- Contains a summary of the PCT's planned expenditure and the approach we will take to financial planning and financial risk management, including demand management and cost improvement plans.
- Describes the developments and benefits we can anticipate through collaborative working
- Describes the ways in which the PCT will develop contracting and provider management and summarises the impact on acute activity of modelling our commissioning intentions
- Sets our approach to manage delivery, including recovery work plans, governance framework through which the PCT will monitor and manage delivery and risk, and our Emergency preparedness
- Sets out the development plans for informatics and workforce that will be required to underpin delivery.

Further supporting information is contained in **Appendices A - I** as follows

**A.** The PCT **work programme** sets out the detailed implementation plan, financial plan, benefits and contribution to Breaking the Cycle of Deprivation (BTCDD), risk log, informatics and workforce requirements and high level delivery schedule milestones for each initiative.

**B.** Details of the work programmes that have undergone/will undergo **equality impact assessments (EIAs)**

**C.** A summary outlining how the Initiatives of the Operational Plan support the delivery of **National commitments, vital signs** , and **Local Delivery Targets** that the PCT will use to help track delivery of initiatives and setting out targets and trajectories for each measure

**D. Finance** sets out the Medium Term Financial Plan (MTFP)

**E. Project documentation** for demand management and cost improvement plans

**F. Recovery templates** for 18 weeks, A&E and Cancer waiting times

**G. Informatics planning** sets out the three year plan for fulfilling informatics aims and objectives

**H. Workforce risk assessment** provides more detail on risks

**I. Glossary** for the Strategic and Operational Plans

## **3.0 Delivery**

### **3.1 Creating a Healthy Oxfordshire (CAHO)**

Oxfordshire will need to deliver substantial reductions in the cost of health and social care alongside a step change in the quality and effectiveness of services. This cannot be delivered just through the kind of service redesign initiatives that formed the core of our operational plan and strategy in 2009.

The PCT therefore began work in July 2009 to develop the Creating a Healthy Oxfordshire programme (CAHO). The purpose of this programme is to:

- Create a shared understanding of the challenges facing the NHS in Oxfordshire
- To understand what needs to change in the system to drive the radical transformation required and to make that change happen
- Develop and implement the programme of work required to meet both the fiscal and health issues in the area and enable the successful delivery of our strategy

The unique quality of the CAHO programme is the system wide commitment to it. Primary, secondary, community and social care partners are driving change and the programme has strong clinical engagement and leadership. Significantly it also complements the Transforming Adult Social Care programme which the local authority is pursuing in parallel to TCS (see section 4.8.4 of the Strategy)

CAHO will lead to reduced levels of activity within the acute (hospital) sector, community services becoming more closely integrated with each other and the radical development of the role of primary care in managing and treating patients at home.

CAHO is the major vehicle through which the local health economy will meet the economic challenges that lie ahead whilst continuing to improve the quality of local services.

The overall scope and outputs of the CAHO work streams are summarised below:

#### **3.1.1 Integrated Community Services Provision**

There is local and national evidence that multi-disciplinary and multi-agency working achieves better outcomes for patients and more efficient use of resources by health and social care organisations. This supports the view that the establishment of integrated locality teams in Oxfordshire involving primary care, district nurses, health visitors, (social service) care managers, therapists, case managers, domiciliary care, voluntary agencies, secondary care practitioners and family carers would create more opportunities for collaborative action to prevent or reduce admissions of patients to hospital, in particular those with long term conditions. This is being addressed in part via the Transforming Community Services initiative, but will also require some infrastructure developments, including enabling informatics. It will reduce overhead costs by clustering staff together in a smaller number of bases.

### **3.1.2 Shaping Future Primary Care**

Primary care can make a substantial contribution to delivering a higher quality health system, while reducing costs. This requires a revolution in working patterns and in skill utilisation across the primary health care team, enabling informatics infrastructure as well as involving other healthcare workers who have not traditionally offered community based services.

Many elderly patients could be managed at home if acceptable risk stratification and clinical monitoring could be achieved, which is often the goal of an acute medical admission in this age group. This will make a major impact on hospital costs while achieving similar or improved outcomes (as has been proven for decompensated heart failure).

This work stream will design and implement a new approach to delivery of primary care and will be the main catalyst to drive the radical redevelopment and change needed in the role of primary care and in the quality and effectiveness of services. The Cross Cutting Primary Care initiative sets out plans to develop a Primary and Community Services Strategy, which will be supported by and delivered through the CAHO programme,.

### **3.1.3 Acute Services**

Overall, CAHO is working towards a reduction in capacity in hospital services. The primary care and community services workstreams will, with this acute programme, be important in ensuring this reduction is achieved. Senior leaders from secondary care services are working together to ensure that areas such as maximising internal efficiencies through sharing good practice, avoiding duplication within Oxfordshire, working with other acute services to drive efficiencies and shifting services out of the acute sector are taken forward.

### **3.1.4 Integrated Commissioning**

Integration will mean the complete joining together of services that are commissioned across providers so that values and principles, objectives and priorities, resources, benefits and risks are fully shared between partners. Service users will experience services that are responsive to their needs and requirements in a fully seamless way and which ensures optimal use of resources.

### **3.1.5 Disinvestment**

The drive for more integrated, locally based services also requires an explicit focus on the potential for cost savings, as well as driving improvements in quality of care, as services are rationalised. Systematic policy approaches to disinvestment will improve equity, efficiency, quality and safety of care, as well as sustainability of resource allocation. Systematic policy approaches to disinvestment should improve equity, efficiency, quality and safety of care, as well as sustainability of resource allocation.

The intention of the work stream is to develop a systematic process for identifying opportunities for disinvestment; reviewing current practice to quantify the benefit and

proposing change to the PCT and its partners. This will include developing a process for decommissioning.

It is not proposed that the work stream will actively “do” the disinvestment, this will be delivered by the most relevant leads for that service, however it will provide the catalyst for change; inform the “how” part of the disinvestment; support stakeholder communication and provide high level review of impact.

### **3.1.6 Patient Responsibility and Engagement**

The goal of this programme will be to give a major boost to the confidence and control people take of their health and wellbeing, reaching many more, including the most disadvantaged, with a bigger impact on their lives. As a result, people will need fewer expensive interventions, remain independent and active for longer with a better quality of life, have better clinical outcomes and make more appropriate use of resources

These work streams underpin and support all of our other initiatives and in particular they build on and take forward the work the PCT did through Transforming Community Services. In early 2010 we will be working up detailed implementation plans to take this programme forward. Programme development will be reported to all Boards and wider community engagement will occur as the work develops.

## **3.2 Commissioning Initiatives - overview**

CAHO will deliver wholesale system change, but this needs to be underpinned by ongoing work to redesign and develop services. In last years Strategy, the PCT's programme of work was grouped into three overall work programmes. These were:

- Transforming health services
- Improving health
- Improving quality for care groups

Each programme was made up of a series of initiatives; 12 in total. This year, activity is being aligned to the 8 Darzi Care Pathways, an additional pathway for Ageing Successfully and a Cross Cutting programme, giving the PCT a suite of 10 initiatives.

The move to align commissioning initiatives to Darzi pathways will help ensure that the change programmes we are delivering next year continue to result in: improved services for local people; effective local contributions to the national and regional Next Stage Review ambitions and the creation of firm foundations for the implementation of CAHO.

Breaking The Cycle of Deprivation (BTCD) remains a key priority for the PCT and its partners. The Oxfordshire Health and Wellbeing Partnership is leading a programme of work involving the County Council, City Council, Cherwell District Council, the PCT and the Police to tackle deprivation in Oxford and Banbury. This programme will focus on partnership work in targeted wards of Oxford and Banbury to:

- Give children a good start in life and support vulnerable families
- Improve the physical environment

- Maximise the involvement of local people
- Ensure local people are able to access health improvement services which improve life chances

From 2010 onwards all initiatives will be required to contribute towards tackling deprivation so there is no longer a discrete Breaking the Cycle of Deprivation initiative. Each initiative summary in Appendix A has a section on BTCD which demonstrates how they will do this.

The PCT continues to have four priority care groups. These are children, older people, people with long term conditions and those with mental health problems – each of which has its own initiative, and each of which will benefit from targeted work within other programmes such as Staying Healthy.

The next section summarises each of the 10 initiatives and Appendix A contains more detailed information about each initiative, including

- The projects through which the initiatives will be delivered
- The contribution each initiative will make to delivery of our strategic goals, outcome measures and national vital signs
- How the initiative will improve quality, productivity and benefits to patients
- The informatics and workforce requirements identified
- The risks associated with delivering each initiative
- Savings the PCT will be making from each initiative
- The delivery milestones for each project for the relevant year

There are a further two appendices as follows:

- Appendix B - Details on the work programmes that have undergone/will undergo equality impact assessments (EIAs)
- Appendix C - A summary outlining how the Initiatives of the Operational Plan support the delivery of National commitments, vital signs, and Local Delivery Targets that the PCT will use to help track delivery of initiatives and setting out targets and trajectories for each measure.

### **3.3 Initiative summaries**

#### **1. Maternity and Newborn**

This initiative will deliver maternity and newborn care in line with Maternity Matters. It will provide safe, high quality, efficient services within current resources. It will be an effective driver in the strategic shift from obstetric-led to midwifery-led delivery, where safe and appropriate, and will both improve patient experience and reduce costs in the next two years.

#### **2. Children and Young People**

This initiative will ensure that commissioners' work with clinicians and partners to develop services that are evidence based and deliver high quality care to improve outcomes for children and young people. As a result care will be integrated at the point of delivery and delivered in the most appropriate setting to meet the needs of children, young people and their families. Service improvement will be targeted at

those children and young people most at risk of becoming long term, substantial users of NHS services as they enter adult life. This initiative will reduce inpatient stays for children and improve the long term health of young people who currently face health inequalities. It will give families a better quality service and reduce costs to the system in the long term through enabling this group of potentially chronically unhealthy adults to mature more healthily.

### **3. Staying Healthy**

This initiative will help us undertake targeted interventions for those living in areas of deprivation, the elderly, those at risk of developing long term conditions and those with mental health issues. These projects will work to reduce the burden of ill health within these specific populations ensuring that people are healthy for as long as is possible, thus reducing the need for interventions. In addition, we will ensure current screening programmes are effective and introduce new screening programmes which are designed to ensure health issues are identified and treated early. Over time, Staying Healthy will improve outcomes for those otherwise at risk of developing chronic, complex, long term health problems, and will therefore reduce the demand for expensive NHS services. We will not deliver the long term reduction in hospital costs without continuing to invest this way in health promotion and protection.

### **4. Long Term Conditions**

This initiative will improve care for that group of people who do develop a range of chronic long term conditions. It will support efficient delivery of care close to home and will reduce unnecessary, stressful and expensive hospital treatment, reducing the cost of secondary care to the local health economy between now and 2013.

### **5. Acute Care**

Through this initiative we will ensure people access the right care in the right setting in the event of an emergency or the need for urgent medical attention. It will result in provision of more care outside hospital and in close to home settings, so reducing unnecessary admissions to Secondary Care and ensuring patients get the right urgent treatment in the right place quickly and efficiently, reducing the overall cost of providing unplanned care across the system in the next three years.

### **6. Planned Care**

This initiative will ensure we manage demand for elective Secondary Care services and that these services are provided as efficiently and effectively as possible. We will work closely with providers to target service improvement in those clinical areas where we can get the maximum improvement in outcomes, quality and cost through service redesign, capping the growth in expenditure as tightly as possible within the life of this plan. These will include:

- Dermatology outpatients
- Ophthalmology outpatients
- Gastroenterology inpatients and outpatients
- Respiratory Medicine inpatients and outpatients
- Trauma and Orthopaedics inpatients and outpatients

Through this initiative we will also improve services for those with conditions such as cancer, cardiac illness or learning disabilities, and will maximise the value of the high cost services for those with rare conditions that we commission through the South Central Specialised Commissioning Group (SCG).

## **7. Mental Health**

Through this initiative we will shift the focus of mental health services to include health promotion work designed to improve the whole populations' well being. It will also enable us to increase access to psychological services and will improve care pathways for users of forensic services, people in crisis and those who will be receiving their mental healthcare in Primary Care settings. Long term this will ensure fewer people develop severe or moderate long term mental health conditions, and will allow those that do to receive the optimum amount of care without the need for a hospital stay, whilst also reducing the overall cost of mental health services to the County within the life of this plan.

## **8. Ageing Successfully**

This initiative will lay the foundations for ensuring we have sustainable, high quality and accessible physical and mental healthcare in place for the growing population of older people in Oxfordshire and that much of this care is provided outside acute hospital settings and in very close partnership with Oxfordshire County Council. It will create the foundations for the increasingly close joint commissioning and delivery mechanisms envisaged by the CAHO programme.

## **9. End of Life**

This initiative will increase the choices available to people in Oxfordshire about the care they receive in the final stages of illness. It should enable more people to die at home, should they wish to, so improving the quality and appropriateness of care and reducing the cost of secondary care services.

## **10. Cross Cutting initiative**

This programme will enhance access to Primary Care and support service improvement in all community settings. It will lead to a reduction in primary care costs within the next three years through a range of measures designed to ensure best value for money is achieved from primary care contracts.

There are a particular set of circumstances in the Banbury area which require the PCT to take a coordinated strategic approach to the development of services in this area. This initiative will determine the future pattern of sustainable hospital based service provision for this population, in line with the recommendations of the Independent Reconfiguration Panel (IRP).

## **4.0 Quality and Productivity**

Oxfordshire currently expects to have to realise savings of up to £203m over the next four years as its share of the national savings targets set for the NHS as a result of the global economic downturn. This needs to be delivered whilst also driving up the quality of patient care.

There is now emerging clarity about how the national Quality, Innovation, Productivity and Performance (QIPP) programmes are structured. At a high level the overall work streams are

- Pathways - LTC, Urgent and EOL, Safe and Right Care
- Provider Efficiency - Back Office, Procurement, Clinical Support Rationalisation, Staff productivity, Medicines use and procurement
- System enablers – Primary Care contracting and commissioning and Technology and digital vision

The QIPP Programme in South Central, Shaping the Future, primarily focuses on the productivity opportunities and sets out the scenarios to drive out the cash releasing savings from the system over the next 3 to 4 years. The Clinical Improvement Programmes based on the Darzi workstreams have been engaged in these discussions and are now moving into a position of shaping how they will make it happen/ influence this agenda across NHS South Central.

### **4.1 NHS South Central Shaping the Future**

The Shaping the Future programme has identified opportunity savings across 4 domains:

- Clinical pathway programmes
- Reduced provider tariffs and budgets
- Provider improvement actions and financial savings
- Enablers to support change

#### **4.1.2 Clinical pathway programmes**

The specific areas identified in the report across the clinical pathways have been reviewed against our strategic initiatives; overall our level of ambition and areas of focus are very much aligned to the report.

<b>Gross Productivity Targets</b>	<b><i>At 12th March PCT</i></b>	<b><i>Shaping the Future</i></b>	<b><i>Difference</i></b>
<b>2010/11 - 2013/14</b>	<b>Gross savings</b>	<b>Gross Savings</b>	
<b>Investment in Commissioning Initiatives</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Planned Care	-44,524	-26,229	-18,295
Acute	-15,250	-21,702	6,452
End of Life	-6,300	-3,273	-3,027
Children & Young People	-813	-1,417	604
Staying Healthy	0	-4,241	4,241
Ageing Successfully	-8,704	-7,000	-1,704
Long Term Conditions	-10,266	-15,097	4,831
Mental Health	-1,449	-10,723	9,274
Maternity & Newborn	-400	-1,167	767
Cross Cutting : Primary Care/Prescribing	-30,036	-7,795	-22,241
<b>Sub-total Investment in Commissioning Initiatives</b>	<b>-117,742</b>	<b>-98,644</b>	<b>-19,098</b>

#### 4.1.3 Reduced provider tariffs and budgets

The assumptions around tariff efficiencies have been shared with the PCT's contracting team and are part of contract negotiations with our core providers.

#### 4.1.4 Provider improvement actions and financial savings and enablers to support change

We would expect that much of this would fall under the scope of the CAHO work streams; for example:

- Reducing non-staff costs and overheads through procurement, back office and administrative savings and outsourcing
- Rationalising estates to significantly reduce costs
- Reconfiguring services, capacity and sites to reflect agreed pathways and to deliver clinically sustainable, high quality care at affordable cost
- Developing proactive, integrated primary and community care
- Mobilising patients to take greater ownership of their health and become active in self care

## 5.0 Financial Plan

This chapter outlines our financial plans, which demonstrate the level of financial risk the PCT would incur if interventions are not successful. The Demand Management and Cost Improvement plans do not only represent traditional savings targets but clearly demonstrates the level of ambition in terms of service change, redesign and opportunities to make efficiency savings that the Trust aspires to in implementing its strategy. Financial planning takes into account the known totality of financial risk facing the organisation and demonstrates how managing this risk is embedded in the day to day management of the organisation.

### 5.1 Financial Plan

The PCT's financial plan for 2010/11 – 2011/12 is based on the operating framework principles, actual PCT allocations announced in December 2008 (for two years) and further guidance from the Strategic Health Authority. The plan builds on the work contained in the strategy to develop longer term financial assumptions around the PCTs commissioning priorities.

Summary financial plans for 2010/11 – 2011/12 are included in **Appendix B** and show planned changes to investment from the 2009-10 baseline in 2010-11. The overall impact in terms of total PCT spend is shown in section 5.4.

In order to deliver a £2m surplus each year over the medium term, the PCT has identified that it will need to deliver additional savings of over £30m each year. The areas that the PCT will focus on to achieve these savings include:

1. Ensuring that the 10 strategic initiatives deliver cost savings across the system as outlined below:
  - Across Planned Care through:
    - Embedding its referral management system
    - Redesigning pathways for outlying specialities across in patients and out patients
    - Threshold management particularly focused on in patients
    - Efficiencies across community services
    - Agreement of further savings programme for Specialist Services
  - Within Acute, the PCT will achieve efficiencies through:
    - Integrating the Front Door for emergencies with different options for treatment
    - Reviewing unscheduled care
    - Expansion of Care Outside of Hospital
  - End of Life will deliver savings from its rapid response service for urgent end of life care
  - Children and Young People will reduce costs from redesigning paediatrics and cost effective placements in children's continuing healthcare

- Maternity and Newborn will focus on modernising of maternity services to produce further savings
  - For the area of Ageing Successfully, the PCT will achieve savings through:
    - Further reviews of use of Continuing Healthcare for Older People, looking at the full year effect of invest to save projects launched in 2009/10, ensuring NHS investment only funds healthcare elements of care packages going forwards and restricting future investment in high cost home based care
    - Review use of complex medication in care homes
    - Implementing improvements in the stroke care pathway
    - Revisiting the service model for continence
  - Long Term Conditions will introduce a range of financial improvements across areas such as: expansion of use of case management and promoting self care, community respiratory service and learning disability services
  - Mental Health will ensure it maximises its recovery interventions and outcomes and makes further gains from the keeping people well project, as well as working with the OBMHFT Trust to reduce core costs.
  - The PCT has classified a range of other projects which will achieve financial benefits under the 'cross cutting' pathway; this includes:
    - Primary Care- list cleaning, review of PMS contracts, review of all discretionary enhanced services, minimal uplift on prescribing and review of primary care infrastructure and estate
    - Internal savings delivered from review of capacity and capability of PCT workforce and reducing spend on Interims and Consultants
    - In year challenge on Commissioning Initiatives with a view to reducing levels of investment from slippage against planned timescales & phasing
2. Maximising the potential of CAHO to deliver transformational and financially sustainable change to the local health economy
  3. Maximising the potential of collaboration with other PCTs in the region to deliver internal cost savings, drive out unwarranted variation and improve commissioning capability
  4. Contract negotiation and contract challenge

## 5.2 PCT Allocation

In 2009-10 the PCT had a recurrent resource limit of £831m and received growth of 5.2% (£41m). The PCT allocation formula for 2010-11 has now been published and the PCT has received confirmation that it will receive growth at a consistent level with last year of £43m.

After 2010/11, the PCT is expecting levels of growth to drop substantially and has based its operating plan on 2.5%, which equates to circa £22m.

### 5.3 Financial Assumptions

The key financial planning assumptions that the PCT has based its financial plan for the next two financial years are shown in the table below. As described above, these assume that the PCT will receive a similar level of funding in 2010/11 to previous years (5.1%) and that this will reduce to 2.5% in the following year. There is an expectation that the PCT will continue to generate a consistent surplus of £2m and that it will set aside a contingency to cover any in year risks; for 2010/11 this will equate to £6.5m for 2011/12 this will be £2.1m. There will be no tariff inflation in 2010/11 and CQUIN will be payable at 1.5%. In 2011/12 a negative uplift will be applied to tariff prices of 2% and CQUIN will be set at 0.5%.

### Planning Assumptions

Key Planning Assumptions	2010/11 %	2011/12 %
Growth	5.1%	2.5%
SHA Lodgement	1.0%	0.0%
General Inflation	(2.5)%	(2.5)%
Primary Care Inflation	2.0%	1.0%
Wage Inflation	2.5%	1.0%
PBR Tariff Inflation (Gross)	3.5%	2.5%
General Efficiency	(3.5)%	(4.5)%
PBR Tariff Inflation (Net of general efficiency)	0.0%	(2.0)%
CQUIN	1.5%	0.5%
PBR Tariff Inflation (inclusive of CQUIN)	1.5%	(1.5)%
Prescribing - Growth	8.0%	8.0%
Prescribing - National Efficiency	(3.0)%	(3.0)%
Contingency	0.8%	0.3%
Planned Surplus	0.3%	0.3%

### 5.4 Overall Summary of Financial Plan

The impact of the proposed financial plan for 2010/11 on the longer term financial model is shown in the table below. It demonstrates a high level of consistency with the original assumptions contained in the PCT's strategy and demonstrates a clear shift from secondary care to the prevention and partnerships agenda.

The reduction in the level of growth from 2011 onwards and the level of inherent financial risk in the local health economy from increased demand in secondary care activity means that the PCT will have a significant financial challenge in the years

ahead. Earlier this year, the Chief Executive announced that Oxfordshire system would need to achieve savings of circa £240m over the medium financial term in order to ensure sustainable financial balance.

Oxfordshire has embarked upon an ambitious programme of change entitled: Creating A Healthy Oxfordshire (CAHO). This has engagement from all major trusts and social services colleagues and has a far reaching set of work streams which are tasked with delivering these savings over the next three financial years.

The organisation does recognise that CAHO will not be able to deliver savings immediately; its focus therefore over the next twelve months; whilst growth in the system is still reasonable, will be to ensure investments are targeted at projects which will produce long term, sustainable changes to the system particularly focused on:

- reducing pressure and hence demand on secondary care sector
- alternatives to admission including use of community services, self care and case management and prevention.

The PCT also expects local service providers to demonstrate that they are delivering non PBR services at affordable prices by increasing their internal efficiencies.

Furthermore, the magnitude of efficiencies expected from the Commissioning Initiatives, to be delivered through the PCT's Financial Risk Improvement Plan, should enable the organisation to generate funds to meet anticipated costs from demand rising in excess of 2% and pump priming strategic change from CAHO programme. These reinvestments have been reflected against individual Commissioning Initiatives. The PCT has therefore set itself far reaching internal targets over the next four years to tackle the shortfall in funding and rise in demand.

NHS Oxfordshire Operational Plan 2010-11

Oxfordshire PCT Financial Strategy	2010/11		2011/12		2012/13		2013/14	
	£000s	% of RRL	£000s	% of RRL	£000s	% of RRL	£000s	% of RRL
<b><i>Changes In Funding</i></b>								
Growth	42,727	5.1%	21,842	2.5%	22,388	2.5%	22,948	2.5%
Surplus carried forward from previous year	0	0.0%	2,184	(0.2)%	2,184	(0.2)%	2,184	0.3%
<b><i>Adjusted for</i></b>								
Inflation Funding	(6,701)	(0.8)%	7,689	0.9 %	8,140	0.9 %	8,589	0.9 %
Commissioning Quality & Innovation (CQUIN)	(6,171)	(0.7)%	(3,277)	(0.4)%	0	0.0%	0	0.0%
Re-establish recurrent contingency	(6,553)	(0.8)%	(2,184)	(0.2)%	(2,184)	(0.2)%	(2,184)	(0.2)%
Provision for Central Budget Shortfall	(6,817)	(0.8)%	(7,000)	(0.8)%	(9,000)	(1.0)%	(11,000)	(1.2)%
RAB Funding	(2,077)	(0.2)%	0	0.0%	0	0.0%	0	0.0%
SHA Lodgement	(7,750)	(0.9)%	0	0.0%	0	0.0%	0	0.0%
<b>Uplift plus Adjustments</b>	<b>6,659</b>	<b>0.8%</b>	<b>19,254</b>	<b>2.2%</b>	<b>21,528</b>	<b>2.3%</b>	<b>20,537</b>	<b>2.2%</b>
<b><i>Impact on Pathways of Care</i></b>								
Planned Care	(15,148)	(1.7)%	(15,071)	(1.7)%	(15,273)	(1.7)%	(15,440)	(1.6)%
Acute	4,980	0.6%	2,250	0.3%	2,000	0.2%	2,000	0.2%
End of Life	972	0.1%	955	0.1%	955	0.1%	955	0.1%
Children & Young People	(570)	(0.1)%	(60)	(0.0)%	(400)	(0.0)%	(400)	(0.0)%
Staying Healthy	(1,652)	(0.2)%	(994)	(0.1)%	(1,650)	(0.2)%	(1,750)	(0.2)%
Ageing Successfully	2,020	0.2%	(750)	(0.1)%	500	0.1%	500	0.1%
Long Term Conditions	695	0.1%	(1,896)	(0.2)%	(1,585)	(0.2)%	(1,823)	(0.2)%
Mental Health	597	0.1%	(678)	(0.1)%	(3,378)	(0.4)%	(2,530)	(0.3)%
Maternity & Newborn	350	0.0%	0	0.0%	0	0.0%	0	0.0%
Cross Cutting	3,281	0.4%	(827)	(0.1)%	(513)	(0.1)%	135	0.0%
<b>Net Saving/(Investment)</b>	<b>(4,475)</b>	<b>(0.5)%</b>	<b>(17,071)</b>	<b>(1.9)%</b>	<b>(19,344)</b>	<b>(2.1)%</b>	<b>(18,353)</b>	<b>(2.0)%</b>
<b>PLANNED SURPLUS</b>	<b>2,184</b>	<b>0.2%</b>	<b>2,184</b>	<b>0.2%</b>	<b>2,184</b>	<b>0.2%</b>	<b>2,184</b>	<b>0.2%</b>
<b>RRL</b>	<b>873,675</b>		<b>895,517</b>		<b>917,905</b>		<b>940,853</b>	

**Key Points to Note from the Table Above:**

The table above summarises the financial plan for 2010-11 and **Appendix D** shows the plan in more detail.

Main points to note:

- **Resources for 2010-11 £42.7m:** includes growth at 5.1%
- **Inflation Funding:** this describes the impact of assumptions on inflation and efficiencies across PBR and non PBR prices, Primary Care Inflation, Wage Inflation and Prescribing (see Planning Assumptions Table above)
- **Commissioning Quality & Innovation (CQUIN):** this is the net impact of CQUIN funding at 1% (gross including 2009/10 1.5%) across providers

- **Re-establishment of Recurrent Contingency:** as defined by the SHA. This represents 0.75% of the PCT's resource limit (£6.5m)
- **Provision for Central Budget Shortfall:** this take account of a range of services which nationally are shifting under PCT control and for which funding has to be covered within existing baselines
- **RAB Funding:** reserve to cover non refundable allocation of £2m from PCT to ORH in 2009/10
- **SHA Lodgement:** just under 1% of the PCT's resource limit has been set aside for South Central wide initiatives such as Commissioning Enablement Service
- **Impact on Pathways of Care:** as defined across the PCT's Commissioning Initiatives, this section describes the net financial impact of the projects which the PCT will focus on to ensure its strategic priorities are achieved
- **Surplus £2.1m:** this equates to 0.25% of the PCT's resource limit in line with SHA guidance

## 5.5 Demand Management and Cost Improvement Plans

The PCT has established an excellent track record in managing financial risk and delivering financial targets. In 2009/10 the Trust experienced higher than expected activity growth (over 6% with its largest provider) and has had to ensure that the level of risk in future years is clearly understood.

The principles of managing financial risk are embedded throughout the Operational Plan and established as standard practice. There is a clear recognition of financial risk across the PCT, and this has ensured that initiatives are focused on improving quality and improving outcomes for patients whilst also delivering value for money.

The Demand Management and Cost Improvement Programme represents a vital aspect of the overall delivery of the PCT's Operational Plan; both in terms of driving system wide change to improve service delivery and also generating net cost reduction to support investment.

The table below shows the impact that key elements of our 2010/11 initiatives will have on the potential pressures facing the PCT. These financial targets are about efficiency, effectiveness and making best use of taxpayers funding. They maximise the resource available to support strategic priorities and therefore represent a central plank of the PCT's operational plan.

Overall the PCT is expecting to invest £39m next year and to deliver efficiencies of £35m resulting in a net financial gain to the local health economy of £4m.

The programme for 2010/11 builds on successful delivery in previous years. Successes to date have allowed us to make this programme bigger and more ambitious than before. We have embraced the opportunities identified in the Darzi pathways and targets laid out in the Shaping the Future report. These targets are commensurate with the benefits from projects already delivered in 2009/10 and those forming this programme for 2010/11 and beyond.

This greater ambition is accompanied by increased risk, which we will mitigate in a number of ways, key amongst them being increased focus on the priority projects by the Executive Board.

### 5.5.1 Key elements of our risk management are:

- We have greater focus and are better prepared: The PCT's fully functioning PMO has allowed us to have a better grip on what needs to be done and when in order to develop our plans and implement changes. In terms of focus, although we have a significant number of projects, the average net financial benefit is more than £1m, which affords a suitable level of investment and priority. The PCT has the flexibility to commission further additional ongoing support to assist in local programmes to ensure the plan is achieved.
- During 2009/10 we evolved a better understanding of the development cycle using NHS Institute of Innovation and Improvement's project management process. We have been able to use this knowledge to develop more realistic phasing for benefits delivery. This reflects and supports our intent that although this is a one year plan, it is not seen in isolation to following years. Rather this is a plan for action in 2010/11 which will have impact both in 2010/11 and in following years. The actions we take in 2010/11 may not realise the full benefits in year but will carry forward into subsequent years. Where we have a lead-in for design prior to implementation, we have taken the part-year financial effect into account. At first glance therefore, some investments may look less favourable when viewed over a 12 month timeline, since the investment is up front. There is also a commensurately later loading of benefits in the financial phasing.
- As with all aspects of the Operational Plan, the PCT has reviewed the robustness and deliverability of its demand management plans. Project teams have put together comprehensive project documentation. The full Demand Management and Cost Improvement plan documentation includes a project brief, detailed costing and financial profiles, milestones, key metrics to measure success, risks, issues and stakeholder management plans. An example of these are found in Appendix E
- These plans will be independently audited and risk assessed by the SHA's quality assurance programme and the PCT has established a dedicated resource to support the implementation and delivery of these plans. We evaluate our projects against the criteria laid out by the SHA which assess likelihood of delivery and level of project complexity and risk. This is an evolving process, but we expect all projects to have entered the set-up stage by the start of 2010/11.
- Clear ownership and accountability for delivery: Key governance includes monthly performance monitoring of our top ten projects once a month by the Executive Board. Project leaders will need to demonstrate progress according to key milestones and next steps agreed at each meeting. Each project has a sponsor whose role is to legitimise the project, together with a clinical champion whose role is to sell the project to their clinician peers. In addition to the projects already identified and managed by the Commissioner, the PCT needs its secondary care providers to support demand management in secondary care – which needs to be owned and delivered by the acute sector and for which they need to be held to account by the Commissioner and the SHA.
- Clear governance: Each project has a project steering group. Progress will be monitored on a weekly, bi-weekly or monthly basis, depending on the status of the project and the level of risk, by the PMO and the project's steering group. In addition to monitoring progress the steering group acts as a key part of the issue resolution process. Regular updates will be presented to the Executive Board,

The projects within the programme are structured into four key sections:

- Commissioning and Pathways - Net savings of £13.7m
- Provider Efficiency - Net savings of £10.6m
- Prescribing – Net savings of £2.5m

The projects within the Demand Management and Cost Improvement Programme are fully aligned with and map to CAHO work streams. As such they will serve well to establish a culture of delivery within this ambitious change programme.

There are a number of projects which lend themselves to collaborative working, for instance Continuing Healthcare, End of life care and Case Management. Benefits from collaborative working will come from scale and strength through consistency; transparent, fair and consistent service delivery across a wider geography make our decisions less open to challenge.

### Impact of Commissioning Initiatives

Strategic Growth by Initiative	2010/11		
	Gross £'000	Efficiency £'000	Net £'000
Planned Care	(26,572)	11,424	(15,148)
Acute	(2,020)	7,000	4,980
End of Life	(288)	1,260	972
Children & Young People	(833)	263	(570)
Staying Healthy	(1,652)	0	(1,652)
Ageing Successfully	(3,080)	5,100	2,020
Long Term Conditions	(2,498)	3,193	695
Mental Health	(530)	1,127	597
Maternity & Newborn	(50)	400	350
Cross Cutting	(1,640)	4,921	3,281
<b>Total</b>	<b>(39,163)</b>	<b>34,688</b>	<b>(4,475)</b>

## 5.6 Other Financial Risk

In its Strategic Plan, the PCT estimated that it potentially has an annual risk in excess of £30m associated with:

- **The growth in demand in acute services.** For 2010/11 the value of the risk is higher than in previous years because of the historic levels in demand which the PCT has experienced in the acute sector and the potential costs of reversing the underperformance against the 18 week target.
- **Systems Management.** The PCT must manage the market to ensure that its key stakeholders and providers are aligned and engaged in delivering the PCT's strategy, the medium term financial plan and in particular the specific Commissioning Initiatives.

- **Capacity and Capability.** The PCT must secure its capability and capacity to deliver its strategy.

Once these risks have been 'adjusted' to reflect the probability of them occurring and compared to the level of contingency that the PCT has set aside, it is anticipated that the PCT should have sufficient reserves to cover these.

## 5.7 Capital Programme

In conjunction with the development of its revenue plans the PCT will progress the development of capital budgets for 2010-11. Capital resource is often an enabler for wider system reform as well as funding certain statutory requirements with regard to the PCT's estate.

The PCT has set indicative capital budgets for the 2010-11 financial year funded from its capital allocation. This formed part of the five year Estates Strategy previously approved by the PCT Board and part of its Long Term Financial Model. This capital plan is based on expected developments during the current timeframe of the PCT Strategy, including investment required to support key developments in Bicester, Chipping Norton, Henley, Banbury and Oxford City.

It incorporates the main issues highlighted in the six facet survey which reviews the PCT's statutory and legislative requirements in areas such as fire safety, health & safety, disability discrimination act and will cover any issues/risks identified through independent annual assessments such as Patient Environment Action Team (PEAT), Estates Return Information Collection (ERIC) and the Healthcare Commissions Standards for Better Health.

The PCT has developed a three year medium term plan for capital which proposes consistent levels of investments in general estates and IT schemes and reflects consequences of redevelopment programmes focused around community hospitals.

<b>Medium Term Capital Plan</b>				
<b>General Programme Summary</b>	<b>2010/11 £000s</b>	<b>2011/12 £000s</b>	<b>2012/13 £000s</b>	<b>2013/14 £000s</b>
<b><u>Estates Schemes</u></b>				
Enhancements	456	479	503	528
General Schemes:	2,464	3,068	3,097	3,258
Capital Expendiure for Developments		2,000	2,000	
<b>IT Schemes</b>	1,157	1,285	1,291	1,299
<b>Capital Grants</b>	1,378	500	500	500
<b>Total Capital Expenditure</b>	<b>5,455</b>	<b>7,332</b>	<b>7,391</b>	<b>5,585</b>

The PCT's anticipated capital allocation for 2010-11 is £5.6m. It intends to commit this on the following schemes:

- Enhancements- upgrades to heating systems across its community hospitals
- IT Improvements- £1.2m; a large element of this will be continued investment into the IT infrastructure in GP practices to ensure that they all meet standards required GP Systems of Choice (GPSoC) Initiative. Costs have been included for the Rio project (£255k) which commenced in 2009/10 is a replacement and upgrade to the current child health system and a new Out of Hours software and hardware package at £230k which was deferred from 2009/10
- General Schemes- focused on Community Hospital Works and Improvements predominately on infection control
- Capital Grants- further investment on upgrades and developments to primary care and dental estate

The revenue implications of these investments have been identified as a specific Commissioning initiatives within the 'Cross Cutting' Pathway entitled: *'Ensuring Primary and Community premises and estates are fit for the future'*. During 2010/11 the PCT will review use of, and investment/disinvestment in, primary care estates and infrastructure, in order to ensure best value for money is being derived from these assets, and capital investment is appropriately targeted.

In line with NHS guidance, the Board has agreed that the assets should remain with the PCT with ongoing maintenance being subcontracted to CHO.

The PCT recognises that there are financial implications with maintaining and improving current estate to ensure statutory and legislative requirements are met and backlog maintenance and environmental issues are addressed. The PCT has entered into an ambitious programme of redevelopment of its community hospitals focused currently on Chipping Norton, Bicester and Henley and is ensuring through this process that many of the inherent issues relating to respective assets are being addressed.

Through the CAHO programme, the PCT with other partners across the system has recognised importance of effective and efficient use of estate and has identified a specific workstream to take this forward.

In the meantime the PCT and CHO are working collaboratively to ensure terms of managing estate are defined, risks are identified and managed & capital invested appropriately.

The overall capital programme including nominal split between provider and commissioning arms and more detail of schemes underpinning these areas will be presented for formal approval to the PCT's March Board.

## 6.0 Contract and Provider Management

### 6.1 Contract Negotiations

At the time of submitting this draft, the PCT is still in negotiations with its main acute providers to agree the contract schedules for 2010/11. There is still a considerable gap between the PCT's affordability envelope and the activity plan proposals made by Providers.

It is fully appreciated that this represents a significant challenge and will require strong and effective partnership working to achieve an agreed contract value in the next month. In order to reconcile the figures, the immediate focus is around

- Working up the detailed business cases for Demand Management commissioning intentions, including and agreeing capacity planning, phasing assumptions and delivery milestones
- Validation of activity figures and growth assumptions
- Escalation to FD / CEO discussions and weekly negotiation meetings to focus solely on contract negotiation until agreement is reached
- Resolving and mitigating current/future risk around the 18 week wait backlog issue at the ORH
- Take forward new opportunities to manage activity levels identified through Cap Gemini workshop

CQUIN is the quality improvement and innovation elements of the commissioner-provider contract negotiations. This includes the goals/targets in the three domains of quality: safety, effectiveness and patient experience. CQUIN proposals are under discussion, with up to 1.5% of the provider contract value available for achievement of these targets, and the quality schedule is largely agreed.

### 6.2 Modelling of Commissioning Initiatives

The PCT's Strategic Planning process has updated and identified a range of Commissioning Initiatives that support the delivery of strategic goals across the system. Those that have an impact on Acute PBR activity have been modelled on StratComm in relation to the ORH (split between impacts on Outpatient care, Elective inpatients, Non-Elective inpatients, and Accident & Emergency) and the NOC and are summarised below.

The total impact of the combined Commissioning Initiatives on PBR activity is in excess of £13m, further work is ongoing to validate these internally in the PCT and through discussion with the providers such that they may be subject to further refinement and revision.

The activity/contract modelling only focuses on PBR activity at the ORH and NOC, which accounts for around 47% of all Acute commissioned costs (inc Specialist). Given this, there cannot be a direct transfer of StratComm figures back into the Finance template; however the estimates of activity changes will be based on StratComm modelling for the main lines of acute activity and as such are aligned.

**The areas that we are focusing on:**

- a) Outpatients:
  - i) **Demand management of GP Referred Outpatient First Attendances** (OPFAs) has been modelled at a Specialty level, with reference to how the PCT performs in relation to peer group PCTs across the UK.
  - ii) **Demand management of Other Referred Outpatient First Attendances:** these have also been modelled in order to achieve a level of activity in line with the lowest activity quintile in the peer group.
  - iii) **Follow-up appointments** – management of growth pressures
  
- b) Inpatient Elective admissions;
  - i) **Threshold management:** of the top 25 highest spend HRGs.
  - ii) **Outlying inpatient specialties:** of the three highest outlying specialties
  - iii) **ISTC Utilisation:** impact of full utilisation of the PCT's contract for ISTC orthopaedic activity.
  - iv) **Low priority surgical interventions** – Lumbar Spine activity is reduced to fall in line with benchmarked performance indicated by Better Care Better Value indicators.
  
- c) Inpatient Non-elective admissions:
  - i) **Delayed Transfers of Care:** Reduction in Excess Bed Days and emergency admissions in those specialties that experience high levels of Delays, to reflect the impact of maintaining lower levels of delays.
  - ii) **Stroke and Fractured Neck of Femur LoS:** reductions in Excess Bed Days in the main HRGs relating to Stroke and NoF admissions, to bring LoS closer to the top 10 nationally (ref Better Care Better Value indicators).
  - iii) **End of Life care:** reduced emergency admissions for patients in the end of life care pathway, to reflect the community-based Rapid Response service.
  - iv) **Long Term Conditions:** reduced emergency admissions in Respiratory care to reflect impact of a range of community-based LTC initiatives, particularly on Asthma and COPD admissions.
  - v) **A&E GP co-location:** impact on general Paediatric Medicine short-stay admissions.
  - vi) **Single Point of Contact:** small impact on emergency admissions.
  
- d) Accident & Emergency
  - i) **A&E GP co-location:** impact of diverting a minor and some standard A&E attendances.
  - ii) **Single Point of Contact:** impact of diverting a small percentage of minor and some standard A&E attendances.

### 6.3 Provider Management

The focus will be on how the PCT will develop and ensure a sustainable and efficient supply side market that delivers the necessary quality and innovation, whilst at the same time addressing the issues of the local market which is characterised by monopoly supply in a number of areas. In particular, the focus will be on CHO and non-FTs - addressing the following areas:

- **Intelligence** – identification of all potential sources of supply and capability which will be underpinned by a comprehensive and multi-functional supplier database.
- **Relationships** – building on the intelligence to ensure productive relationships with existing and potential suppliers
- **Engagement** – proactively sharing the PCTs priorities and service development needs with potential suppliers. This will involve the creation of a wide-ranging communication plan that encourages collaboration and innovation in general and supports individual procurements and initiatives in particular
- **Enablement** – working with suppliers to develop the skills necessary to compete effectively for services and to understand the disciplines of tendering, contract and performance management. Particularly pertinent to the Third Sector and Primary Care Providers, though will be available to all suppliers.
- **Capability** – the PCT will work through the Collaborative Operating Model (COM) to build the infrastructure and capability necessary to deliver its market strategy

The approach of the PCT will be further strengthened in two ways:

- 1) Market Intervention Strategy – following detailed engagement with the Board a first draft of the Market Intervention Strategy will be delivered in late spring. This will have the benefit of refining the organisations approach and providing a consistent framework for market management.
- 2) Collaborative Operating Model (COM) – the capacity and support provided by the COM will considerably improve the organisations capability in all the areas described above. The collective approach allied to the analytical support and clinical expertise will strengthen the position of the PCT in the negotiation and management of healthcare contracts.

In addition, the CAHO Programme will drive change in the local health and social care market. All the existing major public sector players are committed to ensuring that CAHO drives change in service delivery. This will in turn lead to a downsizing of the acute sector, greater integration of organisations providing community based services and organisational change for commissioners and providers.

## 7.0 Collaborative Working

Collaboration beyond the county boundaries is also vital for the delivery of the transformation agenda. Over the last year South Central PCTs have been working together through the PCT Alliance to help improve our world class commissioning capabilities. This work has largely been done through the World Class Commissioning Collaborative Programme.

Going forward Oxfordshire is committed to the Collaborative Operating Model (COM) which is a partnership between the 9 PCTs in the region and it is designed to help us improve our effectiveness and efficiency. Collaboration is largely being developed across two sub regions – SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) and MOBBB (Oxfordshire, Buckinghamshire, the Berkshires and Milton Keynes) and will speed the implementation of best practice and realise economies of scale. Ensuring we get the best possible improvement to the efficiency of our operations from this collaboration will be an important enabler of the transformational change required to reduce costs over time.

The Northern Cluster PCTs (MOBBB) are sharing approaches, methodology and learning and are now planning the detailed implementation of collaborative working arrangements. There are four main elements to this collaboration:

1. Commissioning Enablement Service (CES) –  
The 9 PCTS have contracted with Tribal to provide a range of advanced analysis and modelling services that will let us understand, predict and influence demand for services better and that will improve our contract management.
2. Category Management  
Ensuring that as a system we design once and deploy several times, wherever that is the most prudent approach to take to delivering effective service redesign
3. Provider Relationship Management  
Streamlining contract management with major providers, particularly where they serve the population of more than 1 PCT – this is known as
4. Working together to anticipate and manage the impact of new ways of working on our staff teams and to provide training and development as required.

In addition we are leading MOBBB to look at other areas where it would make sense to work together and to date have had early discussions about;

- Communications and engagement functions where (at minimum) there would be economies of scale if we designed/ran large campaigns together
- Human Resources / Organisational Development / Workforce planning

We would also expect this to be a key enabler of reducing management costs across the system.

## **7.1 Commissioning Enablement Service (CES) Benefits Realisation**

The PCT has identified the following key benefits to be realised through its use of business intelligence, including the increased capabilities and capacity available to the PCT through CES. These are –

- 1) Timely, robust and neutral evidence to diagnose problems in the delivery of healthcare within the local health economy in Oxfordshire
- 2) Application of this evidence to achieve medium-term strategic development to increase effective prevention of ill-health, and to reduce the rate of decline in health for people with existing ill health. This will
  - a) Inform pathway redesign to improve quality of care, health outcomes and value for money, and to
  - b) Ensure that the right level of intervention is provided in the right setting at the right time to significantly reduce unnecessary use of acute provision.
  - c) Inform step change in capacity and capability across primary, community and secondary health care provision
- 3) Application of this evidence to current provider management to
  - a) Drive improvements in productivity, quality of care and invoice validation
  - b) Identify key performance indicators to monitor and measure the rate and effectiveness of improvement in these areas

The initial areas of commissioning that the PCT has identified as priorities for this enhanced business intelligence reflect its immediate strategic priorities of

- Unscheduled care
- Productivity and value for money in acute providers
- Management of long term conditions within community and primary care

The PCT will regularly review and update its priority uses of CES during 2010/11 to ensure ongoing alignment with its strategic priorities and the Quality and Productivity agenda.

## 8.0 Management of delivery

### 8.1 Recovery Plans

Under the SHA's Compliance Framework, the SHA Board has made the decision to place Oxfordshire PCT under formal intervention for failing to deliver the national waiting time targets for 18 weeks, A&E and Cancer. The PCT is currently conducting an internally-led investigation, to be completed on the 18th March, which will incorporate a diagnosis of the performance issues, and set out the actions necessary to resolve them.

An intervention report will then be submitted to both the PCT and SHA Board, the latter who will review plans with a view to determining whether any further action is required, or whether the recovery plan can be approved and the formal measure of intervention lifted.

Recovery templates for these key areas are included at Appendix F

The key findings from the report will help to set out what the PCTs overall approach to managing non-delivery is, not just for the areas currently under intervention, to ensure that the PCT can demonstrate that it is assiduous and focused in its management of poor performance and that all the actions and levers within the PCT's control are being applied to best effect.

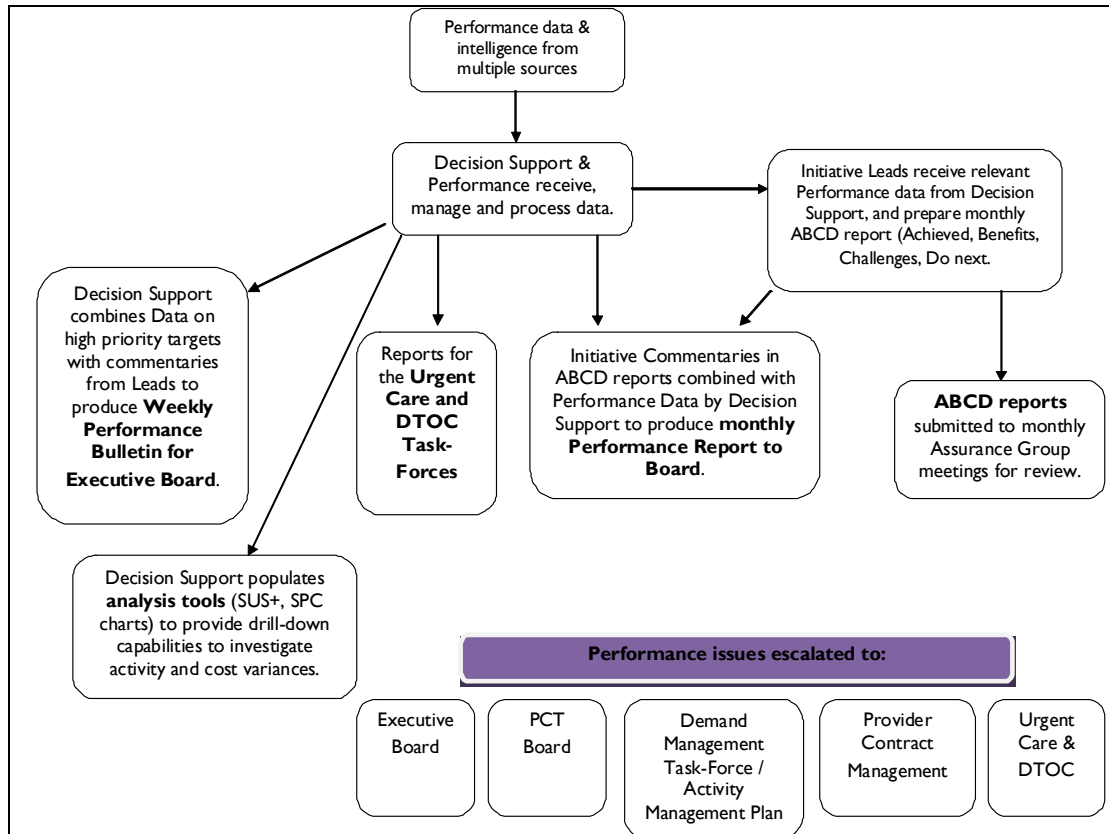
### 8.2 Underpinning governance framework

#### 8.2.1 Performance Framework

The PCT's Performance Management framework provides a basis for proactively managing two aspects of PCT performance:

- **Strategic Delivery** – managing performance delivery of the PCT's strategic Initiatives, by grouping targets and indicators which are led and owned by each initiative, and linking leading and proxy measures with long-term outcome objectives.
- **Specific performance target achievement** – by tracking and escalating performance on individual targets (for example A&E, Delayed Transfers of Care) that present a risk to the performance of the PCT and the quality of health care provision to the community.

This outline of the Performance Management framework summarises the data-flows, analysis, reporting, escalation and management processes that monitor and manage performance/. This is shown in the schematic below. Further work is taking place to ensure that the performance management framework integrates the Programme Management function and moves away from the current Assurance Group set up to reflect the new initiative structures, i.e. the Darzi pathways.



### 8.2.2 Existing commitments and local targets

Appendix C summarises how the Initiatives of the Operational Plan support the delivery of **National Standards / Priorities, Existing Commitments and Local Area Agreement targets** and gives details on the specific targets and trajectories for all these measures that the PCT is committed to achieving. In addition this appendix lists the **Local Delivery Targets** that the PCT will use to help track delivery of initiatives. Target levels and trajectories for all national standards and targets for 2010/11 have been developed and submitted to the SHA, consistent with national guidance and SHA requirements. Targets for the three years beyond 2010/11 will be developed in early 2011.

As in previous years, the local delivery targets that will be used by the PCT to support delivery of each Initiative and are based on the benefits identified for each Initiative in the Appendix A of this plan. A development this year is to move to monthly tracking and reporting of these measures, and this will enhance the value of the process both for operational programme management and for the Board, so that there is a more frequent demonstration of how well Initiatives are delivering the planned benefits for local people. In developing the updated measures for this year, we have put more focus on the practical steps that need to be in place to ensure ongoing data-collection and monthly reporting to feed into the Board report.

Local Delivery Targets will support the delivery of Strategic Outcome Measures and the direct link between them will be highlighted in monthly performance reports, though many outcome measures are achieved through the combined impact of multiple initiatives.

### **8.3 Emergency preparedness**

The following sets out the PCT's four work streams to plan and manage emergencies and major incidents. The PCT has several key obligations for emergency preparedness in 2010-11 to meet requirements set by the Department of Health, South Central SHA (SCSHA) and the Civil Contingencies Act. It should be noted that the PCT has significant additional responsibilities as the "lead PCT" for ensuring NHS emergency preparedness across the Thames Valley (TV) area.

Delivery of the following four work streams will ensure that Oxfordshire PCT and all the NHS organisations in the Thames Valley area are suitably prepared to respond to any emergency that might arise.

#### **8.3.1 Resilience across the NHS in Oxfordshire**

Oxfordshire PCT will ensure it is able to respond effectively to emergencies by updating, testing and exercising its Business Continuity Plan and Emergency Plan during 2010-11. The PCT will lead the Oxfordshire Health Emergency Planning Group which will meet at least four times to prepare resilience for all the NHS organisations which make up the health system across Oxfordshire. Similarly, the PCT will liaise with other agencies including the local authorities through the Oxfordshire Resilience Group.

#### **8.3.2 Thames Valley wide NHS resilience**

As the SCSHA-nominated lead PCT for emergency preparedness across the Thames Valley, the PCT will lead the TV Health Emergency Preparedness (EP) Group which includes representatives from the SCSHA, all of the NHS organisations, the Health Protection Agency (HPA) and partner agencies. The group will meet at least four times. The PCT will also ensure senior representation at the multi-agency TV Local Resilience Forum (LRF) and its sub-committees and take part in agreed exercise programmes for 2010-11 in accordance with the Civil Contingencies Act and NHS EP policies. The PCT will ensure effective leadership of the area health system in responding to emergencies that arise.

As the lead PCT, Oxfordshire will co-ordinate TV-wide NHS training for command and control in emergency response. This will include training for the "Scientific, Technical and Advisory Cell" (STAC) for Thames Valley Public Health on Call, with updates programmed for Winter/Spring 2010 and Autumn 2010.

#### **8.3.3 Emergency Planning Organisational development**

The Public Health Emergency Preparedness Team will provide specialist input to the NHS change management programme for commissioning. This will ensure that emergency preparedness of the NHS in Oxfordshire and the Thames Valley meet:

- the requirements as set out in DH policy guidance
- the Civil Contingencies Act (CCA) and
- the need to ensure efficient and effective health emergency planning and response within the multi agency Thames Valley Local Resilience Forum

#### 8.3.4 H1N1 Pandemic of 2009

The H1N1 Pandemic of 2009 will continue to require coordination of response at both Oxfordshire and Thames Valley level. Exercise debriefs will provide an opportunity for reviewing future responses to pandemic and will be incorporated in to major incident plans.

For the PCT's **Major Incident Plan** - go to the PCT web page:

<http://www.oxfordshirepct.nhs.uk/about-us/how-the-pct-works/trust-board/board-papers/2008/july/default.aspx>

For the PCT's **Business Continuity Plan** – go to the PCT web page:

<http://www.oxfordshirepct.nhs.uk/about-us/how-the-pct-works/trust-board/board-papers/2009/default.aspx>

To access the **Thames Valley Local Resilience Forum**

<http://thamesvalleylrf.org.uk/>

## 9.0 Risk Management and Clinical Quality & Safety

### 9.1 Risk Management

The PCT's approach to risk management is focused on identifying, prioritising and mitigating the risks that will impact on delivery of our Strategy and Operational Plan. The Assurance Framework (AF) and Risk Register (RR) are already structured to reflect the PCT's core aims, and will develop to reflect the strategic initiatives of the PCT.

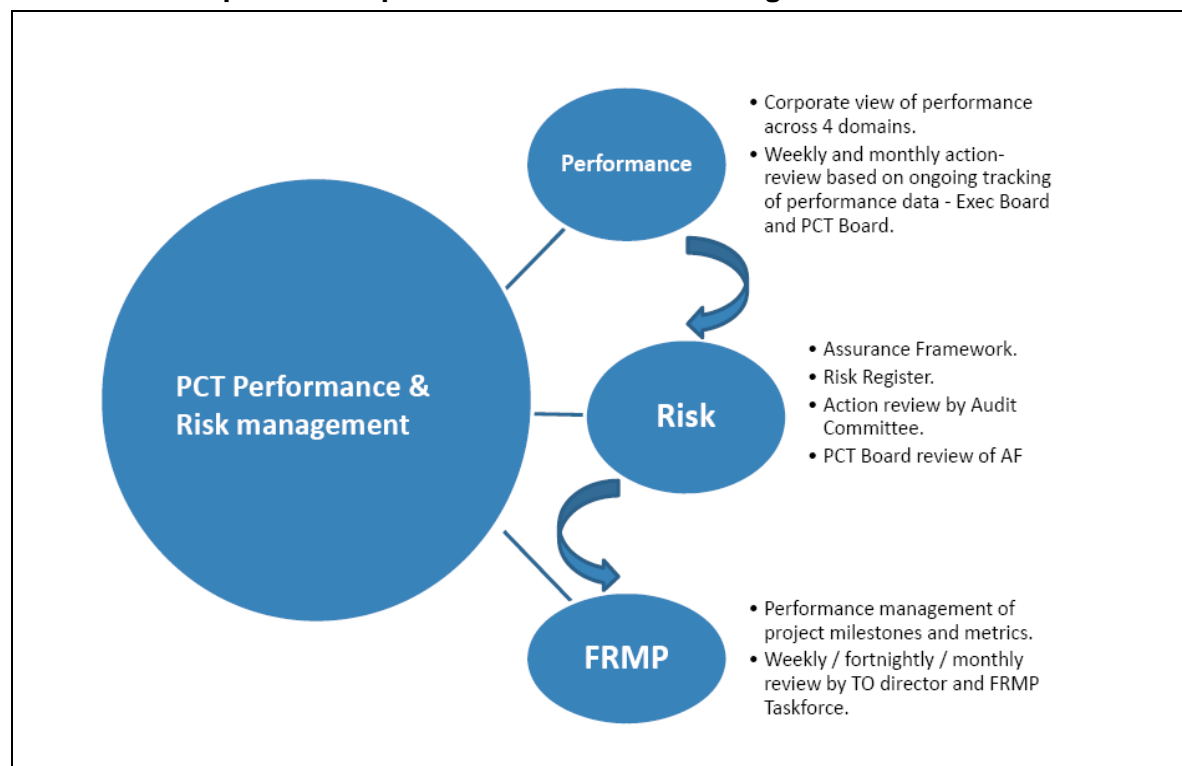
The aim of the PCT is to approach risk management across the organisation by linking financial, organisational, reputational and project risks, both clinical and non clinical and that all parts of the organisation are involved.

The PCT reviews annually the risks it will face in delivering its Strategic and Operational Plans. Principal risks are reflected in the updated Assurance Framework and those risks that do not threaten the core aims of the PCT are reflected in the Risk Register.

To ensure robust management of risk, all identified risks are owned by a named director who will monitor the risk associated with the objectives and ensure adequate controls are in place to actively manage risks. Executive Board looks monthly at the Assurance Framework and Risk Register alongside the performance report. Audit Committee reviews both of these bi-monthly and the Board also reviews the Assurance Framework bi-monthly.

The scope and relationship between the three components of performance and risk management are shown diagrammatically below:

#### The PCT's components of performance and risk management



The risks to delivery of the strategic initiatives and mitigating actions are identified in Appendix A and within the Finance section at chapter 5.

## **9.2 Principal Risks**

The risks associated with the delivery of the Strategy are substantial given the overall state of the economy, the resulting financial pressures on public services and the likely outturn for 9/10 of provider performance against plan for the current year in the County. We have a robust financial plan and an excellent process in place to understand and monitor that risk as described in section 5.5.1.

Appendix A sets out the major risks and mitigating actions associated with delivery of each initiative/pathway and these will be monitored through the individual initiative governance arrangements. The following sets out the four principle risks to overall delivery of the Operational Plan, and ultimately the strategic plan and these be managed through the risk management arrangements described in section 9.1

### **9.2.1. Managing growth and activity**

As the context section on population, health needs and demand makes clear, the growth in demand for acute elective services presents a major challenge for the PCT which is not primarily explained by demographic pressures. For 2010/11 the value of the risk is higher because it reflects the historic levels in demand which the PCT has experienced in the acute sector and the potential costs of the 18 week target being achieved. The following years anticipate demand rising at a consistent rate of 2% per annum. If the PCT does not succeed in delivering a sustained reduction in referrals to secondary care and a reduction in activity within secondary care, it will not be able to afford to deliver any aspect of this strategy. All initiatives will contribute to this work, but it will be primarily driven through our initiative: Planned Care.

### **9.2.2. Delivery of savings**

The saving targets set by initiative leads for their work areas and other savings across the PCT as a whole are ambitious. Savings will come not just from initiatives, but from the contract negotiation process, contract monitoring and challenge and service redesign and organisational change driven from within provider trusts. It would be imprudent to think that there would not be some slippage in terms of delivery and savings targets attached to initiatives in year; even with tighter project management and rigorous planning. The level of risk will be in the difference between those assumptions and what we are currently modelling and what actually happens. To mitigate this, the PCT will only commence initiatives once a rigorous and detailed business case has been agreed and individuals will be closely held to account for delivery of all the benefits articulated within this. Savings are ambitious but realistic and we recognise that there are still opportunities to drive more efficiencies out of the system.

### **9.2.3. System Management**

The PCT will need to develop and manage the market in ways which ensure that all providers and referrers play a committed and effective role in delivering this strategy. This will require a substantial shift in relationships, expectations and approaches to planning, contracting and performance management, requiring change from all parties. The work which is currently relating to Creating a Healthy Oxfordshire Programme (CAHO) will be the mitigating action for this.

#### **9.2.4. Capacity and capability gaps**

The fourth substantial risk lies in the PCT's ability to develop the capacity and capability to deliver it. A detailed analysis of capacity and capability issues has been undertaken and these are articulated fully in the PCT's Organisational Development Plan. The OD plan also sets out the mitigating actions being taken by the PCT in respect of each of these capacity and capability gaps and how it will use the opportunities for collaborative work with other PCTs to maximise capability and build capacity.

### **9.3 Clinical Quality & Safety**

Clinical engagement and leadership is core to meeting the challenges facing the NHS in terms of providing solutions to the increasing levels of demand and the reducing funds. We recognise that clinical leadership is essential to enable change to happen and to mitigate the risk to clinical quality and safety which could occur as a result of change.

The PCT is committed to ensuring high quality care remains central in health provision but recognises that the financial challenges ahead may threaten this goal. The process the PCT has put in place to manage risk to quality will be further developed and strengthened.

The PCT has integrated a number of quality metrics into its contractual arrangements to monitor and improve the quality of care and these are reviewed through regular contract meetings. These metrics cover a wide range of indicators related to quality of service including reducing mortality rates, infection rates, screening targets and outcome measures and has already led to significant improvements in service and will be expanded year on year.

The Clinical Commissioning model strengthens clinical leadership and engagement in the Oxfordshire health economy and builds upon the existing Practice Based Commissioning infrastructure. The model strengthens the current levels of clinical engagement and therefore the clinical leadership contributions to PCT strategy, planning and policy development. Furthermore, the Organisation Development Plan will incorporate the development of clinical leaders and the PCT is working with the SHA on their management development programme for clinicians.

## **10.0 Informatics Planning**

This chapter sets out how the PCT is developing plans to ensure that informatics is used appropriately to support service provision across the local health system and to exploit opportunities for improvements promoted through the national Quality, Innovation, Productivity and Prevention (QIPP) programme. It looks at how the PCT is strengthening its informatics leadership role, supporting local health community wide developments and the overall approach to delivery and priorities for informatics planning 2010/11.

Further details are provided in Appendix G.

### **10.1 Background**

Comprehensive informatics plans were developed for 2008-09 and although still valid, these will be reviewed during 2010/11 to reflect local changes as well as progressive national moves away from an all embracing strategy for the provision of IT solutions. Focus will shift to a more service oriented approach and the use of digital technologies in which standards, connectivity and public access to information play an increasingly important role.

### **10.2 Leadership, capability and capacity**

The requirements identified via the service development initiatives (Strategic Plan section 5.4 and Operational Plan Appendix A) demonstrate the key role for informatics in delivering the PCT's strategy, both by enabling efficient service provision and by providing business intelligence and knowledge management tools to support the commissioning of services.

The PCT understands the importance of its own leadership role in ensuring that the necessary developments are in place to support the strategic service vision and specific goals in this operational plan. During 2009/10 the PCT has undertaken a review of its approach to the management of both the inward and outward facing informatics agenda and agreed a revised structure, led by a Chief Information Officer reporting to the Director of Finance and Performance. New arrangements will be implemented early in 2010 and an initial priority will be to revise the overall informatics strategy for the PCT.

There is wide recognition that Health Informatics can support the re-shaping of care and that it must be mainstreamed to be effective. Internally within the PCT informatics is seen as an integral part of the commissioning process and is involved in planning, service re-design and procurement. Working arrangements are being strengthened through programme management and programme support functions so that informatics both supports and informs commissioning plans.

In addition to developing local infrastructure, the PCT is playing an active role in the collaborative Commissioning Enablement Service to provide a more centralised approach where this offers economies of scale.

The PCT also recognises the importance of developing informatics skills within the specialist and wider workforce and has reflected this within the Organisational Development plan.

### **10.3 Local health community informatics**

There is a well established partnership model for informatics planning and delivery via an Oxfordshire wide IM&T strategy group. The purpose of this group is to support collaborative working and deliver the informatics infrastructure that will help drive service improvements. The group is led by the PCT Director of Strategy and Quality, meets every two months and includes Oxfordshire County Council as well as all main service providers. This group has reporting links to the service change agenda and will align with the QIPP and Creating a Healthy Oxfordshire (CAHO) programmes. Participation is kept under review and will be extended to include new providers of NHS-funded care when appropriate.

#### **10.3.1 Overall Requirements and approach**

The requirements identified via the service development initiatives confirm the need for:

- Detailed electronic records solutions in each provider organisation to support high quality and efficient care
- Improved communications to ensure effective sharing of information along care pathways, improving current and enabling new models of care
- Increasingly, access to shared records
- Changes to underpin the transformation of community services, including the systems needed to support Community Health Oxfordshire (CHO) to operate within a new organisational form
- More use of assistive technologies, particularly in the care of the elderly and people with long term conditions
- Better public facing information – to help people make service choices, undertake self care, avoid risks
- Continued development of the analytical and decision support function to plan and manage service developments more effectively
- Tactical developments to deal with immediate needs e.g. from QIPP initiatives

Many of these priorities are being addressed through the overall NHS agenda for IT, which covers all sectors within the health system, and has been central to the PCT's strategic informatics plans in recent years.

Significant progress has been made recently in the implementation of detailed care records in many settings, including community, learning disability and mental health, and it is hoped that revised contractual arrangements for the Oxford Radcliffe will be agreed shortly.

As these plans are progressed, the PCT will work with service providers and IT suppliers to ensure wider local health system needs are addressed. The PCT will also work across the health community to ensure that projects support the PCT service development agenda and deliver the expected benefits.

Service developments identified via the strategic plan, operational plan and themes emerging from QIPP will be used to inform an updated PCT informatics strategy during 2010/11. This will also take account of the emerging national digital strategy for informatics.

**10.3.2 The main Priorities for 2010-11 include:**

- Appoint to the CIO role and implement revised management structure.
- Strengthen alignment of informatics and the service improvement/QIPP/CAHO agenda.
- Review overall informatics strategy to address changing local needs and national approaches.
- Develop improved approaches to cross sector communications, including the use of messaging technology.
- Consider the case for implementation of the national summary care record.
- Continue to implement the current strategic informatics plans, based around the National Programme for IT.
- Progress tactical developments (e.g. to the Oxford Clinical Intranet) to provide pragmatic improvements to workflow and information sharing.
- Continue to support the efficient commissioning and performance of services through various business intelligence initiatives.

Plans are outlined in more detail in **Appendix G**

## 11.0 Workforce

### 11.1 Commissioning PCT workforce

The PCT has approved a draft organisational development plan which sets out the approach it will take to its own staff development and talent and leadership development. It is also currently developing an HR strategy which will set out issues in relation staff health and wellbeing within the PCT.

The key objectives of the OD Plan are -

- 1. Leadership and Partnership** – the PCT will
  - a. effect transformational change of local health economy through Creating a Healthy Oxfordshire and service redesign initiatives
  - b. deliver its leadership and contribution responsibilities to partnership workstreams
  
- 2. Listening and learning from Communities, Patients & Carers** – the PCT will ensure that
  - a. Effective engagement with patients and the public will significantly influence commissioning decisions, for example in prioritisation of investment / disinvestment in healthcare services, and personalisation of healthcare budgets
  - b. Excellent patient and carer experience will be a key deliverable for all healthcare provision, and patient & carer feedback will drive improvements in healthcare delivery
  
- 3. Market Intervention and Management** – the PCT will
  - a. Intervene and manage the local health care market to achieve defined outcomes in improved clinical quality and patient experience, and value for money
  - b. Have internal processes to enable market intervention and management will be transparent, robust, efficient and reduce unacceptable variation
  
- 4. Clinical Engagement**
  - a. Clinical leadership will be enabled to drive commissioning of healthcare services that are based on best clinical evidence and practice
  - b. Clinicians will be supported to collaborate with the PCT and all health and social care providers to redesign services along care pathways, across organisations and care settings
  
- 5. Effective People & Effective Delivery**
  - a. The PCT's core functions (public health, strategic planning, communications and engagement, clinical leadership, commissioning, procurement, finance, performance and informatics, contracting, quality, IM & T) will have appropriate skills, capabilities and capacity effectively to deliver the PCT's strategic goals

## **6. Business Intelligence & Knowledge Management**

- a. The PCT will make robust, effective decisions to enable delivery of its strategic goals based on effective and efficient use of accurate data and information (own and COM/CES resources)

Actions to achieve these objectives will be prioritised and updated throughout 2010/11 to ensure that the focus of the PCT's organisational development appropriately enables the PCT to deliver its strategic goals through its operating plan.

The PCT has identified management costs savings of £650k from within its own staff budget through internal efficiencies (approximately 7.5% of its 2010/11 management workforce budget, excluding hosted teams). Delivery of this will be monitored through its cost improvement programme.

## **11.2 Local Health Economy Workforce Risk Assessment and Assurance 2010/11**

The PCT has undertaken a risk assessment for workforce in delivery of its strategic goals and operational plan across the local health economy. This has triangulated national workforce risks in specific professions / care pathways against the PCT's own strategic initiatives for 2010/11.

Risks specific for each Darzi pathway have been detailed in Appendix A.

An overview local health economy workforce risk assessment, together with the controls in place to monitor delivery of appropriate mitigating actions, can be found at Appendix H.

However, detailed evaluation of specific provider workforce plans will not be completed until contracting negotiations for 2010/11 are concluded, and the evaluation of the workforce plans can be undertaken in the context of the activity levels agreed within the contracts.

The PCT has included workforce metrics in schedule 3, part 4 of its provider contracts for 2010/11. This will ensure that workforce issues, especially as they impact on quality, will be reviewed within contract monitoring, alongside assurance on provider delivery of medical revalidation.

## **11.3 Local Health Economy Workforce Planning Development**

Workforce change is anticipated as a result of both the Creating a Healthy Oxfordshire (CAHO) and commissioning initiative programmes. The county's workforce planning forum, Careforce, will play a central role in addressing the workforce implications of delivering the changes arising from both these work streams, and will consider issues such as workforce flexibility. The CAHO Board has already tasked Careforce with developing plans and arrangements to support any transition of staff as a result of the workstreams within CAHO.

It will continue to collaborate with providers and partners on workforce planning and development for the county through the Careforce forum as CAHO work-streams are implemented.

## 12 Conclusion

The Operational Plan sets out the changes the PCT expects to make in 2010/11 and describes the overall context in which services will be delivered. It is underpinned by a clear commitment to providing better services and improving the health and wellbeing of our population in partnership with others in the local health economy, whilst also continuing to improve the efficiency of services.

The PCT has a good track record for being an operationally strong and well performing organisation and recognises the scale and complexity of the challenges facing it. This is clearly reflected in the level of ambition set out in the 5 year Strategy and this 1 year Operational Plan.

Moving forward on delivering our priorities whilst managing a challenging financial situation and maintaining and developing partnerships is a difficult agenda to manage. It isn't one we can deliver by ourselves and we will need to get our partners to help drive and push change across all parts of the system. Working with the whole system is the right approach and the CAHO programme will help ensure that this continues to happen.

We have set ourselves a considerable work programme and while we need to be realistic about the size of the agenda and our capacity to deliver, we firmly believe that the focus and ambition is right and absolutely necessary to ensure that we deliver value for money, financial savings and efficiencies for the people of Oxfordshire.