Buckinghamshire County Council

Select Committee

Health and Adult Social Care

Date: Tuesday 21 February 2017

Time: 10.00 am

Venue: Large Dining Room, Judges Lodgings, Aylesbury

AGENDA

9.15 am Pre-meeting Discussion

This session is for members of the Committee only. It is to allow the members time to discuss lines of questioning, areas for discussion and what needs to be achieved during the meeting.

10.00 am Formal Meeting Begins

Agenda Item		Time	Page No
1	**APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP**	**10.00am**	
2	**DECLARATIONS OF INTEREST** To disclose any Personal or Disclosable Pecuniary Interests		
3	**PUBLIC QUESTIONS** This is an opportunity for members of the public to put a question or raise an issue of concern, related to health. Where possible, the relevant organisation to which the question/issue is directed will be present to give a verbal response. Members of the public will be invited to speak for up to four minutes on their issue. A maximum of 30 minutes is set aside for the Public Questions slot in total (including responses and any Committee discussion). This may be extended with the Chairman's discretion. For full guidance on Public Questions, including how to register a request to speak during this slot, please follow		

this link:

http://www.buckscc.gov.uk/about-your-council/scrutiny/getting-involved/

4	**BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST SUSTAINABILITY AND TRANSFORMATION PLAN NHS ENGLAND SOUTH** For Members to receive an update on the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan, including an update on delivering the "Bucks" chapter. **Attendees:** **Lou Patten, Chief Accountable Officer, Clinical Commissioning Groups** **Neil Dardis, Chief Executive, Buckinghamshire Healthcare NHS Trust** **Mike Appleyard, Deputy Leader and Cabinet Member for Health & Wellbeing** **Graeme Betts, Interim Managing Director, Adult Social Care** Attached is a copy of the draft Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan and the vision and programme for digital transformation in health and care.	**10.05am**	**5 - 176**
5	**DEVELOPING CARE IN THE COMMUNITY** This is an opportunity for Committee Members to receive an update on Buckinghamshire Healthcare NHS Trust's plans for developing care in the community. **Attendees:** **Neil Dardis, Chief Executive, Buckinghamshire Healthcare NHS Trust** **Dr Tina Kenny, Medical Director, Buckinghamshire Healthcare NHS Trust** **Dr Martin Thornton, GP, Trinity Health**	**12 noon**	**To Follow**
6	**DATE AND TIME OF NEXT MEETING** The next meeting is due to take place on Tuesday 28th March at 10am in the Large Dining Room, Judges Lodgings, Aylesbury.	**12.45pm**	

Purpose of the committee

The role of the Health and Adult Social Care Select Committee is to hold decision-makers to account for improving outcomes and services for Buckinghamshire.

It shall have the power to scrutinise all issues in relation to Health and Adult Social Care. This will include, but not exclusively, responsibility for scrutinising issues in relation to:

- Public health and wellbeing
- NHS services
- Health and social care commissioning
- GPs and medical centres
- Dental Practices
- Health and social care performance
- Private health services
- Family wellbeing
- Adult social services
- Older people
- Adult safeguarding
- Physical and sensory services
- Learning disabilities
- Drugs and Alcohol Action Team (DAAT services)

* *In accordance with the BCC Constitution, this Committee shall act as the designated Committee responsible for the scrutiny of health matters holding external health partners to account.*

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For further information please contact: Liz Wheaton on 01296 383856 , email: ewheaton@buckscc.gov.uk

Members

Mr B Roberts (C)
Mr R Reed (VC)
Mr B Adams
Mr C Adams
Mr N Brown
Mrs A Davies
Mr C Etholen
Ms R Vigor-Hedderly
Julia Wassell
Vacancy
Vacancy

Co-opted Members

Ms T Jervis, Healthwatch Bucks
Mr A Green, Wycombe District Council
Ms S Jenkins, Aylesbury Vale District Council
Mr N Shepherd, Chiltern District Council
Dr W Matthews, South Bucks District Council

Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan NHS England South

Improving health outcomes and adding value by working together

Footprint lead:
David Smith, Chief Executive,
Oxfordshire Clinical Commissioning Group
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Contents

1. Executive summary

The NHS and local authorities across Buckinghamshire, Oxfordshire and Berkshire West (BOB) are working together to support delivery of the Five Year Forward View, which is a national plan to deliver better health, better patient care and improved NHS efficiency.

The Government has asked us to do this as there are a number of challenges facing the NHS that require us to transform the way in which we provide local services and care and ensure local communities are the healthiest they can be.

These challenges include the changing needs of patients, new treatment options and increasing demand for services. At the same time, we know that quality of care can vary, many illnesses are preventable and social deprivation can significantly impact health outcomes. Together with ongoing financial pressures, this means that we need to take positive action to ensure patients, their families and carers are empowered to take more control over their own care and treatment; services are offered in a range of ways yet provide consistent high quality care and treatment; and local budgets are spent wisely.

Across BOB, these challenges mean that over the next five years, we face the following gaps:

Health and wellbeing gap due to:

- increasing demand for services, particularly for over 75s
- pockets of deprivation which are difficult to overcome
- the population growing faster than expected as a result of significantly increased new housing.

Care and quality gap due to:

- community hospital buildings which require repair and are not fit for modern needs
- variable access to specialised cancer and interventional cardiology treatments
- difficulty in recruiting and retaining staff due to the high cost of living, leading to unsustainable services and poor performance
- fragmented and poorly coordinated specialist mental health services and out of area placements.

Financial gap

- If we carry on as we are, there will be a financial gap of £479m by 2020.

To address these challenges and close the three gaps, NHS organisations and local authorities across Buckinghamshire, Oxfordshire and Berkshire West have come together to develop and deliver a Sustainability and Transformation Plan (STP). We are one of 44 STP footprints set up across England to become more efficient and use our resources as well as we can to improve the quality of care and health of our population while managing increased demand.

Our plan describes our ambitions, the intended benefits for patients and how local organisations will work together to achieve this. At the same time, it builds on the

work we are already doing across Buckinghamshire, Oxfordshire and Berkshire West, using patient feedback and insight from past engagement and consultation activity, views from local Healthwatch organisations and clinical best practice to inform key areas of focus.

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

By this, we mean:

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

Our ambition is to co-design with patients and clinicians and implement new models of care to address the challenges facing our health and social care system.

Our proposals focus on the following priority areas:

- Preventing ill health, by shifting focus from treatment to prevention.
- Improving access to the highest quality primary, community and urgent care services.
- Collaborating across acute trusts to improve quality and efficiency by delivering effective clinical networks.
- Improving the health outcomes of patients using mental health services, ensuring services are operating efficiently.
- Improving alternatives to specialised services, such as cancer treatments, which are of greater value to patients.
- Increasing efficiency by planning and buying services, where appropriate, at scale across the BOB geography.
- Increasing our ability to support people in their own homes and avoid an emergency admission to hospital.
- Improving our workforce offer and increasing staff retention by working with trusts and Health Education England Thames Valley (TV) to improve recruitment, standardise terms and conditions and offer employees interesting rotational opportunities.
- Providing digital solutions for self-care, virtual consultations and interoperability to increase patients' access to information and reduce duplication and travel.

Our proposals have been informed by patient and public feedback from engagement and consultation activities, such as 'Your Community, Your Care' in Buckinghamshire, the 'Big Conversation' in Oxfordshire and Call To Action events in Berkshire West; feedback and insight from our clinicians; and strategic health needs assessments and health and wellbeing strategies from across BOB. We have also benefitted from the clinical expertise of the Thames Valley Clinical Senate, the Oxford Academic Health Sciences Network (AHSN) and the Thames Valley Urgent and Emergency Care Network.

Implementing our proposals will have major benefits for patients as health outcomes are improved:

Improvements in access to services

- By standardising access to urgent care across the system and maximising the use of technology, we will provide patients with faster access to clinicians.
- Workforce plans will improve the sustainability of primary care, ambulance services and other key services.
- More care provided closer to home through strengthening the availability of services available within primary care; reducing the need for travel for many routine appointments and investigations.
- Closer working across the health and social care system will make it easier to access for patients.
- More services provided on a day or out-patient basis reducing the need for hospital admission.
- Reduced waiting times for referral to see a specialist.
- Greater availability of GP appointments seven days a week.
- Improved access for all cancer patients.

Improvements in care and quality

- Reduction in sepsis.
- Reduction in the length of time patients wait for discharge from a hospital bed when their acute care has ended.
- Fewer 'never events'.
- Releasing GP time to work at scale and integrate with community services so they can focus on complex patients will mean patients will have more time with their GP when required.
- The proposed changes to the Horton Hospital and the development of community hubs based around GP populations and bed based services across Buckinghamshire, Oxfordshire and Berkshire West will mean patients have reliable and sustainable access to high quality evidence based services closer to home which will lead to improved patient outcomes.

Improvements in population health

- Reduction in lives lost and illness due to preventable disease and reduced inequalities.
- Reduction in obesity and diabetes.
- Increased mental wellbeing and more people supported to live healthier and fuller lives.
- Improved one year cancer survival rates.

- Improvements in dementia care – diagnosis, support and end of life care.

Across our footprint we have a proven track record of implementing innovation and excellence in clinical practice to deliver high quality patient care. This has led to us being a highly cost effective system, which we will build on as part of this plan. We cannot however do this by organisations working on their own, nor can we do this without the involvement of patients, the public and clinicians and health and social care staff. Working together is important for success and we will ensure that we continue to share information and proposals relating to this plan. We also want to hear people's views on our proposals and involve them in developing and delivering our plan to ensure everyone has their say. Together, we are committed to improving health services and health outcomes to ensure our population are supported to live life to the full for years to come.

2. Introduction

Delivering improved services for our local communities is the driving force of this plan.

Local health and social care organisations have come together to form the Buckinghamshire, Oxfordshire and Berkshire West (BOB) footprint to develop and deliver a Sustainability and Transformation Plan (STP). This plan is intended to support local delivery of the Five Year Forward View, which sets out a vision of better health, better patient care and improved NHS efficiency.

Although we use the term Sustainability and Transformation Plan, it is much more than this. It is a large scale programme of transformation with managers and clinicians from health and social care organisations working together with patients and the public, to transform the way in which we provide local services and care and ensure local communities are the healthiest they can be.

The needs of patients are changing, new treatment options are emerging and demand for services is increasing. At the same time, we know that quality of care can vary, many illnesses are preventable and social deprivation can significantly impact health outcomes. Coupled with ongoing financial pressures, this means that we need to take positive action to ensure patients, their families and carers are empowered to take more control over their own care and treatment; services are offered in a range of ways yet provide consistent high quality care and treatment; and local budgets are spent wisely.

Our plan sets out how we will address these challenges across the Buckinghamshire, Oxfordshire and Berkshire West areas, which is one of 44 STP footprints set up across England. It also describes our ambitions, the intended benefits for patients and how local organisations will work together to achieve this. At the same time, it builds on the work we are already doing across each of the three areas, using patient feedback and insight from past engagement and consultation activity, as well as clinical best practice, to inform key areas of focus.

BOB STP is a large foot print comprising three well developed local health economies (LHE) with established governance arrangements and a track record of

delivery. Relationships are well established with local authorities and the voluntary and third sector, who are key STP delivery partners. Collectively, there are 27 statutory organisations supporting the work of the STP (see Appendix A for details).

Delivery of the STP plan will take place at LHE level where relationships with provider trusts and local authorities are well established and the transformation of primary care can best be supported. The STP welcomes the flexibility provided in the planning guidance for large STPs to operate through sub-divisions with their own financial control totals and this is the model BOB will adopt. Clinical commissioning group (CCG) operating plans will provide substantial detail on how this will be achieved, with this submission providing an overview of LHE programmes.

In this context BOB STP has three core functions:

1. Delivery of BOB wide programmes that require the scale of the footprint to have maximum benefit.

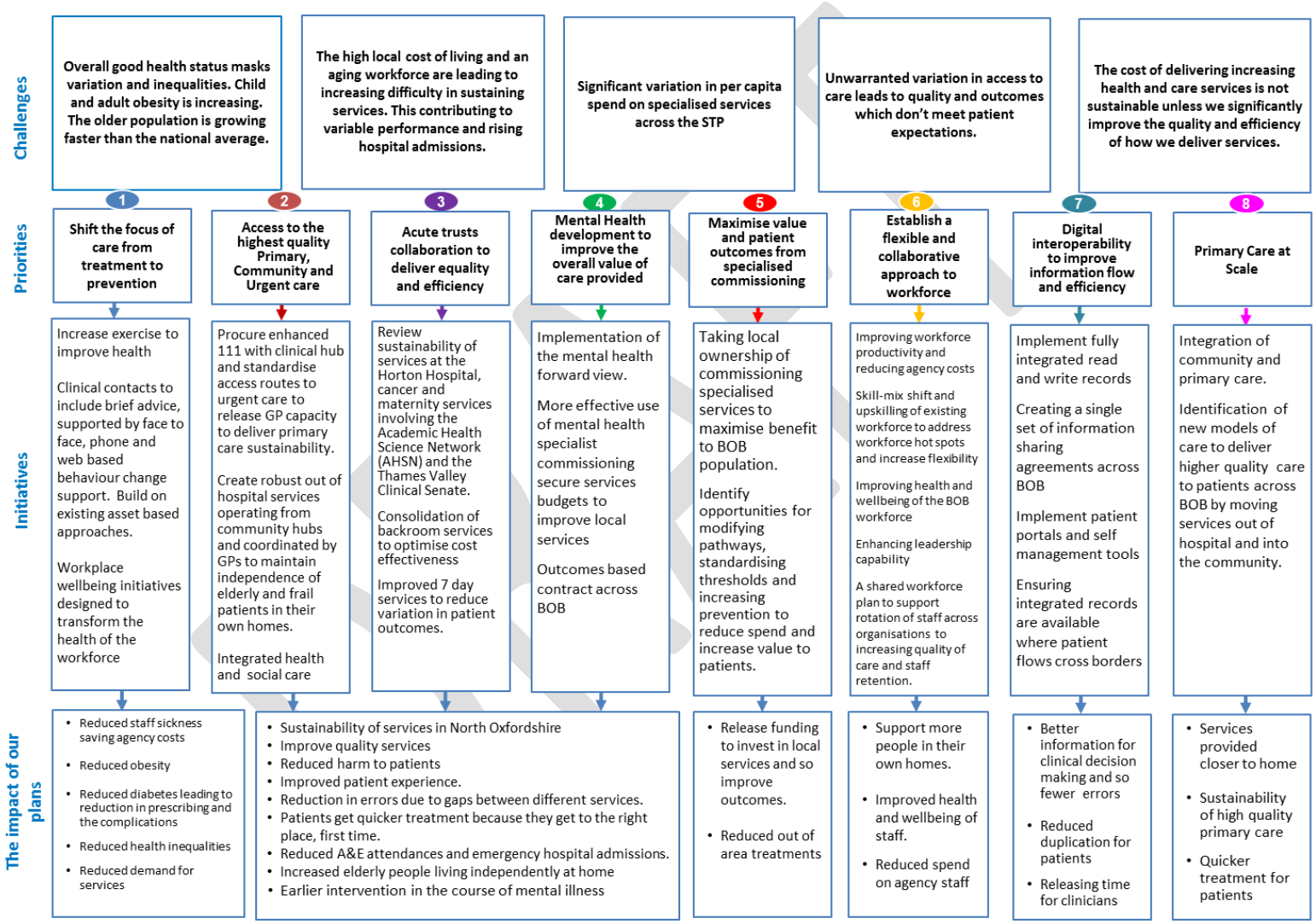
2. Establishment of an STP wide planning and commissioning function for services such as cancer, stroke, ambulance and 111, through a joint CCG Commissioning Executive.

3. Identification, adoption and spread of innovative practice, mobilising the expertise and support of arm's length bodies.

For specialist health services, clinical networks extend beyond the boundaries of the BOB footprint and therefore we are collaborating with other STPs, using established clinical networks, such as those supported by the Oxford AHSN and specialist clinical networks, as well as participating in national new care models, such as secure mental health, to coordinate national activities with neighbouring health economies.

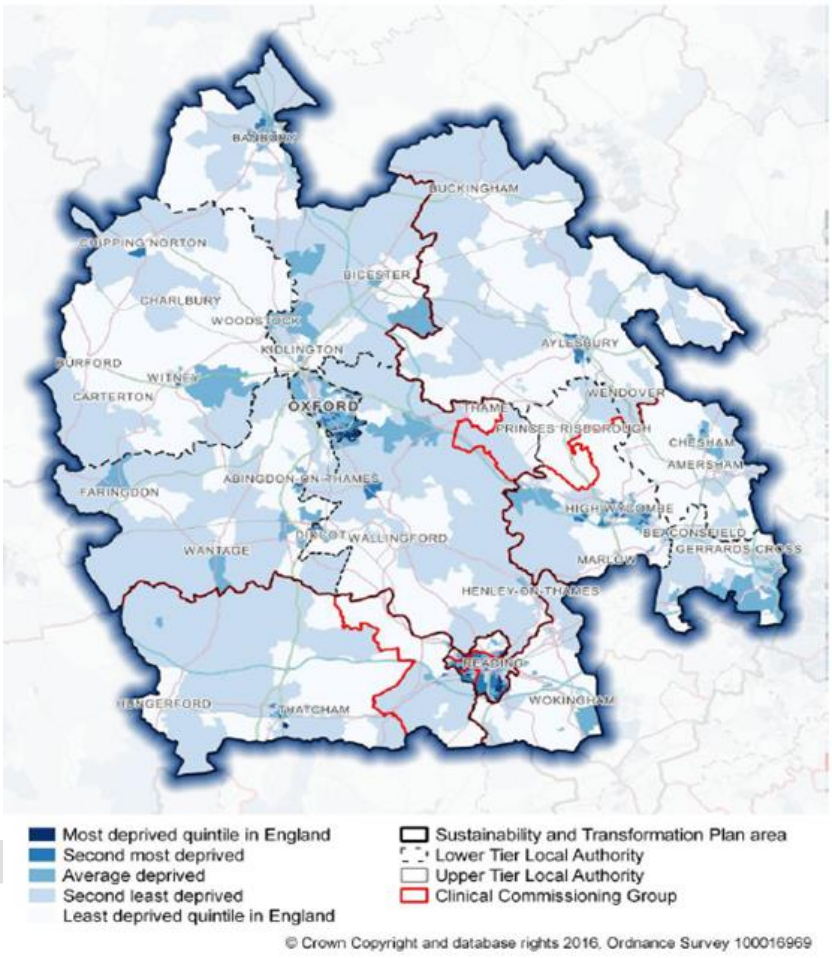
This plan describes how BOB wide programmes and work in local health economies are integrated to bridge the gaps in health and wellbeing, care and quality and sustainability.

3. The Buckinghamshire, Oxfordshire and Berkshire West STP on a page



4. The Buckinghamshire, Oxfordshire and Berkshire West footprint

4.1 The BOB geography



- **1.8 million population**
- **£2.5 billion budget**
- **7 clinical commissioning groups**
- **6 NHS trusts**
- **14 local authorities**

The BOB STP footprint covers a population of 1.8m people living in a mix of urban centres and rural areas.

Our major population centres are in the towns of Aylesbury, Oxford and Reading, however 22.74% of our population lives in market towns, villages and more rural

areas. Due to the proximity to London and the number of universities, there is a large transitory population across the area. These are both important factors to consider when it comes to planning health services, such as ensuring access to GP surgeries. A further consideration is the scale at which different health and social care services operate in relation to the type of care offered, the number of patients seen and the length of treatment required.

The BOB footprint is surrounded by nine other STPs (Gloucestershire; Bath, Swindon and Wiltshire; Hampshire and the Isle of Wight; Frimley Health; Coventry and Warwickshire; Northamptonshire; Milton Keynes, Bedfordshire and Luton; Hertfordshire and West Essex; and North West London) with whom we will work with to deliver this plan. This is important to ensure that neighbouring communities, who may use our services, can benefit from the intended outcomes of this plan and are supported to achieve improved health outcomes for years to come.

4.2 The health of our population

Compared with many parts of the NHS, we have a healthy population and life expectancy is better than the England average. There are, however, areas of deprivation with some people suffering poorer health outcomes than those in more affluent areas.

We know that much disease is preventable and there is more that we can do around this. Diabetes, for example, is increasing and a significant contributory factor is obesity. Two thirds of our adult population are either overweight or obese and in all our local government areas across BOB, this has doubled in recent years.

A challenge for the NHS across England is the growing population, in particular the number of people over the age of 85. It is a great success story that we are all living longer, however, in doing so, people must be supported to live healthy lives. Across our area, 2.2% of our population is over 85 and this is set to increase by 22% by 2020 to approximately 49,000.

Another area of growth across our area is housing, which will result in our population increasing by 3% by 2020. This in turn will increase pressure on transport, making the case for care closer to home progressively important. For example, Wokingham Borough Council have published a local plan that provides for an additional 15,000 houses in the next ten years with more likely to be added.

Collectively, the above factors will result in rising demand for services and treatments that need to adapt to the changing needs of our population.

Tackling these lifestyle factors and areas of growth is a key element of our plan, in which we seek to shift resources, where appropriate, from treatment of people when they are unwell into prevention before they become ill or are experiencing the early onset of disease.

4.3 Accelerating health and economic gains across our area

The STP area is part of the Oxford AHSN through which the NHS, universities and industry work together to turn innovations into everyday practice. It is also home to

world leading science and innovation in clinical care, which is supporting economic growth of the region.

We have evidence that local lives are improving and our area is becoming a better place to live and work. There is a strong correlation between economic prosperity and health, with better care resulting in improved patient health outcomes and less financial pressure on the health and social care system.

This is a driving factor in successful delivery of our plan and we will work with the Oxford AHSN to pull on clinical excellence and innovative best practice to transform care and support new developments that are at the cutting edge of medicine.

The Oxford AHSN comprises clinicians and managers from the local NHS, universities and life science industry working across seven programmes and themes. Its eight clinical networks have almost 3,000 members from acute, community, mental health and primary care services. There is much to be proud of in our area, which includes a genomic medicine centre that is developing new forms of cancer care and the development of a new Biomedical Research Centre for mental health and dementia care.

The Oxford AHSN has been supporting the implementation of 49 innovations throughout the region, such as reducing the risk of blood clots after stroke, monitoring of diabetes in pregnant women, and improving more than 30 areas of patient safety, such as the prescribing of antibiotics for children, managing asthma in A&E departments, and reducing the causes and complications from sepsis and acute kidney injury. Oxford AHSN's three mental health networks have been recognised nationally for their leadership in improving clinical practice in dementia and early intervention in psychosis and recovery rates from anxiety and depression.

The Thames Valley Strategic Clinical Network (TV SCN) has worked with commissioners, providers, patients and third sector organisations to drive improvements in diabetes, cancer, mental health, stroke, vascular and other clinical areas. Working in partnership with Public Health England (PHE), Health Education England TV and the Oxford AHSN, the TV SCN has developed a commissioning guidance portal for use by the health economies, which benchmarks local practice and performance against key criteria, and outlines national and international best practice.

4.4 Organisation of the NHS in BOB

NHS services in BOB are delivered by a vast network of NHS organisations and independent contractors, together with some use of private sector companies for a number of surgical procedures. In addition, some patients access services across our borders, either because this is more convenient or because they choose to go elsewhere. Most patients are treated by organisations within our geography – our outflow of patients to hospitals outside of BOB amounts to only a small percentage of our spending. However, hospitals in our area also treat patients from other STP areas, most significantly through the specialist services provided by Oxford University Hospitals NHS Foundation Trust, some of which serve a catchment of 3 million people. Additionally, some providers in the BOB footprint, such as Oxford

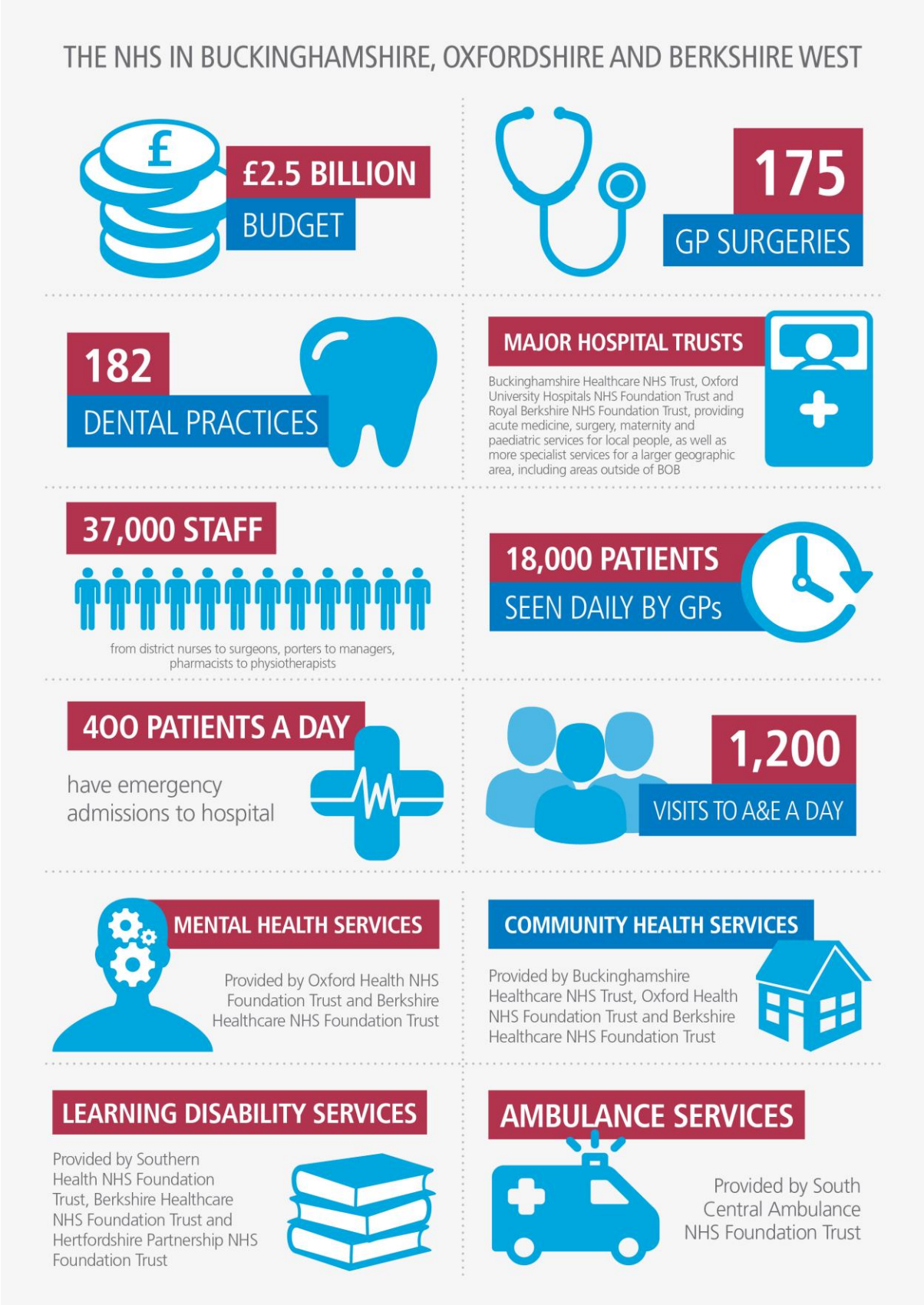
University Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust, deliver specialist services located in other STP footprints.

Our acute hospital services are provided from three main locations in Oxford, Aylesbury and Reading, together with some services provided in Banbury and High Wycombe. We see this as the pattern for future provision, however there will be changes to some services which will need to be consulted on by local CCGs. One of our BOB projects which is being led by the acute trusts will evaluate the level of unwarranted clinical variation in access.

Primary care services include GPs, dentists, opticians and community pharmacies. These are delivered at a local level so that they are accessible and can best meet the majority of people's day to day health needs. They also actively work with patients to prevent them from developing seriously illnesses through immunisations, smoking cessation and managing their long term mental and physical conditions. Across BOB, this excellent work results in our population having relatively few emergency admissions to hospital. This in turn means that we are making good use of our public funding.

Contracts with primary care services have been managed by NHS England across a large geographical area. However, to improve integration of primary care with other community services, CCGs across BOB are taking on the commissioning of primary care. This means we can work more effectively with federations of GP practices to bring additional services into the community and so tailor services to benefit patients. Naturally, much of this work is undertaken within local populations, however, to support delivery of this plan, we are bringing GP federations and other primary care providers and stakeholders together to identify areas where working at scale across our geography will add value.

4.5 The NHS in Buckinghamshire, Oxfordshire and Berkshire West



This vast array of services is commissioned by seven CCGs, NHS England and five local authorities.

5. BOB – a high performing system

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

The TV SCH has received strong support from local clinicians which has enabled them to support the implementation and adoption of innovative practice in a number of areas:

- The establishment of a BOB wide vascular service network that is now compliant with national best practice. A vascular Patient Related Outcome Measure (PROM) programme in partnership with Oxford University Hospitals NHS Foundation Trust is leading the way nationally in setting out how patient views are considered and incorporated.

- The long term conditions programme in partnership with Health Education England Thames Valley, has delivered change at scale and pace across the majority of CCGs in transforming the consultation between patient and clinician through care and support planning, delivering improved self-management, better clinical outcomes and improved job satisfaction for clinicians. Across BOB, around 90% of practices are trained in this approach.

- The development and inclusion of a still birth training package in the consultant midwifery training programme so that 100% of midwives are better able to deliver care to pregnant women in BOB and ultimately improvements to perinatal care.

- The Suicide Prevention Intervention Network, supported by the TV SCN and hosted by Oxford Health NHS Foundation Trust, is recognised as a national beacon of best practice.

- The Anxiety and Depression Clinical Network achieved recovery for an additional 2,659 patients in local improving access to psychological therapies (IAPT) between January 2014 and November 2015, despite a 16% increase in the number of patients accessing services and no additional funding.

See Appendix D for best practice case studies.

5.1 Partnership working

Partnership working across BOB is well established and will underpin the work of our plan over the next five years along with local clinical, research and commercial expertise. Our unique academic and commercial strengths in the region are fully

integrated into the STP with the Oxford AHSN, TV SCN, Health Education England TV and PHE involved at a granular level with each programme.

The partnership has already delivered a number of successes, including:

- Implementation of the national Diabetes Prevention Programme, whereby Berkshire West has been recognised as an exemplar and included in wave 1 of this national initiative. The learning from this has been shared through the TV SCN diabetes reference group, with additional submissions for wave 2.

- Innovation is being spread through the Oxford University Hospitals NHS Foundation Trust centre of global digital excellence, working with other acute hospitals across the BOB footprint and beyond.

- Health Education England TV dementia collaborative to tackle improved dementia awareness with training of over 35,000 staff across the Thames Valley. The TV SCN, working in partnership with Health Education England TV, has helped to increase the dementia diagnosis rate through innovation challenges to improve the physical environment of GP practices teamed with dementia training.

- Patient Safety Academy combined programme of training and safety improvement for 500 clinicians across Thames Valley.

- Thames Valley and Wessex Leadership Academy, the TV SCN and Oxford AHSN collaborative approach supporting 120 health professionals and lay people as patient leaders across the Thames Valley Leading Together programme.

- The Structural Genomics Consortium, winners of the Oxford AHSN Best Public-Private Collaboration Award 2016.

- The TV SCN End of Life network is working with commissioners on improving care to reduce poor experience, unwarranted unplanned admissions and so positively contributing to the urgent care agenda and financial challenge.

Thames Valley Strategic Clinical Network

As described in the national operating framework, clinical networks support local health economies to improve the health outcomes of their local communities by connecting commissioners, providers, professionals, patients and the public across a pathway of care / service area to share best practice and innovation, measure and benchmark quality and outcomes, and drive improvement.

Clinical networks have an important role in supporting the delivery of the Five Year Forward View at a local level, including new models of care, through their specific functions to:

- coordinate and support health and care systems to reduce unwarranted variation and improve cohesion between services within and across patient pathways

- enable clinical and patient engagement to inform commissioning decisions, including acting as an 'honest broker' to support commissioner and provider discussions
- provide support and guidance to health systems to review, develop and enhance care pathways where improvements in outcomes or efficiencies could be made
- support commissioners and providers to develop transformational programmes, in particular where benefits can be gained by working across commissioning boundaries.

Thames Valley Clinical Senate
The Thames Valley Clinical Senate covers Buckinghamshire, Oxfordshire and Berkshire, providing impartial, independent and evidence-based clinical advice to commissioners and providers on major service changes and transformation. It maintains a broad, strategic overview of the totality of healthcare within its geographical area, and beyond where appropriate for patient pathways. Its advice is provided on a whole system basis to ensure that:

- services will be sustainable
- service change is based on a clear clinical evidence base
- services will be accessible of a high quality enhancing the patient experience
- any proposed service change clearly articulates the benefits to patients.

The Senate also has a role in the NHS England function to support and assure the development of proposals and the cases for change proposed by commissioners. Service change is often highly complex and attracts high levels of public interest so it is important that schemes are appropriately assured so that communities can be reassured that schemes are of a high quality, align with best practice and will deliver the benefits expected. Clinical Senates will carry out a formal review of the service change proposals against the four tests from the Government's Mandate to NHS England (strong public and patient engagement; consistency with current and prospective need for patient choice; clear, clinical evidence base; and support for proposals from commissioners) and the best practice checks that relate to clinical quality. The Clinical Senate may be involved much earlier in the life of a scheme, providing impartial clinical advice as it develops.

Health and social care collaboration
Across BOB, NHS organisations and local authorities must work together as STP system leaders and delivery partners to support successful delivery of the plan. Local authorities are particularly involved in prevention and the support workforce and will be a driving force of improvements in these areas.

6. The case for change

There are a number of challenges facing our health and social care system, which require changes to be made to how we deliver local services. These challenges are as follows:

6.1 Our financial challenge

Although significant progress has been made since June and September 2016 in developing this STP, there is recognition that there is still work to be done in ensuring the plan is sufficiently developed and deliverable.

Resources provided by the Government to commissioners for purchasing health services total £2.55bn in 2016/17 and will increase to £2.87bn by 2020/21 (including primary care and specialist services), a composite increase of 12%. This increase is to pay for the increase in our costs as a result of population growth, inflation and technological advances, together with funding for elements of new national initiatives, such as implementing seven day working across the NHS, implementing the GP and Mental Health Five year Forward view objectives locally, some funding for these initiatives has been retained centrally.

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

Whilst we recognise that our STP finance plans should ideally balance provider and commissioner control totals, it is our understanding that these are still indicative for providers and have not necessarily been accepted by them. They have therefore not been incorporated into the provider submissions for this iteration of the STP. We acknowledge the need to reflect these system control totals into our operational plans and will work together in our local systems collaborate to achieve the efficiencies and savings necessary to operate within them. Equally whilst we recognise the recently issued CCG control totals we await the release of final CCG Allocations for the coming two financial years.

The STF funds supporting providers totalling £41m have been included in the 'Do Something' template for 2017/18 and 2018/19, while nothing has been assumed in 2019/20 and the entire £106m allocation included in 2020/21.

Our plan at the end of year 5 (2020/21) shows a surplus position of £11m.

Summary position year 5 (from templates)

BOB STP SUMMARY YEAR 5						
			£m	£m	£m	
Do Nothing Position					-479	
Do Something solutions					384	
Deficit					-95	
SFT Funding					106	
Year 5 Position - surplus					**11**	
Do Something						
BAU CIPs	2.0%		213			Solution 1
BAU QIPP	0.7%		63			Solution 2
		72%		276		
BOB Schemes						
Prevention			3			Solution 3
Urgent Care			2			Solution 4
Acute			7			Solution 5
Mental Health			4			Solution 6
Workforce			34			Solution 7
Specialist			60			Solution 8
Digital			-27			Solution 9
		22%		83		
Local Schemes						
Oxford			8			Solution 10
Berkshire West			5			Solution 11
Bucks			12			Solution 12
		7%		25		
Total					384	

The 'do nothing' scenario

The do nothing scenario includes 100% of the financials relating to each STP footprint CCG, plus Buckinghamshire Healthcare NHS Trust (BHT), Royal Berkshire NHS Foundation Trust (RBFT), Oxford University Hospitals NHS Foundation Trust (OUH) and Oxford Health NHS Foundation Trust (OHFT). It also includes a 50% share of Berkshire Healthcare NHS Foundation Trust and a 42% share of South Central Ambulance Service NHS Foundation Trust. The do nothing scenario results in a £479m deficit at the end of 2020/21.

Buckinghamshire, Oxfordshire and Berkshire West

Footprint Summary		Do Nothing					
		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Commissioner Surplus / (Deficit)	£000s	(8,434)	(1,171)	(71,963)	(115,200)	(161,462)	(194,042)
Provider Surplus / (Deficit)	£000s	(39,048)	(15,207)	(80,504)	(134,358)	(185,369)	(285,354)
Footprint NHS Surplus / (Deficit)	**£000s**	(47,482)	(16,378)	(152,468)	(249,558)	(346,831)	(479,396)
Indicative STF Allocation 2020/21	£000s						
Footprint NHS Surplus / (Deficit) after STF Allocation	**£000s**	(47,482)	(16,378)	(152,468)	(249,558)	(346,831)	(479,396)

The only financials relating to local authorities are as per the latest guidance, ie only the amounts invested in the Better Care Funds (net of amounts reinvested in the NHS).

The commissioner gap by 20/21 of £194m divides between Berkshire West CCGs (£59m), Buckinghamshire CCGs (£46m) and Oxfordshire CCG (£89m). The provider gap of £285m is split; OUH (£119m), Royal Berkshire NHS Foundation Trust (£45m), BHT (£61m), OHFT (£27m), Berkshire Healthcare NHS Foundation Trust (£21m) and South Central Ambulance Service NHS Foundation Trust (£12m).

The 'do nothing' scenario excludes STF funding in 2016/17 (normalised), with the normalised position being used as the baseline for provider organisations.
This submission does not reflect any changes that may result from the recent IR and HRG4+ exercise, the impact of which on allocations will be factored in to Operational plans.

The 'do something' scenario

(i) **'Business as usual' provider efficiencies (CIPs) (Solution 1)** of 2% (from 2017/18) amounting to almost £213m. 2016/17 CIPs are incorporated into the 'do nothing' scenario.

	2017/18	2018/19	2019/20	2020/21
Provider CIPs	£k	£k	£k	£k
Workforce - Substantive and Bank	20,221	37,569	55,717	73,770
Workforce - Agency	9,561	12,241	14,917	17,807
Drugs	736	1,472	2,108	2,793
Procurement (Non Pay)	14,653	28,922	44,231	60,001
Capital (Revenue Cost)	463	8	217	1,365
Litigation				
Provider Other	10,761	19,673	28,091	36,400
Provider Income	11,570	14,292	17,942	21,536
Total	67,965	114,177	163,223	213,672

(ii) **'Business as usual' CCG (QIPP) savings (Solution 2)** of 0.7% amounting to £63m. This as shown on the QIPP line is less than the 1% planning guidance as amounts relating to the local transformation

programme are incorporated in those solutions. QIPP programmes are a combination of Transformational and Transactional plans and also incorporate Right Care ambitions where these have not been factored in to local or BOB wide transformation schemes. It is important to note that QIPP savings are shown net of their impact on NHS providers which recognises that providers will be left with stranded overhead costs where QIPP is based on reducing activity.

	2017/18	2018/19	2019/20	2020/21
Secondary Care	£k	£k	£k	£k
Acute - NHS	-15,037	-26,042	-35,640	-45,268
Acute - Non-NHS	-413	-837	-1,270	-1,706
Mental Health - NHS	-338	-684	-1,038	-1,395
Mental Health - Non NHS	-	-	-	-
Community Health Services - NHS	-459	-929	-1,410	-1,895
Community Health Services - Non NHS	-100	-200	-300	-450
Other NHS	439	377	314	250
Continuing Care	-2,700	-3,950	-5,200	-6,450
GP Prescribing	-3,900	-7,571	-11,263	-14,963
Other Primary Care	-250	-500	-750	-1,000
Running Cost (Admin)	-671	-1,345	-2,022	-2,700
CCG Other	-250	-250	-250	-250
Social Care Expenditure	-170	-343	-521	-700
Total CCG expenditure adjustment	-23,848	-42,274	-59,350	-76,526
Net effect on providers	2,773	6,495	9,803	13,140
Net savings	**-21,075**	**-35,779**	**-49,547**	**-63,386**

The financial gap after business as usual provider and commissioner efficiencies therefore drops from £479m in 2020/21 to £203m.

(iii) BOB wide system solutions £83m (22% solution)

Further work has been done on costing the impact of our BOB wide transformation plans and ensuring there is no double counting between the organisational CIP and QIPP plans and local system plans. The current iteration assumes net savings as follows:

- **Prevention £3m net savings in each year (Solution 3)**

The prevention priorities across BOB are mobility, obesity and physical inactivity. However this financial submission incorporates a wider set of interventions (eg diabetes and tobacco) for a number of reasons:

- Obesity and physical inactivity tend to generate savings over a longer time period and in the STP the time period for savings are five years, therefore

the requirement to generate short and medium term savings requires other programmes to be included. PHE have produced evidence across a range of themes that are nationally supported to address ill health and these can be delivered as part of a joined up obesity / physical inactivity approach through health care and digital settings efficiently. The savings are derived from national models, with local interpretation. The key areas reflect key lifestyle behaviours that underpin long term conditions and drive NHS usage and also have PHE / NICE models that back the savings. Savings associated with work based interventions (notably in Oxford) are incorporated within the BAU CIPs and are therefore not duplicated under prevention. These savings are also excluded from the savings attributed to the workforce programme.

- The national Diabetes Prevention Programme identifies patients through general practice and supports those patients with abnormal sugar levels to address weight and exercise. Using the national diabetes tool, savings are seen by the end of year five: costs are not included as these are nationally funded for the duration of the STP. The assumption is that Buckinghamshire and Oxfordshire are members of the phase 2 programme (Berkshire West is within the first phase of the programme). The savings associated with this are £1.03m by year five.

- It is well recognised that tobacco cessation is one of the most effective ways to improve health. Whilst most savings are calculated on the medium and long term impact, savings can be delivered in year within health care settings if a focussed and concerted effort is made on reducing significantly the number of smokers who have surgical interventions. This investment would see a new programme run in conjunction with surgical departments within hospitals and primary care to contact and support all surgical elective admissions to stop smoking. The savings of £1.7m attributable to a reduction in smoking are based on a study by Moller et al applied to local activity.

- The health care costs of physical inactivity are modelled by the national Health Impact of Physical Inactivity Model and outline yearly costs driven by the number of major long term conditions and subsequent costs due to physical inactivity, such as cancer, cardiovascular disease. The savings of £430k are annual but the assumption is that this will not be achieved until year five of the STP, when it will then be recurrent.

- **£1.8m from urgent care schemes; (Solution 4)**

The savings of £1.8m have been calculated based on national guidance assumption that integrated urgent care will save £122m nationally (BOB is

3.3% of the national population), less the BOB proportion of the cost pressure associated with the reprocurement of the new Thames Valley 111 service. This results in a gross saving to commissioners of £2.5m, reduced to £1.8m through the assumption that providers can only reduce costs by 70%.

- **£7.2m from acute services (Solution 5)**

The savings associated with the BOB wide acute services solution are based on a number of initiatives including:

(i) Procurement, including drugs, particularly biosimilars and elderly care supplements

(ii) Sharing good practice and driving out variations in clinical practice and outcomes on specified clinical pathways, ensuring services are managed effectively and seamlessly across entire clinical pathways. The system is looking to roll out OARS, an electronic referral system between acute trusts.

(iii) Strengthening collaboration around the urgent care pathway and its associated clinical pathways with an initial focus on stroke.

(iv) Collaborative working on clinical support services, particularly pathology and radiology. The development of a collaborative interventional radiology service is an early priority. The Oxford AHSN imaging clinical network is progressing the development of improved image sharing across the network.

The savings of £7.2m are over and above the BAU provider CIPs identified in Solution 1.

- **£4.0m from mental health (Solution 6)**

The use of outcomes based contracts in mental health and moving to lead provider contracting arrangements for forensic services is estimated to save £4m across the BOB footprint. This is on the assumption that all the savings associated with this are on a place based methodology and therefore are assigned to the BOB system.

- **£34m workforce savings (Solution 7)**

Inevitably, substantial workforce savings have already been incorporated into provider CIPs. This additional £34m is derived from the following costed plans:

(i) Skill mix changes to support a more flexible workforce – use of generic support workers (across health and social care), reduction of nursing grade input, increased use of healthcare assistants and physicians associates and more flexible use of emergency care practitioners and advanced nurse practitioners.

(ii) Enhanced leadership capability

(iii) Jointly agreed terms and conditions (1%)

(iv) Introduction of a strategic framework for overseas recruitment (initially nursing and it is only the impact of this element that is currently factored in to then plan)

(v) BOB wide staff 'Bank' to further reduce agency costs.

- **£60.2m in savings from specialised commissioning (we are assuming this excludes the estimated savings from the New Care Models in Mental Health referred to in solution 6) (Solution 8).**

The 'do nothing' scenario by STP sets out the financial impact of assumed growth based on national indicators for population growth for the CCGs in the STP. In order to close the specialist gap to break even, we are planning for both transactional and transformational QIPP, which will be cumulative over the duration of the STP.

QIPP has been set at c3% for all providers across the STP and for the duration of the plan. This is split down as follows:

- Transactional – For year one, this will be 1.5% inclusive of c1% for high cost drugs and devices – leaving a balance of 0.5% to be delivered via other transactional means. In future years, we would anticipate transactional QIPP at no more than 1%.
- Transformational – For year one this will be 1.5%, increasing over time.

The split is even across providers at the moment but transformational schemes may have a greater impact on certain services and this will be reflected in reporting during the course of delivery of the STP.

- **Digital – Cost of £26.8m (Solution 9)**

No savings have been identified in relation to the digital work stream. This is a cost to the system which is now shown as a cost pressure as original capital bids have now been moved to revenue. The local digital roadmap is seen as an enabler to support the delivery of savings elsewhere through the use of (for example) e-consultations, or self-care apps. Some of the projects within the Digital Transformation GP IT programme which produce benefits for patients, public and clinicians, such as GP Online, the electronic prescription service and GP to GP record sharing and infrastructure upgrades, will support more efficient ways of working to clinicians or support ease of use for patients. The benefits, however, are non-cash releasing to the local economy.

(iv) Individual local system solutions £25m

- **Oxfordshire transformation programme £7.9m (Solution 10)**

The Oxfordshire transformation programme covers six work streams: urgent and integrated care; planned care; primary care; maternity; children's services; and mental health and learning disabilities. New models of care are currently being worked up and will be subject to

public consultation in early 2017. We have estimated savings based on current working assumptions about a shift of acute activity away from the John Radcliffe and Horton hospitals – initial work has focused on savings from avoiding A&E attendances and non-elective admissions, with further work to be done on planned care and community hospital efficiencies. Savings relating to potential changes to the clinical model within the main acute provider are included within OUH's CIPs. The £7.9m estimated is after allowing for stranded costs which we expect to be left in the provider sector as activity shifts into community settings and after also allowing for the marginal cost of new and enhanced community services designed to enable the transformation.

- **Berkshire West Accountable Care System £6.9m gross (£5m net of provider impact), (Solution 11)**

The Berkshire West Accountable Care System sets out a complete transformation of how the NHS organisations within Berkshire West will work and transact with each other. It has established a single leadership and management team with an independent chair and comprises the following work streams:

(i) Clinical improvement including the frail elderly pathway – a new model which evaluates new ways of providing services to these patients and delivers savings of £5.6m over five years. Further new models of care are being developed including:

i. Reducing frequent NEL admission
ii. New respiratory pathway
iii. Enhanced GP / consultant interface
iv. New model for crisis care
v. Dealing with on the day demand more appropriately
vi. Clinical review of services with low value
vii. Transformation of the outpatient function
viii. Planned care pathways, such as musculo-skeletal and ophthalmology
ix. Review of whole system bed stock and usage
x. Redesign of system wide use of diagnostics.

(ii) Workforce – largely back office services – anticipated to deliver savings of £1.25m per annum and new roles including generic support workers between health organisations and across health and social care (yet to be evaluated)

(iii) Prevention – focus on areas such as alcohol, brief intervention, cardiac early detection, stroke and falls which are aimed at delivering savings of up to £1m per annum in the five years of this STP (over and above the BOB wide savings).

The Berkshire West sub system of the STP is keen to agree a System Wide Control Total and will be submitting a bid to do so as required by 31 October.

- **Healthy Bucks Programme £12m (Solution 12)**
  The Buckinghamshire health and care system plan 'One Buckinghamshire, One Integrated Health and Care System', covers four transformational programme areas – reforming urgent and emergency care, planned and specialised care, integrated health and social care commissioning and delivery, and self-care and prevention, with three underpinning infrastructure programmes – estates, workforce and technology-enabled change.

These programmes are being developed across the public services system particularly with Buckinghamshire County Council.

The transformational programmes focus on:

- implementing the top six priorities within the refreshed health and wellbeing strategy through the promotion of healthy lifestyles, building self-help and tackling inequality and well-being.
- shifting spend on bed-based care into prevention and care at home
- integrating health and care services avoiding unnecessary steps in pathways to reduce waste and duplication and improve access for children and families, and reduce acute hospital utilisation through redesign of community hospital care and investment in community and primary care
- delivering urgent and emergency care services in the right place at the right time.

(iv) Estates

The work on estates has been progressed with NHS Property Services and the STP endorses the contents of the estates document being submitted through the Estates Programme Board.

1. Investment in national priorities

2017/18 onwards reflects our investment in national priorities which reaches £50m per annum by 2020/21 – details are shown in the table below.

Investments		2016/17	2017/18	2018/19	2019/20	2020/21
Seven Day Services Roll Out Through To 2019/20	£000s	-	-	-	2,782	5,564
Taking Forward The Programmes Set Out In The General Practice Forward View and Delivering Extended GP Access	£000s	-	5,846	5,846	7,237	10,019
Increasing Capacity Of Children And Adolescent Mental Health Services And Implementing Access and Wait Targets For Eating Disorders Services	£000s	-	5,581	6,566	7,223	8,011
Implementing The Recommendations Of The Mental Health Taskforce	£000s	-	2,782	4,173	5,564	6,955
Cancer Taskforce Strategy	£000s	-	4,279	5,190	6,177	6,975
National Maternity Review	£000s	-	2,782	4,173	5,564	6,955
Investment In Prevention, Tackling Childhood Obesity, And Improving Diabetes Diagnosis and Care	£000s	-	1,391	1,391	1,391	1,391
Local Digital Roadmaps Supporting Paper Free At The Point Of Care And Electronic Health Records	£000s	-	4,173	4,173	4,173	4,173
			26,833	31,511	40,110	50,041

These investment plans are net of any savings; we recognise that some associated funding streams have been retained centrally and are not reflected within current published CCG allocations.

2. Capital

The capital investment reflects the current provider and CCG plans. This includes £150m investment linked to the Oxfordshire transformation programme for the redevelopment of community hospitals. Estates and technology transformation fund (ETTF) applications have also been reflected.

The STP incorporates:

- a status of readiness to proceed assessment for each scheme, including a statement in respect of consultation readiness
- evidence base where available for the investment proposals, including a link to savings set out in solutions, risks to the achievement of such savings and relevant plans for mitigation of those risks
- phasing and anticipated sources of capital, such as property sales and ETTF
- return on investment and payback period of each scheme where available
- revenue consequences of capital investments have been fully incorporated in to the relevant solution.

3. Workforce

Workforce numbers would increase by 4,527 wte (11.7%) under the 'do nothing' scenario. Solutions mitigate the increase by 3,549 wte by the end of 2020/21 resulting in a forecast 'do something' increase of 978 (2.5%). Not yet fully reflected in the STP are skill mix changes that will result from transformation plans. Our plans also reduce agency costs by £17.8m.

4. Further work required

(i) Further develop CIP and QIPP plans particularly in years 2018/19 to 2020/21 – the assumptions made in our plans reflect the national guidance of 2% provider efficiencies and 0.7% commissioner activity reductions, which given the continued increasing pressures on demand that we are seeing locally, make these extremely challenging. Commissioner QIPP savings of £63m currently could appear under ambitious and we need to ensure that these appropriately reflect any further opportunities from 'Right Care' addressing unwarranted variation.

(ii) Further development of BOB system wide plans - although project charters have been developed for each of these work streams, these now need further development and rigour that will be provided by the development of business cases with robust financial, workforce and activity assumptions and plans that support their current and future level of intent. Although the specialist commissioning plan is looking to generate £60m savings this needs further testing to ensure it is real. This will be done through the use of benchmarking using available data on spend per head / allocation distance from target to calculate quantum of potential activity reduction.

(iii) Impact of HRG4+ IR rules values will need to be factored in to operational plans.

(iv) Impact of control totals of providers. These have not yet been agreed and the impact on the baseline position needs to be further reflected.

(v) Further development of local system wide plans.

5. Risks

Financial risk share / control totals

We will develop our approach to managing financial risk across the footprint up to and including the operation of shared control totals both at STP and local health economy level, building on existing local arrangements on sharing financial risk and the control total arrangements set out in the planning guidance. It is recognised that to do this properly we need to do more work to:

- Understand the future risk profile and existing options available already to manage financial risk collectively, eg through contracting arrangements or through collaborative commissioning or the gain share on specialist services.

- Agree the framework and fiscal environmental conditions that would trigger an application to a shared control total and the expectations on systems that do apply and

- Have clearly documented the risks, benefits and governance so that all organisations can formally agree.

We wish to explore with NHS England and NHS Improvement how the control totals set for CCGs and trusts can best be used to enable us to deliver our STP whilst balancing the ability to manage financial, operational and quality risk in the whole system and for individual organisations.

As an STP with significant specialist service spend, we need to be clear on the risks and benefits of the inclusion of this into the system risk profile. Berkshire West, through the development of its Accountable Care System, is the most advanced in developing its approach and wishes to operate with a single control total for 2017/18. Buckinghamshire is exploring the evolution of the risk share in place in 2016/17 between the CCGs and the integrated acute and community provider and Oxfordshire is evaluating the impact on the risk profile to its health economy of the inclusion of specialist spend at the Oxford University Hospitals NHS Foundation Trust as well as progressing plans for transformation in Oxfordshire.

6.2 Our workforce challenge

The NHS is the largest employer across the BOB area, directly employing 34,000 staff, as well as a further workforce of 3,500 staff across GP surgeries.

Despite this large number, we have significant workforce challenges, due to the high cost of living and housing prices in our area. We also have a high staff turnover rate of 14% due to an ageing workforce and the accessibility of London which pays premium salaries.

Across many professions there are high levels of vacancies, meaning that posts have to be covered by agency staff. This adds to our financial bill and in a number of disciplines there is a national shortage of staff which further affects our ability to recruit. This has particularly affected the Horton Hospital in Banbury where there are ongoing issues with recruiting to junior doctor posts, as well as in Wycombe, where a temporary shortage of midwives led to the transfer of births from a midwifery led unit to Stoke Mandeville in the summer of 2016.

We already have an ambitious workforce programme which is aimed at improving recruitment, aiding retention of existing staff and addressing skills shortages. This forms a key element of our STP and requires us to build on our close work with the higher education sector in the fields of under graduate and postgraduate teaching, and utilise the strengths of our world class higher education institutions.

We will also build on the work we are undertaking with local authorities on joint strategies for developing our paid care workforce and recognising the valuable role of carers.

7. Our vision

Our vision is to improve health outcomes and add value by working together and in doing so close the health and well being, care and quality and financial gaps.

By this, we mean:

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

8. Transforming care, our ambition

Our ambition, subject to engagement with local clinicians, patients and the public, is to co-design and implement new models of care to address the challenges facing our health and social care system. This would help us to implement our priorities in an integrated way to get greatest benefit for our patients. Under the proposed new models of care, we will seek to do the following:

- **Prevent ill health**, with a particular focus on obesity to reduce demand for services over the medium to long term.

- **Standardise access to urgent care** so a range of well-informed clinicians can safely diagnose and prescribe treatment while minimising the number of duplicated consultations a patient receives. This will release GP time so they can work together at scale, become more integrated with community services operating out of community hubs and focus on people with more complex conditions. GPs will also be able to call on an increased number of home carers to enable more people to be cared for in their own homes rather than being sent to hospital. In the long term, this will avoid the cost of building and running additional hospital wards.

- **Centralise back office functions** to deliver savings by procuring at scale, such as using the Shelford Group framework.

- **Undertake meaningful engagement and consultation activity** on services, such as those at the Horton Hospital in Banbury, community hubs in Buckinghamshire and community hospital provision in Berkshire West, to help inform decisions on the commissioning of future services.

- **Increase efficiency** by commissioning, where appropriate, at scale across the BOB geography. For example, there is significant variation in spend from £175 to £290 per patient for co-commissioning specialised services with NHS England. Benchmarking higher than the national average, we have an opportunity to work across the geography to manage demand and identify alternative pathways of care. We have already started to do this in specialised mental health secure services, with OHFT managing the budget. We are also reinvesting in local services and supplementing increases from CCG allocations to support delivery of the Mental Health Forward View.

- **Improve our workforce offer and increase staff retention** by working with trusts and Health Education England TV to improve recruitment, standardise terms and conditions and offer employees interesting rotational opportunities.

- **Provide digital solutions** for self-care, virtual consultations and interoperability to increase patient access to information and reduce duplication and travel.

The proposed new models of care have been informed by:

- information from patient and public feedback from previous engagement and consultation activities, such as 'Your Community, Your Care' in Buckinghamshire, the 'Big Conversation' in Oxfordshire and Call To Action events in Berkshire West.

- engagement with our clinicians who see patients everyday and understand how services can be improved.

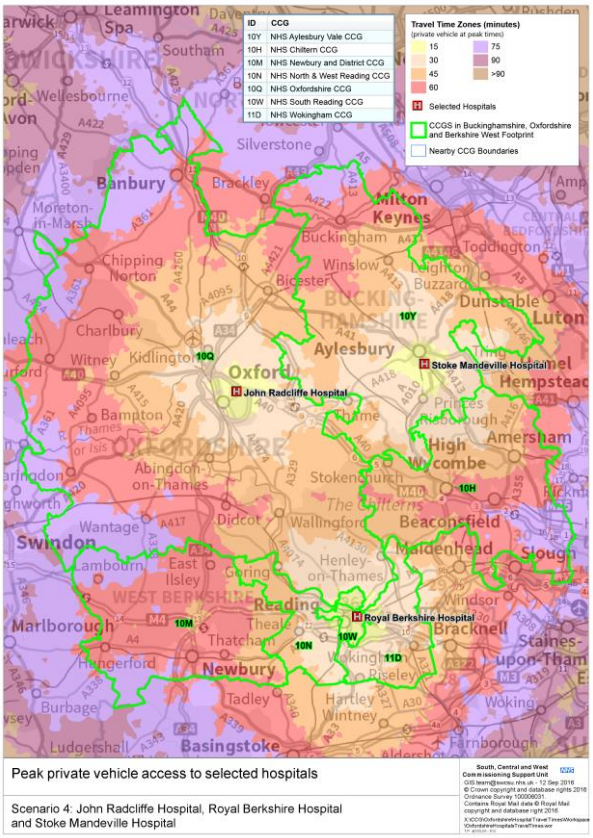
- strategic health needs assessments and health and wellbeing strategies from across BOB.

- input from

- the Thames Valley Clinical Senate
- the Oxford AHSN to provide the evidence base
- the Thames Valley Urgent and Emergency Care Network.

Our configuration of acute hospitals means that 96.1% of the population is within 60 minutes' drive time of acute services, which limits the changes that are required as part of our proposed new models of care.

The below map shows that the three principal major acute hospitals are well distributed across the BOB footprint to optimise access for the population as a whole. There are no obvious overlaps or duplications.



The following diagram highlights travel times between acute hospital sites with A&E departments in the BOB footprint and other areas, demonstrating a good distribution of services.

Travel times between providers

Travel times between A&E sites	John Radcliffe Hospital	Horton General Hospital	Royal Berkshire Hospital	Stoke Mandeville Hospital	Milton Keynes General Hospital	Great Western Hospital Swindon	Wexham Park Hospital Slough	Luton & Dunstable Hospital
	(OX3 9DU)	(OX16 9AL)	(RG1 5AN)	(HP21 8AL)	(MK6 5LD)	(SN3 6BB)	(SL2 4HL)	(LU4 0DZ)
John Radcliffe Hospital		41	60	41	60	55	50	68
Horton General Hospital	41		80	60	50	74	67	74
Royal Berkshire Hospital	60	80		63	86	48	40	66
Stoke Mandeville Hospital	41	60	63		39	87	44	47
Milton Keynes General Hospital	60	50	86	39		92	64	28
Great Western Hospital Swindon	55	74	48	87	92		66	93
Wexham Park Hospital Slough	50	67	40	44	64	66		43
Luton & Dunstable Hospital	68	74	66	47	28	93	43	

30 mins or less- potential for collaboration (travel time not a barrier)

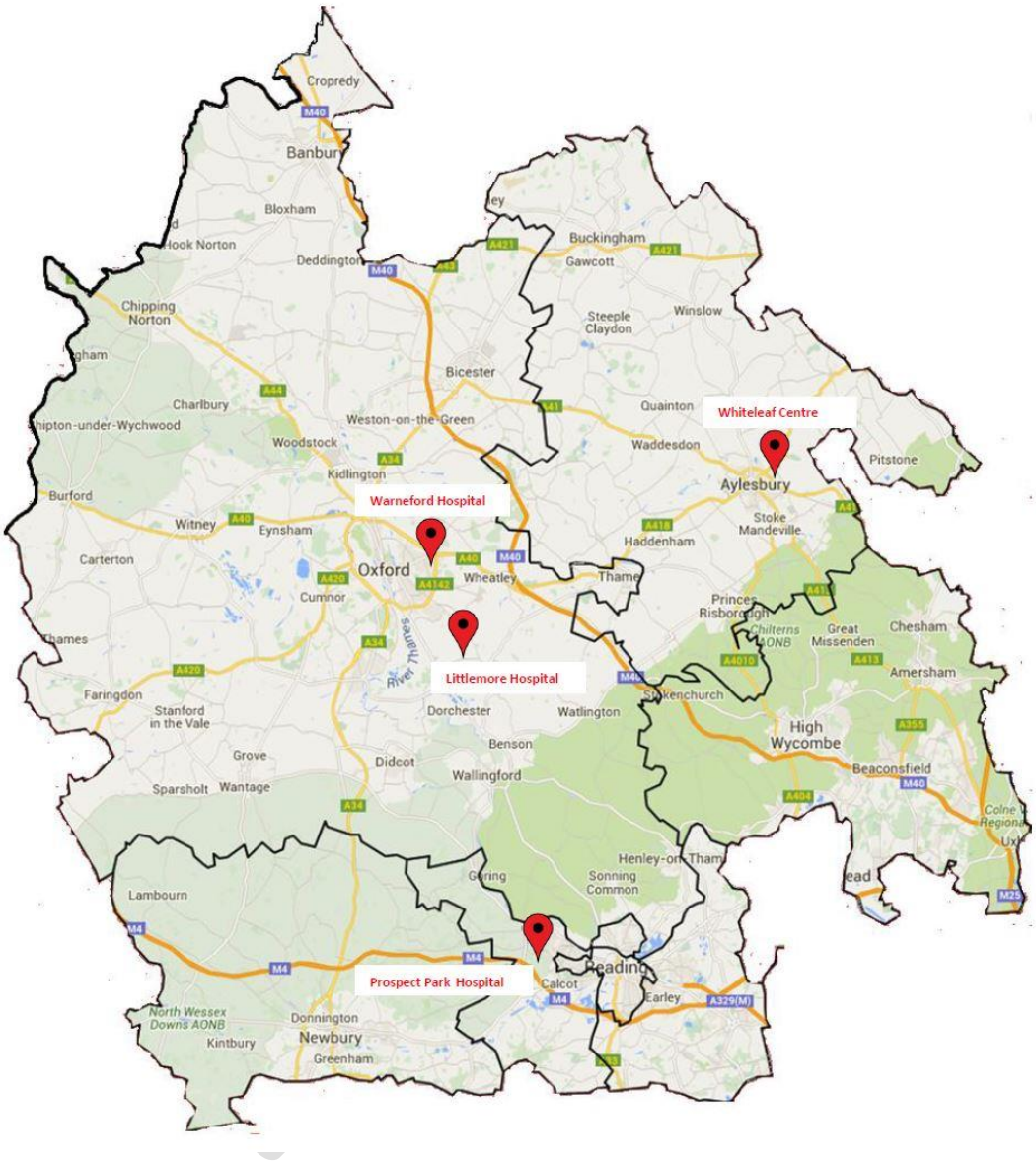
30-45 mins - potential for collaboration of tertiary services

45-60 mins - potential for collaboration

over 60 mins - limited potential for collaboration

Opportunities for making savings from within existing mental health services are minimal as the trusts acute bed base already benchmarks well (low) and is geographically distributed across the STP appropriately. This is therefore an effective model we want to continue.

Diagram showing mental health in-patient sites across BOB



- Whiteleaf Centre, Buckinghamshire local mental health services
- Warneford Hospital, Oxfordshire local mental health services
- Prospect Park Hospital, Berkshire local mental health services
- Littlemore Hospital, specialist mental health services

9. Proposed Buckinghamshire, Oxfordshire and Berkshire West programmes

To deliver our vision and ambition, we have identified a number of area wide STP programmes and new and existing work programmes that underpin our proposed model care. We are for the first time linking together these programmes as we are convinced that this will deliver the improvements we are seeking. Too often in the past our planning has not been joined up well enough with parts of the NHS working in isolation from each other. This leads to poor outcomes for patients and increased costs.

Our proposed programmes and supporting programme management structure will bring together under a single architecture:

- The transformation programmes in each of the three local areas
- The specific BOB wide programmes on prevention, urgent care, acute services, mental health, specialised commissioning, workforce, digital technology and primary care
- Other cross cutting work being undertaken by the Oxford AHSN; the strategic clinical networks run by NHS England; and the work of the Local Workforce Action Board.

For each of these proposed programmes we have developed project charters, with clear leadership, milestones and descriptions of benefits. Please see Appendix C for details of these.

These proposed programmes will reduce health inequalities by offering tailored 'packages' to different population groups. This is not a 'one-size fits all' plan. Failure to tailor our interventions to specific needs will result in worsening inequalities and must be avoided. The publication of a report from the Oxfordshire Health Inequalities Commission is due in autumn 2016 and is expected to be a source of more detailed recommendations to be taken up through this plan.

9.1 Summary of STP wide and local programmes and how they address our gaps

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
Prevention	• Reducing obesity • Rollout of the Diabetes Prevention Programme • Making every contact count • Digital approach for prompting to increase personal motivation • Healthy workplace programmes • Improved weight management	• All areas: reducing admissions from falls, alcohol, AF, hypertension, smoking • Buckinghamshire: life-course approach • Oxfordshire: utilise technology so patients can manage their conditions and self-refer to promote self-care, eg physiotherapy and podiatry • Berkshire West: alcohol care team approach and brief intervention to reduce hospital admissions	Reduce adult and child obesity and sedentary lifestyles Reduced inequalities as greatest benefit to deprived populations	Maintain mobility and independence Reduce avoidable ill health	Reduced cost of treatment of chronic disease Reduced staff sickness, bank and agency costs £3m benefit
Urgent Care	• Regional 111 including enhanced clinical hub and enhanced Directory of Services • Standardisation of clinical pathways • Designation of urgent and emergency care services • Urgent and emergency care competency framework • Establish interface clinician role	Buckinghamshire: • Out of hours integration with 111 • Front door A&E redesign to improve flow • Improve transitional care for those medically fit for discharge Berkshire West: New respiratory pathway Oxfordshire • Ambulatory 'by default' • Integrated single 'front door' • One hyper-acute stroke service delivering the best outcomes		Improved patient experience Reduced emergency admissions to hospital Reduction in errors due to gaps between different services	£1.8m net benefit
Acute Care	Reduction of unwarranted variation Maternity review led by TV SCN Pathology consolidation Back office procurement integration Specialised paediatric services provision	Oxfordshire • Horton Hospital sustainability (Emergency and urgent care, obstetrics and paediatrics) • Increase availability of a wider range of diagnostics in the community and locally delivered diagnostics available to GPs Buckinghamshire • Implementation of iMSK lead provider contract (£35m pa contract). EMIS system rollout for community services and diabetes • Increase range of diagnostic and outpatient services in local community hubs Berkshire West • Enhanced GP / consultant interface • Transformation of the outpatient function • Planned care pathways e.g. MSK, ophthalmology	Equity of access to planned care services Consistency of access, performance and outcomes across the specialist paediatric network	• Sustainability of services in north Oxfordshire • Improve quality service • Reduced harm • Better value • Maternity capacity • Improve pathology turnaround time	• Horton Hospital changes: cost neutral • Reduced unwarranted variation by 5% • Reduced hospital delays • Reduced paediatric admissions • Pathology efficiencies • Procurement savings • Overall £7.2m benefit

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
Mental Health	• More effective use of mental health specialist commissioning secure services budgets to improve local services • Outcomes based contract across BOB for mental health and learning disabilities	All areas: Increasing services where required as descried in the Mental Health Forward View.	Reduced inequality in patient outcomes	Increased wellbeing, more effective transitions between services Earlier intervention in the course of mental illness	• Reduced demand for mental and physical health services • £4m better value through mental health new care models on place based methodology
Specialised Commissioning	• Identify treatments where patient outcomes provide poor outcomes and low value for patients. • Identify alternative pathways providing better value for patients			• Reduce unwarranted variation • Improved patient experience and outcomes	Predicted 3% growth mitigated (£60.2m)
Workforce	• Increased support workforce • Establish flexible working across BOB • Overseas recruitment joint working	• Identify and eliminate duplicative or unnecessary activity • Move workforce around the system • Identify new and more efficient ways of working (including digital) to enable staff to manage more activity	Improved health and wellbeing of staff.	• Support more people in their own homes • Improve staff and patient experience	• Minimise, or eliminate, the use of high cost agency staff across the BOB geography • £34m benefit
Digital	• Interoperability • Draw inward investment into BOB, eg OUH Global Digital Centre of Excellence • Maximise benefits of technology, eg Bicester Healthy New Town • Enable individual GP practices to work at scale • Direct booking from 111 into general practice	Buckinghamshire: • Digital Life Science initiative to manage demand for primary care • Airedale telehealth to provide clinical advice to care homes • Baby Buddy App • EMIS adoption countywide as integrated primary and community IT system • Visibility of GP patient record across the system • Oxfordshire: Real time GP-consultant information in hospital	Empowered patient wellbeing and self-care through the use of personal health records Increased personal motivation	Reduced errors Better information for clinical decision making Reduced travel by using Skype	• Lower cost of services procured. • Reduced administrative and clinical time spent • Reduced emergency admissions • Reduced length of stay • £26.8m investment

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
Primary care	• Working at scale and coproduction of improved quality of care across healthcare • Scale up quality care for patients already occurring through the federations • Explore new models care	All areas: • Implementing the GP Forward View. • CCG / NHS England co-commissioning of primary care in all areas by April 2017 • Developing new approaches to on the day demand, population based health care, proactively managing individuals at risk, and enhanced support to care homes Buckinghamshire: • Integrated acute and community trust working with primary care • Development of community hubs in each locality • Visibility of GP patient record across the system • Health and social care in a single organisational system Berkshire West: • South Reading merged or federated arrangements will emerge using PMS • Wokingham neighbourhood clusters with shared posts, pooled back office • Newbury and District and N and W Reading: Workforce changes including a new role of GP administrative assistant and also clinical pharmacists. Oxfordshire • Develop a wider skill mix to allow GPs to operate at the top of their license • Primary care neighbourhoods connected to locality hubs • 'Primary Care Plus' to enable more out-patient consultants and non-consultant clinics in the community, supported by a local diagnostic service		Increased access over seven days a week Sustainable high quality primary care Quicker treatment for patients Increased GP job satisfaction and retention Reduced emergency admissions for older people	
New Models of Care		• Develop the established Accountable Care System (ACS) in Berkshire West to invest in transformation and share risk • Integrate health and social care commissioning and delivery system through the 14 projects in the Berkshire W10 Integration Programme • Deliver care close to patients' homes, shifting services into the community, such as community diabetologist, geriatricians and respiratory consultants in West Berkshire. • Create robust out of hospital services operating from community hubs integrated with primary and social care in Oxfordshire and Buckinghamshire • Review of Berkshire West community hospital provision		Provision of sustainable and high quality care	£63m combined CCGs QIPPs Additional transformation: • Oxfordshire £8m • Buckinghamshire £12m • Berkshire W £5m

For full details on each of the above work programmes, please see Appendix B.

9.2 Local population partnership working

In addition to these key transformational programmes, there is work being delivered across each local population that includes a huge range of initiatives aimed at improving the health of the population and the effectiveness of how services are delivered. This demonstrates where the bulk of the work will be undertaken to bridge the health and wellbeing, care and quality and financial gaps.

Buckinghamshire health and care system

- Co-designing new models of care with patients and communities.
- Jointly commission new service models based on different pathways of care and development of provider collaboratives.
- Multi-disciplinary teams of healthcare, social care and voluntary sector professionals working together in each locality with a single point of access to services, particularly for those at risk of hospital admission.
- Community hubs in each locality providing support for health and wellbeing initiatives, a base for integrated locality teams and expanded specialist support in ambulatory, outpatient and diagnostic care.
- More care and support closer to home reducing the reliance on community and hospital bed based provision.
- Single commissioning team for health and social care.

Oxfordshire's transformation programme

- Describes proposed future models of care in the following clinical pathway:
    - primary care
    - urgent and emergency care
    - planned, diagnostics and specialist care
    - maternity care
    - children's care
    - mental health, learning disability and autism care.
- Ensures health care in Oxfordshire is of high quality for all and provided on a sustainable basis.
- Brings forward proposals for consultation in relation to:
    - reductions in acute bed based care across Oxfordshire
    - service changes at the Horton Hospital in Banbury (part of Oxford University Hospitals Foundation Trust)
    - the development of community hubs based around GP populations across Oxfordshire.

Berkshire West

- System leaders clinical workshop to discuss, agree and define the pathway level opportunities for implementation in 17/18 and 18/19.
- Commence new approach to commercial / contracting agreements and formally apply for Accountable Care System control total and STP sub-division arrangements.

- Complete project ‘deep-dive’ exercise to ensure complete suite of clinical improvement project information is defined for implementation. Publish Accountable Care System programme plan and implementation roadmap.
- Formally sign new contracting arrangements.
- Pre-implementation activities progressed and completed.
- Implementation of new models of care.

9.3 Delivering national priorities at a BOB level

In developing our STP plan and proposed models of care, we have considered transformational opportunities across the following nationally identified priority areas, which along with improvements already achieved, are highlighted below:

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
Primary care	Primary care commissioners, providers, statutory representative groups and academic / improvement organisations are working together to develop, implement and imbed mechanisms and infrastructure for working at scale, identify and agree key target areas for service improvement, share proven good practice and implement transformational integrated improvement with measurable deliverables. This partnership is concentrating on securing adequate, trained workforce and system resilience, faster uptake of evidence based practice, streamlining of patient journeys and clear measures of the effectiveness, efficiency and patient benefits across care pathways. This will support the transfer of a greater portion of service delivery into primary care within integrated patient pathways. It also provides the forum, support structures and service	• Development of 'at scale' primary care services, with GPs working in larger alliances as lead co-ordinators of health and care. • Pilot 'Bucks GP Services' collaboration across groups of GPs to manage on the day demand. • Continued development of the use of QOF to support adoption of care and support planning. • All practices organised into hubs by 2018. • Buckinghamshire Healthcare NHS Trust is actively working with primary care to scale up effective joint pilot working between primary and community services, which are significantly reducing emergency admissions for older people. • Development of community hubs / NMC Buckingham, Aylesbury and Wycombe. • Creation of Fedbucks.	• Develop a wider skill mix to allow GPs to operate 'at the top of their licence'. • Scaling services and supporting practices to form primary care neighbourhoods connected to locality hubs. • Named GPs and neighbourhood teams for the 4% of the population with complex needs, together with the 1% of patients experiencing a health crisis. • Access to same day urgent appointments if clinically appropriate. • 'Primary Care Plus' to enable more out-patient consultants and non-consultant clinics in the community, supported by a local diagnostic service. • Use of technology, such as Skype, for tele-consultations and improve secondary care interface.	• Addressing pressures and creating sustainable primary care. • Interfacing in new ways with specialisms historically provided in secondary care to manage complex chronic disease in a community setting. • Working in partnership to prevent ill-health. Acting as accountable clinicians for the over 75s and other high risk patients and co-ordinating multi-disciplinary team to support patients at home. • Improving access and patient experience through new technologies. • Making effective referrals to other services when patients will most benefit.

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
	improvement and quality assessment expertise for joint working of organisations relevant to care pathways. Properly resourced integrated care in the community can be tested, adapted and scaled to provide enhanced services to the population for a variety of long term conditions.	• EMIS as system of choice for primary and community. • Local implementation teams for over 75s.		
Mental health	• Accelerating IAPT for people with long term conditions, working with Thames Valley Police and South Central Ambulance Service to improve mental health triage in ambulance and police dispatch and diverting people in crisis to appropriate local services. • We have identified additional investment to match CCG baseline increases. Increases in services will be tailored to local populations. • Improving outcomes in secure mental health units and prevent suicide.	• Integrated all age services and pathways for mental health and learning disability services. • Achieve parity of esteem with improved health and wellbeing for individuals with mental health, a learning disability or behaviours that challenge. • Initiate planning for re-provision of small learning disability or mental health care homes for medium sized fit for purpose units. • Integrated health and social care pathways to support autism. • Co-located health and social care teams for learning disability and mental health. • Community based-provision for those leaving residential educational placements. • Expansion of an outcome based mental health contract enabling patients to benefit from care quicker.	• Outcomes based contract for adults living with severe mental illness. • Psychological therapy and preventative wellbeing contract for mild to moderate anxiety and depression. • Oxfordshire's transformation plan for children and young adult mental health and wellbeing. • Transforming Care Plan for learning disabilities and autism.	• Local Future In Mind Transformation Plan offering early emotional health and wellbeing support in the community. • Additional specialist child and adolescent mental health services (CAMHs) staff recruited and trained, increasing the availability of evidence based interventions for children. • Reducing CAMHs crisis mental health presentations through swifter risk assessment of new referrals and better risk mitigation of new and existing cases. • CAMHs urgent response service pilot with referrals triaged quicker and same day urgent cases access help. • Developing admission avoidance care pathways with improved step up / step down arrangements with Tier 4 in

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
		• Comprehensive perinatal mental health services to ensure early intervention and better outcomes for mothers, their babies and families. • Public health programme to promote mental wellbeing to increase understanding of mental illness and prevention. • Adult psychiatric trauma services, eg historic abuse. • Development of primary care mental health liaison services to work with GPs for those with medically unexplained symptoms and other complex presentations. • Improve timely access to inpatient mental health services for those who present at A&E.		patient providers and social care. • Work in progress to reduce the number of children and young people who are admitted to hospitals and units out of area. • Joint commissioning of improving early identification and help for emerging emotional health and wellbeing problems. • Partnership working to enhance emotional and physical healthcare service to young people who are in contact with criminal justice and developing services to support Liaison and Diversion for young people.
Dementia	8,500 dementia patients and carers are getting better care following expert input from a specialist nurse and peer support. All memory clinics have been brought up to the standard of the best in the region through a comprehensive national accreditation programme. By January 2016, all six memory clinics with which the Oxford AHSN worked had been accredited by the Royal College of Psychiatrists (RCP) Memory Services National	• University of Bedfordshire has jointly funded a three year Nurse Consultant in Older People post focussed on research and clinical practice in dementia care. • New Clinical Director for mental health leading recovery plan – 'Project 414'. • New Memory Support Service commissioned and launched in April 2016 with focus on Chiltern practices.	• Reviewing the older adult mental health pathways with a view to developing separate functional and organic care pathways. • Commissioning with Oxfordshire County Council dementia service for post diagnosis support and advice to practices and other organisations to improve management of dementia. • Within urgent care work steam we have initiated work to	• Improving diagnosis rates to 67% by 31 March 2017. • Further raising awareness of recording Dementia diagnosis, mapping and improving referral routes into the Memory Clinic focusing on newly identified dementia patients from several local care homes. • Develop new pathway in 2017 for mild cognitive impairment to monitor and identify deterioration.

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
	Accreditation Programme (MSNAP), with three of them receiving the highest 'excellent' rating. This work was led by the Oxford AHSN, building on the excellence in West Berkshire. Patient and carer experience has improved with more positive feedback. Multi-disciplinary and inter-agency working has improved, leading to resources being used more efficiently, eg more nurse assessment in GP surgeries.	• Additional Memory Assessment Capacity commissioned and referrals/outcomes monitored at practice level. • Quality Improvement Scheme in place in Chiltern to encourage practice dementia champions and dementia friendly action plans. • Focus on variation between practices especially <50% - running Dementia toolkit.	develop suitable accommodation for people with dementia and the clinical support to manage these people in the least restrictive setting possible. • Oxfordshire performs well on diagnosis and review in primary care.	• Target and promote support and training to practices, with the aim of achieving 100% Dementia Friendly practices. • Continue work with our nationally accredited Memory Clinic to refine patient pathways and follow ups, exploring other models of assessment and delivery of on-going high quality care. • Achievement of a dementia initial assessment within 6 weeks of GP referrals. • Wider integration of Dementia Care Advisors within GP practices. • Refocus on improving the quality of post-diagnosis treatment and support in line with the 2020 vision using benchmarking and best practice wherever possible. • Our dementia stakeholders group will take responsibility for the implementation and monitoring of the Dementia action plan for 2017/18 and beyond. • Further integration of older people's mental health specialists within our GP practices. • Outcome measures will include admission avoidance, reduction in requirements for

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
				respite /social care intervention as well as reductions in the need for medical intervention (e.g. measure reduction in mental Health practitioner and community support worker contacts).
Cancer	We are taking forward work led by the Oxford AHSN to address variation with delivery of savings through strong local systems. We plan to work with the TV SCN, OUH and cancer alliances to identify optimum pathways for specialised care and opportunities for improving value to patients from alternative pathways.	Local implementation of the national cancer strategy with deep dive into specialities affecting performance and preparing for the new standard of 38 day onward referral.	• Ongoing review of Mandatory referral pro-formas from GPs to providers. • Potential alternative rapid access clinics for .underperforming specialties • Rapid access for non two week wait if a possible cancer. • Educational events. • Implementation of the new Suspected CANcer Multi-Disciplinary Centre pathway (for early diagnosis). • Increasing cervical screening uptake. • Improving services for survivorship patients. • Introduction of the HOPE programme. • OUH to carry out electronic holistic needs assessments and treatment summaries for each tumour site, which is fed back to GPs. • To improve quality of performance data to enable ongoing performance management, review and	• Joint development of a framework with stakeholders to improve the outcomes for people affected by cancer. • Reduce the mortality rate and increase survival rates through early diagnosis, appropriate interventions and care closer to home. • Prevent people from dying prematurely by decreasing the potential years of life lost from cancer related causes and decreasing the under 75 mortality rate from associated cancers. • Improving early detection of cancers by increasing access to diagnostics • Improving one year survival rates for cancer by delivering year on year improvement in the proportion of cancers diagnosed at stage one and stage two and reducing the proportion of cancers diagnosed following an emergency presentation.

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
			improvement and measurement of patient quality of care and satisfaction.	• Ensure faster access to treatment and shorter patient journey. • Increase prevention of cancers • Increasing the number of patients supported to die in their place of choice.
Maternity	Maternity services across BOB will need to make changes both locally and across the STP footprint to deliver the recommendations in the national maternity review, 'Better Births: Improving outcomes of maternity services in England; A Five Year Forward View for maternity care', February 2016. The Thames Valley Senate is leading work across BOB and STP neighbours to identify the additional capacity required to meet the changing needs of our population. This work involves changing the model of care based on the national maternity review to better suit patients rather than just increasing capacity of current services.	Buckinghamshire five year strategic maternity plan in place that reflects the ambitions of the national maternity review. Key elements include: • Agreeing and implementing a Buckinghamshire perinatal mental health pathway • Developing choice and personalised maternity care provision • Proposal to expand maternity services • Implementation of electronic maternity records.	Oxfordshire CCG is reviewing obstetric provision and supporting midwifery led units via public consultation. The proposed model of care is as follows: • Clear pre-conceptual offer • Early medical risk assessment • Evidence based pathways for low risk care • Evidence based pathways for high risk care • Informed choice for all women • Expanded offer of postnatal support • Integrated perinatal mental health service • Decisions based around choice and risk • Centralise scarce consultants to overcome significant workforce challenges	• A maternity steering group, alongside lead clinicians will work with the TV SCN to support the ambitions of the national review, as well as the challenges facing the system around workforce, particularly midwife recruitment and predicted increase in birth rate over the next four years. **Improving women's choice through**: • Commissioning a dedicated Homebirth Service • Increasing % midwifery led births in the AMLU • Reducing the number of unit Diversions • Development of a maternity high dependency unit, to free up labour rooms and midwife capacity, as well as improve quality of care **Establishing smaller community-based teams by:** • Aiming to set up teams of 4 – 6 midwives to cover smaller

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
				areas and for close links to be developed between each team and a named Consultant Obstetrician. **Postnatal care and perinatal mental health** • Use of a post-natal allocation resource model, looking at improvements required in the care of women and babies from admission to post-natal wards to handover to health visitors.

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
Children's and young people's services	We are increasing prevention of obesity for children and adults through our STP wide prevention programme. While simultaneously reducing dependency on acute care by increasing focus on ambulatory and community services in each local population. This is supplemented by reducing variation in paediatric admissions being led by the Oxford AHSN by standardising paediatric guidelines. A number of issues emerging from these priorities are the subject of wider work across the whole of the BOBW STP footprint: • Workforce (maternity and paediatrics) • Mental health inpatient facilities including mental health and learning disabilities • Reducing childhood obesity	Health and social care partners have a well-developed strategy for children, young people and maternity care which covers the planning period. The 5 NHS-led led local priorities for transformation that impact on the whole system of care for children and their families in Buckinghamshire are: • Maternity care (covered in the Planned Care section) – ensuring the best start in life for all • Mental health – ensuring early access and treatment including perinatal mental health • Integrating services for children and young people with complex needs 0-25 year olds – coordinated, efficient and effective health, education and social care to meet needs • Childhood obesity – reducing obesity levels in childhood • Tackling exploitation in its broadest sense – for example Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM) Key priorities include: • Integrated therapies and continuing care commissioned	• A radical upgrade in prevention, tackling childhood obesity and mental wellbeing • Revised primary care offer to enable more children to be treated in neighbourhood settings • Integrated teams with easier access to community diagnostics • Specialist outreach clinics with paediatricians and GPs • Integrated teams for children with disabilities and/or socially complex children • New model that provides early help and speedy access for children experiencing mental health problems	• Improving collaborative working across education, health and care for children and young people with Special Educational Needs and Disabilities (SEND) aged 0 – 25 years and to give parents more control. A Designated Clinical Officer is in post to support CCGs in meeting their statutory responsibilities for children and young people with SEND. 'Local Offers' have been published in each area, providing accessible information on local services and resources for children with SEND and their families. • The 'Ready Steady Go' programme has been introduced in many clinical areas to improve transition into adult services and to better prepare young people and their families for adulthood. Education partners are considering how the Ready Steady Go principles can be aligned to Education Health and Care Plans to improve integrated working. • Community health services for children, young people and families have integrated into a single team. The needs of CYP referred to services are

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
		• Exploitation programme developed and implemented • Family support delivery model introduced • Residential short breaks introduced • Childhood obesity prevention programme implemented • Integration of services for 19 to 25 year olds across education, social care and health		considered in a more holistic and collaborative manner with a greater emphasis on agreeing a joint care plan with meaningful outcomes with families. • Collaborative working with primary care, Berkshire Healthcare NHS Foundation Trust and acute care to reduce the number of non-elective attendances to hospital by CYP and their families. • A system wide child and youth healthy weight care pathway team has been established. Mapping and gap analysis against the National Child Obesity Action Plan has been undertaken and an action plan is in development. • Increased investment into emotional health and wellbeing services for children and young people
End of life care	Increased digital interoperability is enabling increased access to proactive care plans for the top 2% of the population who are high risk of deterioration. This includes end of life patients so ambulance service, out of hours service, 111 and A&E departments can support patients and families to maintain	• Buckinghamshire Healthcare NHS Trust secured significant charitable funding in end of life care to fund a 'home from home' environment for patients in our Florence Nightingale Hospice • MacMillan are partners with us funding specialist nursing posts to help improve end of	• Standardisation of End of Life contract across providers to improve equity of access • Planning to implement a 24/7 telephone palliative care advice line for patients who are on the End of Life register and have a care plan	End of life care planning service offer: • New 24/7 Single Point of Access for Palliative patients • Rolling programme of education • Palliative Care Community Enhanced Service (CES) • EOL Steering Group meets quarterly and reports into Long

National priority	BOB wide work	Buckinghamshire	Oxfordshire	Berkshire West
	their preferred place of death and preserve their dignity.	life care for patients discharged from our care back home. • SCR+ in place, significant improvement in preferred place of death through primary care work on identification and support. • Single Point of Access based on the Sue Ryder model to be scoped and commissioned, • Recommended Summary Plan for Emergency Care • Airedale model being piloted in 30 care homes		Term Conditions Programme Board • All GPs, A&E and parts of community services have access to the Electronic Palliative Care Co-ordination System • Recommended Summary Plan for Emergency Care (ReSPECT)

10. Key areas for engagement and consultation

Given our ambitions to improve the quality and standards of services provided, deal with our inequalities and tackle our financial challenges, it is inevitable that a number of service changes will be proposed. CCGs have a legal duty to consult citizens on substantial changes to services in liaison with Health Overview and Scrutiny Committees.

Any major service changes and reconfigurations should be able to demonstrate evidence of four tests which are:

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. A clear clinical evidence base
4. Support for proposals from clinical commissioners.

As part of these four tests, the Thames Valley Clinical Senate will provide recommendation and assurance of clinical plans.

Each of the three areas will be engaging and consulting on proposed service changes in their areas, which includes:

- Proposed changes to obstetric services and paediatrics at the Horton Hospital in Banbury
- Consultation on options for the Horton Hospital
- New roles for Oxfordshire community hospitals
- Consultation on bed closures at Oxford University Hospitals NHS Foundation Trust
- Review of Berkshire West community hospital provision
- Development of community hubs in Buckinghamshire including model of bed-based services
- Potential changes to specialised commissioning pathways for specialised services, such as cancer and cardiology treatment.

Our detailed proposals for communications and engagement are set out in Appendix E. These are underpinned by separate communications and engagement plans for each of the LHEs.

11. Intended benefits for our local communities

Implementing our proposals will have major benefits for patients and drive efficiencies as health outcomes are improved:

Improvements in access to services

- By standardising access to urgent care across the system and maximising the use of technology, we will provide patients with faster access to clinicians. As clinicians will have access to patients' records, they will be better informed and so able to meet patients' needs via a range of ways, such as phone and Skype, thus avoiding the need for patients to travel for a face to face consultation.

- Workforce plans will improve the sustainability of primary care, ambulance services and other key services, ensuring patients can get an appointment when required and a timely response by ambulance if needed.
- More care provided closer to home through strengthening the availability of services available within primary care; reducing the need for travel for many routine appointments and investigations.
- Closer working across the health and social care system will make it easier to access for patients.
- More services provided on a day or out patient basis reducing the need for hospital admission.
- Reduced waiting times for referral to see a specialist.
- Greater availability of GP appointments seven days a week.
- Improved access for all cancer patients.

Improvements in care and quality

- Reduction in sepsis.
- Reduction in the length of time patients wait for discharge from a hospital bed when their acute care has ended.
- Fewer 'never events'.
- Releasing GP time to work at scale and integrate with community services so they can focus on complex patients will mean patients will have more time with their GP when required. As GPs will have rapid access to home care support, it also means that frail patients will more often be supported in their own homes so they can be with their family while they recover and maintain their mobility, independence and dignity. This will also reduce the number of people who become increasingly immobile while in hospital while waiting for home support to be put in place following treatment in hospital for a serious condition. So reducing people's long term dependency.
- The proposed changes to the Horton Hospital and the development of community hubs based around GP populations and bed based services across Oxfordshire and Buckinghamshire will mean patients have reliable and sustainable access to high quality evidence based services closer to home which will lead to improved patient outcomes. It will also improve value for public money by releasing funding to provide better healthcare for the local population, facilitate the uniformity of clinical and professional standards and improve responsiveness.

Improvements in population health

- Initiatives to prevent ill health will reduce lives lost and illness due to preventable disease and reduced inequalities.
- Reduction in obesity and diabetes.
- Delivering the Mental Health Forward View will increase mental wellbeing and enable more people to live healthier and fuller lives. This will be supported through investment in early intervention services building on the nationally recognised work of Oxford AHSN's three mental health networks.
- Improved one year cancer survival rates.
- Improvements in dementia care – diagnosis, support and end of life care.

12. How we will deliver our ambition

Having great ambitions is important, but we need to ensure delivery. The leaders of the organisations across BOB are committed to working together to deliver these plans. All leaders recognise that the scale of change we envisage cannot be delivered by an organisation working on its own, so the strength of partnerships between NHS organisations, between the NHS and other bodies and the partnership with citizens are key to success.

The challenge for leaders of our organisations is substantial. Organisations can no longer focus primarily on their own interests and narrowly defined accountabilities, but need to fulfil their responsibilities to the population as a whole and the wider system of care. The challenge for our clinical leaders is no easier, with clinical networks across our area being critical to enabling clinicians to work together to improve standards for patients and adopt innovation.

12.1 STP governance and structure

We have developed a governance structure to steer delivery of our plans. This will enable senior leaders to come together to ensure our plans are implemented through collaboration. In designing this structure, we have been mindful that the organisations across the BOB area have to work at multiple levels. We have therefore created a structure which minimises extra bureaucracy and expenditure on management and administration.

Professor Gary Ford, Chief Executive of the Oxford AHSN and a consultant physician, has been appointed as Chair of the Delivery and Oversight Boards.

David Smith, Chief Executive of Oxfordshire CCG, is the Senior Responsible Officer.

We are expanding our team to cover additional support for the finance group and communications and engagement.

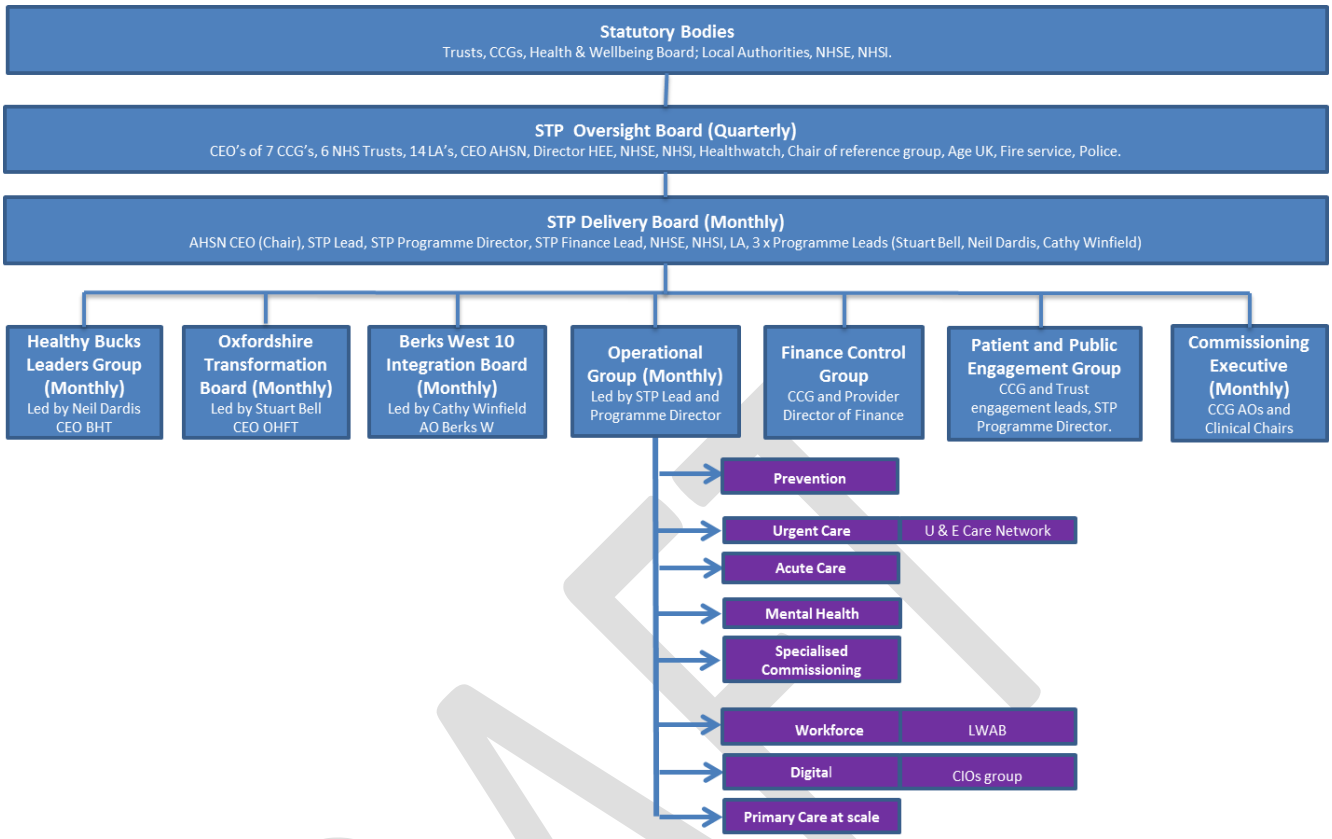
Governance meetings are taking place as follows:

- The heart of our delivery will be through the STP Delivery Board which brings together each month the leaders of the three local health economies, with the STP Chair and Executive Lead, the lead of the Finance Group and representatives from NHS England and NHS Improvement.

- An Operational Group that meets monthly to oversee delivery of STP projects.

- On a quarterly basis the STP Oversight Board leaders of all organisations come together to ensure that the STP is connected with their own organisations, that we are fostering system leadership and a quality improvement culture across the area, and ensuring we have the right level of co-production, engagement and communications in everything we do.

STP structure



System wide governance arrangements have a strong grip on delivery to ensure benefits are realised. This is driven by the monthly STP Delivery Board involving the Oxford AHSN, STP leaders, finance, NHS England, NHS Improvement, local authorities and the three local system leaders, which will also be informed by patient and public engagement by the group dedicated to this function.

The STP Delivery Board holds each local system and STP wide programmes to account. This will be through rigorous scrutiny of key performance measures for BOB wide programmes as shown in the project charters in Appendix C, which demonstrate impact on quality, activity and finance against planned trajectories. It will also hold local systems to account for system level financial delivery against local system control totals when these are agreed and performance. The meetings give an opportunity for issues escalation and cross system partnership working to resolve problems as they are identified and progress against planned milestones. Programme management capacity is provided both within each local system and the BOB wide programmes.

If there is insufficient capacity to move the programmes forward at pace, then this can be escalated through this governance structure if required. The Delivery Board will be able to task specific groups with making recommendations to inform decisions. For example the use of funding awarded to the STP for primary care. Where the group might have a conflict of interest, such as in commissioning decisions, then these will be decided by the Commissioning Executive.

We have developed the following draft collaborative principles for STP partner organisations to sign up to with the intention that these then form the basis of a Memorandum of Understanding:

- Activities are delivered and actions taken as required.
- Be accountable: Take on, manage and account to each other for delivery of the STP.
- Be open: Communicate openly about major concerns, issues or opportunities relating to the BOB STP.
- Adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, competition law, data protection and freedom of information legislation.
- Act in a timely manner. Recognise the time-critical nature of the STP and respond accordingly to requests for support.
- Work constructively with stakeholders with the aim of securing their support for the STP and its delivery.
- Deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to support delivery of the STP.
- Engage with patients, carers and the local population in the development and implementation of our proposals.

12.2 Leadership development to support delivery

As we move from STP development to implementation and delivery, STPs will become more than just plans: ***"They represent a different way of working, with partnership behaviours becoming the new norm."*** (page 4, NHS Operational Planning and Contracting Guidance for 2017-19)

It is acknowledged that no one organisation holds the solution to the system leadership challenge required to transform the health and care system and equally we acknowledge that no one organisation can provide the leadership, organisational development, innovation and improvement capabilities needed to support health and care staff to deliver the changes required.

This is a significant leadership challenge for all involved and we will invest in leadership development to support this. The BOB Local Workforce Action Board (BOB LWAB) brings together health and care organisations, and the relevant enabling organisations to develop solutions to current and future workforce issues including the embedding of system leadership and organisational development capability for STP delivery. It is the role of the BOB LWAB to work collaboratively with the BOB system to enable the creation of a Systems Leadership and

organisational development plan, developed and owned by the BOB partner organisations.

This will facilitate the development of system leadership behaviours at all levels of the workforce supporting the development of effective partnership relationships across the system and enabling large scale up-skilling of the workforce in collaborative change management and improvement skills.

Work is already underway to support progress in this area:

- Individuals from across the STP organisations are in the process of being accredited by NHS Improvement in Quality, Service Improvement and Redesign (QSIR) to learn, tailor, and deliver an improvement methodology programme across 2016 and 2017, to around100-125 participants in the BOB STP footprint.

- Thematic analysis of organisational development and workforce plans to identify shared issues, innovative practice and gaps to provide an 'organisational development map' of the BOB system and the three LHE footprints.

- Mapping of available innovation and improvement support in the BOB STP footprint.

As the STP programme develops, we will focus on the co-production of more detailed planning and delivery of leadership and organisational development interventions using an enabling partnership approach between Health Education England TV, Oxford AHSN and Thames Valley and Wessex Leadership Academy.

12.3 Collaborative commissioning

There are seven CCGs across the BOB footprint, which operate with shared management arrangements across the four CCGs in Berkshire West; the two CCGs in Buckinghamshire and Oxfordshire has its own management team. In Buckinghamshire, collaborative commissioning is as much about working with Buckinghamshire County Council as with other CCGs.

A Commissioning Executive across all CCGs has been established to improve commissioning efficiency further and support delivery of the STP plan. This will deliver faster decision making, which will be of particular value where there are significant service changes just outside our borders that impact our population. In such cases, we can speak with one voice to regional and national partners. The Executive will initially focus on specialised commissioning; ambulance services; 111; mental health; and cancer.

There is a history of joint working across the CCGs with individuals taking on roles across the footprint and for some functions this includes the CCGs in Berkshire East, which is part of the Frimley Health footprint. For example, the Director of Strategy in Berkshire Wests CCGs leads the Thames Valley procurement of the new 111 service. CCG Chairs and Chief Officers meet with NHS England bi-monthly. By

April 2017, all CCGs will have taken on primary care commissioning from NHS England.

12.4 Challenges, risks and mitigating actions

The challenges to our system are from a growing population, particularly as we have more older people than the national average, which puts increasing demand on health and care services. Our workforce challenge is due to a significant proportion of our staff retiring in the next few years, combined with the high cost of living locally and higher wages in London causing recruitment problems. We also have small areas of deprivation where it is difficult to overcome inequalities in health and a rising tide of obesity which is causing increasing ill health.

There are also challenges in delivering our plans. We have come together as a system very recently and have excellent working across health and care sectors within our three local populations. Working at scale across the larger STP geography, however, requires a broader awareness of how we rely on each other and the benefits we can gain by working at this scale.

Risk	Mitigation
Identifying ways to manage approximately 15% more patients with a similar sized workforce as today.	• Using world class innovation to release time for administrative and clinical staff to manage more patients. • Use of digital technology to enable our citizens to adopt healthy lifestyles and manage their health, so reducing avoidable conditions. • Integration of services to reduce duplication and gaps between services where patients experience delays and errors occur. • Making full use of the skills of our staff and identifying new roles.
Financial risk to the STP if one part of the system is unable to fully deliver its plans.	• Exploring a risk share agreement across NHS Trusts and CCGs. • Agreeing local system control totals across key organisations in local populations to focus work on real cost savings.
Identifying sufficient human resource capacity and capability to produce robust plans for effective change and implement them.	• Utilising existing resources across the health and care system and working with partners such as arm's length bodies, voluntary sector and fire and police services.
The strength in delivery of our three well established local health economies works against delivery at an STP level.	• The governance structure, the Memorandum of Understanding and the leadership work.

13. Next steps

To take forward our plan, we have identified the following priorities:

- Agree a Memorandum of Understanding, based on the draft discussed by leaders in October 2016 to enhance system wide collaboration and delivery.
- Develop a risk sharing agreement across NHS organisations to ensure financial balance across the STP.
- Build on existing system leadership to achieve collective accountability to deliver the proposals at pace.
- Strengthen engagement with patients and the public, clinicians, staff, local authorities, voluntary organisations and other key stakeholders to shape our plans and to ensure that they are implemented in partnership.
- Ensure sufficient resourcing to drive delivery of our plans.
- Review estates and capital plans so they are deliverable within local and national constraints.
- Further develop of business cases to access national sources of revenue and capital funding to enable delivery of our plans.

14. Appendix A: STP statutory partners

Type of organisation	STP statutory partners
NHS clinical commissioning groups	**Buckinghamshire** • Aylesbury Vale CCG • Chiltern CCG **Oxfordshire** • Oxfordshire CCG **Berkshire West** • Newbury and District CCG • North and West Reading CCG • South Reading CCG • Wokingham CCG
NHS acute, mental health and community trusts	**Berkshire West** • Berkshire Healthcare NHS Foundation Trust • Royal Berkshire NHS Foundation Trust **Buckinghamshire** • Buckinghamshire Healthcare NHS Trust **Oxfordshire** • Oxford Health NHS Foundation Trust • Oxford University Hospitals NHS Foundation Trust
NHS ambulance trust	• South Central Ambulance Service NHS Foundation Trust
Local authority	**Berkshire West** • Reading Borough Council • West Berkshire Council • Wokingham Borough Council **Buckinghamshire** • Buckinghamshire County Council • Aylesbury Vale District Council • Chiltern District Council • South Buckinghamshire District Council • Wycombe District Council

	Oxfordshire • Oxfordshire County Council • Oxford City Council • Cherwell District Council • South Oxfordshire District Council • Vale of White Horse District Council • West Oxfordshire District Council

15. Appendix B: Proposed STP wide and local programmes and impact on gaps

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
Prevention	Focus on reducing adult and child obesity and sedentary lifestyles while increasing activity, using evidence-based solutions involving Oxford AHSN, TV SCN and CLAHRC (Collaborations for Leadership in Applied Health Research and Care) Implementation of primary obesity prevention programmes Rollout of the Diabetes Prevention Programme across BOB from its current implementation in Berkshire West NHS staff making every contact count by discussing prevention and signposting patients to a range of services Use of digital approach for prompting to increase personal motivation e.g. initial focus on physical inactivity Key healthy workplace programmes in place across the NHS and other large employers Focus on initiatives that address inequalities and will deliver NHS savings within the five years of the programme Improved weight management support to patients across BOB Improved targeted tobacco cessation for patients requiring elective surgery	Reducing avoidable admissions through secondary prevention: falls, alcohol, atrial fibrillation, hypertension, and smoking. In Buckinghamshire a life-course approach to: • Promoting healthy lifestyles • Improving mental health and wellbeing • Tackling inequalities • Building community capacity and self help Oxfordshire • Utilise technology to ensure patients can manage and monitor their conditions and avoid travelling to hospital • Self-referral to promote self-care, such as physiotherapy and podiatry • Reduce preventable diseases and improve uptake of screening programmes In the West of Berkshire • Addressing alcohol admissions through implementing the alcohol care team approach and brief intervention • Developing community and primary care approaches to identify residents with high blood pressure and atrial fibrillation not known • Rationalise falls programmes in the community to ensure maximum outcomes for residents	Reduced adult and child obesity and sedentary lifestyles Reduced inequalities as greatest benefit to deprived populations	Maintained mobility and independence Reduced avoidable ill health	Reduced cost of treatment of chronic disease, hypertension cardiovascular disease, some cancers, sleep apnoea, some MSK problems and mental health problems Reduced staff sickness, bank and agency costs £3m benefit

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
Urgent Care	Regional 111 integrated urgent care service, including enhanced clinical hub and enhanced Directory of Services Standardisation of clinical pathways Designation of urgent and emergency care services across Thames Valley Connected systems so the patient record is accessible to healthcare professionals across the patient pathway. Urgent and emergency care competency framework and workforce 'passport' arrangements across providers Establishment of interface clinician role offering portfolio employment across urgent and emergency care services Best practice framework for seven day access to standardised care across primary, community and secondary settings	Berkshire West: New respiratory pathway. Buckinghamshire: • OOH integration with 111 • Front door A&E redesign to improve flow • Falls service • Implement new urgent and emergency care network model • Improve transitional care for those medically fit for discharge • Reduce length of stay and unnecessary use of beds within the acute sector Oxfordshire • Ambulatory 'by default' (ACSC) • Integrated single 'front door' • One hyper-acute stroke service delivering the best outcomes • Avoid people with dementia disproportionately experiencing delayed transfers of care • Direct access (no requirement to go via A&E) to bed based care. Direct access beds to have 24/7 medical support and access to CT scanners • Rehabilitation and hospital at home		Improved patient experience. Reduced the need for emergency admissions to hospital. Reduction in errors due to gaps between different services.	£1.8m net benefit

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
Acute Care	Reduction of unwarranted variation in access to clinical care and delivery of clinical outcomes by application of Right Care initiatives led by Oxford AHSN. Maternity review led by TV SCN Reduce unwarranted variation in paediatric admissions as identified by Oxford AHSN. Pathology consolidation Back office procurement integration. Specialised paediatric services provision.	Oxfordshire • Horton Hospital sustainability (Urgent and emergency care, obstetrics and paediatrics). • Skill-up to provide more surgical, medical and psychological care in the community • Deliver outpatient care including pre-operative assessment as 'one stop shop' • Increase availability of a wider range of diagnostics in the community and locally delivered diagnostics available to GPs Buckinghamshire • Implementation of iMSK lead provider contract (£35m pa contract).EMIS system rollout for community services and diabetes. • Musculo-skeletal Services: An innovative commercial model is being developed that reflects a sharing of whole system costs and risk. • Agree Buckinghamshire perinatal mental health pathway • Implement electronic maternity record • Business cases for next 4 pathways – CVD, respiratory, GU and ophthalmology • Delivery of Heart Failure projects Berkshire • Enhanced GP / Consultant interface • Transformation of the outpatient function; • Planned care pathways e.g. MSK, ophthalmology; Review of whole system bed stock and usage; Redesign of system wide use of diagnostics.	Equity of access to planned care services Consistency of access, performance and outcomes across the specialist paediatric network	Sustainability of services: urgent and emergency care, obstetrics and paediatrics in north Oxfordshire and also specialist paediatric services. Improve consistency and quality of service Reduced harm from variation. Better value from resources dedicated to care, with potential for generating resources for delivery of care in other areas Capacity and capability of maternity services to respond to growing demand. Improve turnaround time for pathology testing	Horton Hospital changes are cost neutral Reduction of unwarranted variation by 5% over 3-5 years Buckinghamshire: Activity increases reduced to in line with demographic growth. Reduced bed days to 900 per 100,000 population. Maintain adult social care Delayed transfer of care to 22% per 100,000 population Reduction in paediatric emergency admissions and lengths of stay. c 15% saving at BHT pathology 1% procurement savings Overall £7.2m benefit

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
Mental Health	More effective use of mental health specialist commissioning budgets to improve pathways, starting with secure services. Outcomes based contract across BOB for mental health and learning disabilities	All areas: Increasing services where required as descried in the Mental Health Forward View. Berkshire West: New model for Crisis Care Buckinghamshire: • Dementia work • Improve access to care for tier 4 child and adolescent mental health services • Improve the lives of children with special educational needs • Integrated health and social care pathways to support autism • Co-located health and social care teams for mental health and learning disabilities	Reduced inequality in patient outcomes.	Increased wellbeing, more effective transitions between services. Earlier intervention in the course of mental illness	Reduced demand for mental and physical health services £4m better value through mental health new care models on place based methodology.
Specialised Commissioning	Engage TV SCN and patients to identify specialised treatments where patient outcomes appear to provide poor outcomes and low value for patients. Initial focus on: cancer; cardiology; neonatal intensive care; children's services. Identify alternative pathways providing better value for patients.			Reduce unwarranted variation in specialised treatments. Improved patient experience and outcomes.	Predicted 3% growth mitigated (£60.2m)

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
Workforce	Increased numbers of support workforce and professionals working in care homes and domiciliary care Provide shared and multidisciplinary training to health and social care support workforce Establish a contingent (bank) workforce that has the capacity and capability to be flexibly deployed across the BOB geography, in response to prevailing demand. Improve employment 'portability' across the BOB geography. Achieve efficiencies of scale in the recruitment and retention of staff from outside of the UK. Development and implementation of a common recruitment framework and model contracts of employment.	Identify opportunities to eliminate duplicative or unnecessary activity Move workforce around the system, filling new roles in the community with appropriately skilled staff currently in the acute sector Identify new and more efficient ways of working (including digital) to enable staff to manage more activity without raising hours worked Consolidate the remaining gaps that exist and hire new workforce	Improved health and wellbeing of staff.	Reduced time patients spend in hospital and prevent unnecessary admissions by supporting more people in their own homes. Reduction in people managed in more intensive settings than clinically necessary so releasing bed capacity and improved value for public funds. Improved staff and patient experience.	Minimised, or eliminated use of high cost agency staff across the BOB geography. Improved the staff retention £34m benefit

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
Digital	Interoperability to share information across organisations and with patients (integrated health and care records). Ensuring exemplar initiatives draw inward investment into BOB to benefit local population e.g. OUH Global Digital Centre of Excellence. Digital approach to achieve consistent and personal prompting messaging Maximise benefits of technology across public sector e.g. smart cities, Bicester Healthy New Town and broadband Enable individual GP practices to work at scale through technology. Supporting governance and security by agreeing a shared approach to patient identity management and information sharing agreements To have a secure and agreed method for using health and care data to inform commissioning, research and service transformation being led by Oxford AHSN Finding opportunities to share learning and best practice and to collaborate where efficiency can be delivered across the STP Direct booking from 111 into general practice	Buckinghamshire: • Digital Life Science initiative to manage demand for primary care • Airedale telehealth to provide clinical advice to care homes • Baby Buddy App • EMIS adoption countywide as integrated primary and community IT system Oxfordshire: • Real time GP-consultant info in hospital	Empowered patient wellbeing and self-care through the use of personal health records. Increased personal motivation.	Reduced errors Improved clinical decision making as based on accurate, up to date information about patients. Reduced travel for patients and clinicians where Skype type consultations replace face to face consultations.	Reduced CSU, CCG and trust management time required and lower cost of services procured. Reduced administrative and clinical time spent on transactional work e.g. sending letters etc. Reduced emergency admissions as front line clinicians have access to patient care plans and records. Reduced hospital length of stay by enabling shared trusted assessments £26.8m investment

Primary care	Support the transformation of primary care to deliver high quality care through working at scale and coproduction of improved quality of care across the healthcare system though the development of new ways of working and integrated systems of care. Identify and develop the areas of quality care for patients already occurring throughout the BOB footprint in primary care and the measures required to scale these through the networks of localities and federations within and across the three local populations. Explore across the footprint how new models of care might be developed to provide quality primary care for patients, leading to efficiency for the healthcare system and sustainability of GP and primary care across the STP footprint.	All areas: • Implementing the GP Forward View. • CCG / NHS England co-commissioning of primary care in all areas by April 2017. • Developing new approaches to on the day demand, population based health care, proactively managing individuals at risk, and enhanced support to care homes. Buckinghamshire: • Buckinghamshire Healthcare NHS Trust an integrated acute and community trust is actively working with primary care to scale up effective joint pilot working between primary and community services, which are significantly reducing emergency admissions for older people. • Development of community hubs / NMC Buckingham, Aylesbury and Wycombe. • Creation of Fedbucks • EMIS as system of choice for primary and community • Local Implementation teams for over 75s Berkshire West: • South Reading where there are a large number of smaller practices, merged or federated arrangements will emerge using PMS premium funding, together with NHS England's vulnerable practice funding. • Wokingham neighbourhood cluster model has created three clusters of practices, each serving a population of 40,000 - 60,000 patients, which are considering shared posts, pooled back office functions and a joint approach to meeting on-the-day demand. • In North West Reading procurement exercises will stabilise two practices. • Newbury and District and North and West Reading are exploring practices working together around workforce, including training a new role called a GP administrative assistant and piloting clinical pharmacists.		Increased access seven days per week Sustainability to high quality primary care Quicker treatment for patients Increased GP job satisfaction and retention.	

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
		Oxfordshire • Develop a wider skill mix to allow GPs to operate 'at the top of their license • Scaling services and supporting practices to form primary care neighbourhoods connected to locality hubs • Named GPs and neighbourhood teams for the 4% of the population with complex needs • Access to same day urgent appointments • 'Primary Care Plus' to enable more out-patient consultants and non-consultant clinics in the community, supported by a local diagnostic service			

	STP wide programmes	Local population level programmes	Health and wellbeing benefits	Care and quality benefits	Financial benefits
New Models of Care		Develop the established Accountable Care System (ACS) in Berkshire West to invest in transformation and share risk Integrate health and social care commissioning and delivery system through the 14 projects in the Berkshire W10 Integration Programme Deliver care close to patients' homes, shifting services into the community, eg community diabetologist, geriatricians and respiratory consultants in W Berkshire. Create robust out of hospital services operating from community hubs via a single point of access, integrated with primary and social care in Oxfordshire and Buckinghamshire Review of Berkshire West community hospital provision Health and social care in a single organisational system in Buckinghamshire A joint approach to residential care and continuing health care market in Buckinghamshire		Provision of sustainable and high quality care	£63m combined CCGs QIPPs Additional transformation: • Oxfordshire £8m • Buckinghamshire £12m • Berkshire West £5m

15.1 Local population partnership working

Berkshire West

- As a part of its work with other organisations to improve outcomes for patients and residents, the CCGs play a key leadership role within a number of strategic partnerships such as:
    - Berkshire West 10 integrated care programme
    - Berkshire West Accountable Care System (ACS)
    - Berkshire West frail elderly pathway transformation programme.

The Berkshire West Accountable Care System is a complete transformation of how the three NHS trusts and four CCGs within Berkshire West will work and transact with each other. By moving away from a system of contractual transactions and closer to an allocative distribution of monies coming into the local health economy, the ACS seeks to move to a system whereby resources are allocated to the efficient delivery of pathways at cost rather than price. By moving to this new contractual relationship, providers and commissioners will need to share the risk of delivering services across the geography within an overall cost allocation rather than individual organisations being required to protect their own financial positions.

Programme and delivery architecture

2016/17 is the first year of the overall programme mobilisation. As the programme continues towards implementation, key workstreams include:

- The creation of a Berkshire West 'Group Account' – a single balance sheet for the ACS comprised of the seven current financial positions of the constituent organisations.

- The vision, design and implementation of cross organisational efficiency opportunities, such as back office integration, shared use of estates and workforce initiatives.

- The identification and initial implementation of clinical pathway improvement schemes, which release cost from the overall delivery system due to new ways of working which prioritise cost reduction rather than revenue protection.

- Analysis of the patient population across the system in order to identify areas of high spend and target interventions more appropriately.

In 2016/17 and beyond, the key priorities within the overall programme include the shadow implementation of a financial system control total, confirmed regulatory approval for the operation of the ACS and the implementation of agreed clinical pathway improvement schemes to release cost reductions.

Berkshire West 10 integrated care programme

The Berkshire West 10 is the health and social care integration programme which is well established within the local economy. It spans the seven NHS statutory organisations and three local authorities. In operation since 2013, the programme aims to achieve the following objectives:

- Strengthen cross-organisational working between partners
- Facilitate joint investments in cross-organisation service redesign
- Design and deliver innovative models of care across the geography
- Provide a forum for learning and knowledge share to enable the 'scaling up' of local successes.

The Berkshire West 10 programme is the vehicle through which 14 integration projects are delivered. All of these projects are managed closely by the following:

- Each of the three 'localities' (aligned to a borough council) has an integration board which facilitates the design and implementation of integrated services at a local level
- A pan-Berkshire West Delivery Group meets on a monthly basis to review local and Berkshire West wide operational progress in either design or implementation. A finance sub-group provides expertise on investment and return.
- Strategic oversight for all of this work is provided by a pan-Berkshire West Integration Board which is attended by Chief Officers from all ten organisations and the Chair / Vice-Chair of the Delivery Group.

A strategic project management office function provides visibility through reporting and challenge.

In 2016/17 and beyond, the key priorities within the overall programme portfolio include the implementation of the Connected Care information sharing system, an overall transformation of the frail elderly pathway and the successful realisation of local schemes to reduce delayed transfers of care.

An example of the 14 projects governed by the Berkshire West 10 integration programme is the frail elderly pathway transformation programme. The Berkshire West health and care system spend on the frail elderly is expected to increase by a predicted 29% (£55m) by 2020. The frail elderly population of Berkshire West is approximately 9,000 people (2% of the local population) but this cohort represents 28% of all local NHS spending. Recognising the pressures arising to the local delivery system from these trends, the Berkshire West 10 established the frail elderly pathway transformation programme.

Programme and delivery architecture

Overseen by a dedicated Frail Elderly Steering Group, this programme of work has created:

- An economic model which sets out the impact of proposed new care models across the system
- Proposed system wide improvements to the overall pathway model which are aligned to the Five Year Forward View
- A suite of targeted improvement schemes worth £6m of savings which will be further developed for deployment in Berkshire West.
- The foundation for the development of an additional wave of savings and improvements opportunities, such as telecare.

In 2016/17 and beyond, the key priorities within the overall programme include the further development of the schemes' implementation plans and the identification of further savings opportunities.

Buckinghamshire health and care system

The Buckinghamshire health system has targeted £12m of transformation schemes between 2017/18 and 2020/21. The top three areas are:

- £3.5m from the impact of new models of care in reducing length of stay – currently 9% of non-elective admissions are utilising the equivalent of 62% of the system beds. By utilising this funding more effectively we will reduce this. We will monitor this through a reduction in excess bed days in the system.
- £3m from the development of community hubs through the work across the system on integration.
- £2m through the local prevention work including preventing CVD, the impact of an integrated long term conditions / IAPT single point of access and the 'Stop Before the Op' on smoking cessation and the implementation of a Diabetes Prevention Programme.

The Buckinghamshire health and care system is working together to integrate services around the needs of the population. The system is using learning from the national vanguard programme to develop seven localities of care with services networking to share wider expertise and care at scale. The main elements of this model are:

- Jointly commission new service models based on different pathways of care
- Co-designing new models of care with patients and communities
- Multi-disciplinary teams of healthcare, social care and voluntary sector professionals working together in each locality
- Single points of access to services for those at risk of hospital admission
- Community hubs in each locality providing support for health and wellbeing initiatives, a base for integrated locality teams and expanded specialist support in ambulatory, outpatient and diagnostic care
- More care and support closer to home reducing the reliance on community and hospital bed based provision
- Single commissioning team for health and social care
- Develop provider collaboratives.

Oxfordshire's transformation programme

Oxfordshire CCG has been working with its partners across the healthcare system to develop a transformation programme, which:

- reaffirms the case for changing health services across Oxfordshire
- describes the proposed future models of care and how they have been developed
- incorporates the views of the public, clinicians, staff and stakeholders in the proposed future models of care
- ensures health care in Oxfordshire is of high quality for all and provided on a sustainable basis.

We are systematically reviewing all services commissioned for our population and developing improved options for out of hospital urgent care, planned care, maternity, children, mental health and learning disability, so reducing need for acute capacity. Our plan is to be in a position to launch public consultation on major changes to services in early 2017.

At this stage in our process no decisions have been made, however it is probable that we will be consulting on:

- reductions in acute beds within Oxford University Hospitals NHS Foundation Trust
- changes to our community hospitals
- service changes at the Horton Hospital in Banbury (part of Oxford University Hospitals NHS Foundation Trust)

The Oxfordshire transformation programme sits within the context of planning across the BOB footprint. The programme seeks to link to BOB work but does not duplicate it and organises its activity in work streams, which are:

1. primary care
2. urgent and emergency care
3. planned, diagnostics and specialist care
4. maternity care
5. children's care
6. mental health, learning disability and autism care.

16. Appendix C: Project charters

Project Charter: Prevention Programme

Senior Responsible Officer: C. WINFIELD; Clinical Lead: Dr Lise Llewellyn (DPH), Project management from AHSN.
Clinical Lead: DS PH x 3

Overall Objectives

- To reduce levels of adult obesity
- To reduce levels of childhood obesity
- To increase levels of physical activity
- To reduce sedentary lifestyles

Deliverables

- Healthy workplace programmes in place across the NHS with clear measures of impact and benefit
- Consider a targeted approach to midwifery staff as part of a programme to support optimal maternal weight and physical activity
- Healthy work place programmes in place across large non NHS employers
- Embed the Making Every Contact Count programme , supported by signposting to a range of services
- Use the Diabetes Prevention pilot in Berkshire West and the Healthy Towns programme in Bicester and Barton as exemplars to develop an integrated approach and accelerate the adoption of best practice
- Develop co-ordinated comms and messaging across the BOB foot print
- Use a digital approach to achieve consistent and personal prompting messaging and increase personal motivation
- CCGs to commission consistent BOB wide weight management services collectively

Milestones

• Prevention Workstream Steering Group established	09.08.16
• ToR agreed	09.08.16
• Target reduction in obesity by 2021 agreed	09.09.16
• Target increase in physical activity agreed	09.09.16
• Target reduction in sedentary lifestyles agreed	09.09.16
• Investment and savings identified	09.09.16
• Potential workstreams identified	09.09.16
• PIDs and Project Plans Approved	28.10.16

Critical Success Factors and key risks

Success Factor:
- Ability to create a social movement across the BOB geography
- Ability to demonstrate impact and delivery of trajectory

Risks:
- Capacity to run the programme
- Delivery of financial savings by 2021

Scope and exclusions

In scope:
- Obesity and physical activity programmes
- Reducing sedentary lifestyles
- Identification of further prevention work streams

Human and other resources committed

- AHSN to lead on Healthy Workplace workstream
- Provider Trusts to create the necessary culture and embed their Health and Well Being Plans
- Project Manager to be appointed

Benefits

- ↓ Staff sickness rates leading to reduced bank and agency costs
- ↓ Levels of obesity and its complications
- ↓ Levels of diabetes leading to reduction in prescribing and the complications of diabetes

Measures and planned trajectory

- ↑ Levels of physical activity and reduction in sedentary lifestyle and obesity leading to reduction in chronic disease, hypertension cardiovascular disease, some cancers, sleep apnoea, some MSK problems and mental health problems

Project Charter: Urgent and Emergency Care Programme

Senior Responsible Officer: Annet Gamell Clinical Lead: Dr Annet Gamell Project Manager: Matthew Staples

Overall Objectives

- Provide an accessible and consistent high quality urgent and emergency care telephone and online advice service that promotes self-care and direct access to community based services via a single call (111)
- To provide positive experiences of care through the IUC that promote experiential learning and lead patients to choose to contact 111 to be directed to their care.
- To support community based clinical decision making through an Enhanced Directory of Services and MDT support via a clinical hub.
- Standardise urgent care pathways and improve access to same day care by directly booked appointments to manage physical, mental and social care needs.
- Achieve consistent standard of 7 day services across primary, unscheduled and planned care.
- Integrate access to shared patient records.
- Competency framework for multidisciplinary staff

Deliverables

- Regional 111 Integrated Urgent Care service, including enhanced clinical hub and enhanced Directory of Services
- Standardisation of urgent and emergency clinical pathways
- Designation of UEC services across Thames Valley
- Connected systems so the patient record is accessible to healthcare professionals across the patient pathway.
- Urgent & Emergency Care competency framework and workforce 'passport' arrangements across providers
- Establishment of Interface clinician role offering portfolio employment across UEC services
- Best practice framework for 7 day access to standardised care across primary, community and secondary settings

Milestones

- 111 IUC: Service launch – April 17

UEC competency framework and Interface medic role:

- Development of framework – to April 2017
- 'Pathfinder' testing of framework – 17/18
- Publication of national framework by NHSE – Summer 2018
- Public and professional engagement and communication - 16/17

- 7 Day services: Dissemination of best practice from OUH 16/17. Framework to support standardisation of care 17/18

Critical Success Factors and key risks

Launch of regional 111 IUC service

- Key risks –level of integration required across disparate services, requires enhanced interactions between commissioners and providers. Failure to deliver this will lead to patients accessing multiple points of care due to dissatisfaction with time frames for access to recommended services.

Workforce development

- Key risks- competing organisational demands for scarce clinical resource; Lack of co-ordinated approach to core requirements (e.g. mandatory training) across region

Thames Valley U&EC Network

- Resourcing, representation of senior decision making, lack of levers to enforce change

Scope and exclusions

Scope: Urgent & Emergency care services across BOB STP and East Berkshire in Frimley STP.

Exclusions: Planned Care (except for 7 Day Service development)

Human and other resources committed

- 111 IUC Procurement Programme Board
- TVUECN Clinical Pathways, Workforce, Pharmacy, Comms & Engagement workstream membership

Benefits

- Increased self-care and reduced inappropriate use of ambulance and ED
- Improved patient experience.
- Improved recruitment ,retention and optimal use of staffing

Measures and planned trajectory

- 111 self care, Emergency Ambulance and ED and primary care dispositions – trajectory to be confirmed during IUC mobilisation
- 111 IUC and wider UEC workforce retention rates
- Development of Intelligent Data Tools for measuring accurate, real time flow / activity
- Patient Reported Outcome Measures (PROMs)
- £4m saving from IUC service (based on national assumptions, following £1.5m investment), i.e. £2.5m saving by year 5.

Project Charter: Acute Programme - Reducing Clinical Variation Project

Senior Responsible Officer: Chandi Ratnatunga
Clinical Lead: AHSN Clinical Network Clinical Leads
Project Manager: AHSN Clinical Network Managers

Overall Objectives

- Reduction of unwarranted variation in access to clinical care and delivery of clinical outcomes
- Achievement of a common standard of care across the STP footprint
- Use of this common standard of care as a baseline to improve care by adoption of innovation
- Evaluation that assesses the impact of reduction of unwarranted variation on the STP footprint health economy

Deliverables

- Mapping of activity and clinical outcomes across the STP geography for specific clinical conditions
- Annual Report describing the picture of care across the STP geography for these conditions
- Common care pathways for these specific conditions to address unwarranted variation
- Targeted training packages for the clinical workforce to enable them to deliver a reduction in unwarranted variation
- Reduction of unwarranted variation by 5% over a 3-5 year period
- Health economic analysis of the return on investment (human resource and financial)

Milestones

- Creation and establishment of working Clinical Networks as a delivery mechanism to collect and exchange information
- Definition of outcomes
- Creation and the sharing of solutions to reduce unwarranted variation
- Analysis of the success of implementation of these solutions

Critical Success Factors and key risks

- Clinical leadership
- Clinical engagement
- Engagement and overt, committed support from Boards of STP partner organisations to partnership working and to clinical engagement
- Failure to deliver an informatics infrastructure that facilitates information collection and sharing

Scope and exclusions

- Focus on activities and outcomes in the areas of existing clinical networks in the first instance
- Exclude pure mental health workstreams, but address the integration of mental and physical health by including liaison psychiatry services

Human and other resources committed

- Clinical Leads and Network Managers together with clinical workforce
- Programme budget

Benefits

- Equity of access
- Improved quality of care and reduced harm
- Better value from resources dedicated to care, with potential for generating resources for delivery of care in other areas

Measures and planned trajectory

- Outcomes defined by mutual agreement
- Reduction of unwarranted variation by 5% over 3-5 years

Project Charter: Acute Programme - Maternity project

Senior Responsible Officer: Neil Dardis
Clinical Lead: Jane Herve
Project Manager: Rebecca Furlong

Overall Objectives

- To ensure capacity and capability of maternity services within Thames Valley is sufficient to respond to demand over the next 10 years

Deliverables

- Strategic Plan for the maternity services within Thames Valley agreed with service and financial implications understood as part of the STP by March 2017

Milestones

- 'TVSCN Maternity Capacity and Future planning Report' discussed at TV Clinical Senate July 2016
- Report highlights capacity shortfall of 3,000 taking into account predicted birth rates in 2025.
- SCN to consider report at its meeting on 14th September and plan workshop

Provider and Commissioner Workshop organised for 22nd November to consider findings and agree options to meet the gap in service include

- Neonatal
- Choice
- Commissioner functions
- Transportation issues
- Provider perspectives
- Interdependencies
- Digital technology
- Workforce

Critical Success Factors and key risks

- There is a risk that capital resources will not be available to support increased capacity requirements
- There is a risk that business cases to expand maternity Services beyond 6,000 in individual units are not affordable given the constraints of the tariff
- There is a risk that to recruiting and retaining sufficient maternity staff to meet the populations requirements in the future

Scope and exclusions

- The project focusses on capacity and capability of maternity services for the future in Thames Valley
- The project will include implications of plans from neighbouring STPs in Frimley and MK/Luton/Beds
- Project to be managed through TV Strategic Clinical Network and the TV Clinical Senate

Human and other resources committed

- Thames Valley Strategic Clinical Network in Maternity
- Clinical Senate support

Benefits

- The STP can plan and implement capacity to meet the needs of the future population of the Thames Valley for maternity services

Measures and planned trajectory

- Implementation trajectories to be agreed following outcome of the review.

Project Charter: Acute Programme - Paediatric project

Senior Responsible Officer: Neil Dardis
Clinical Leads: Chandi Ratnatunga
Project Lead Will Pank

Overall Objectives

To reduce unwarranted paediatric admissions within the Bucks, Oxon, West Berks region as identified by AHSN report.

Deliverables

- Progressive harmonisation of common clinical guidelines for different childhood conditions across acute Trusts.
- Ongoing monitoring of admissions through Variation report
- Regional programme of audit on common childhood conditions, to compare treatment and share best practice
- Use of smartphone App with aim of getting guidelines closer to the bedside
- Production of e-Learning modules on childhood conditions to encourage better clinical management in primary and secondary care.
- Focused training for GPs in areas with higher than expected admissions.
- Engagement with Commissioners, Providers and other stakeholders to identify opportunities for innovative approaches to reducing unnecessary admissions.

Milestones

- Adoption across region of (**n**) common clinical guidelines per annum based on expert evidence (ie NICE, Royal Colleges). Benefits include greater adherence to best practice as reduction in duplication of time spent drafting/updating.
- Regional audits to monitor adherence to guidelines
- Rollout of clinical guideline smartphone App across all acute Trusts
- One eLearning module per annum hosted on e-LfH
- Delivery of two annual GP training courses.
- Piloting of innovations designed to provide better primary paediatric care e.g. Point of Care Testing

Critical Success Factors and key risks

- Adherence to agreed clinical guidelines across the Thames Valley
- Risks: lack of engagement

Scope and exclusions

- Focus on hospital admissions and inpatient care within Thames Valley units

Human and other resources committed

- Clinical leads from acute trusts
- AHSN Children's Clinical Network

Benefits

- Improved quality of care for children
- Reduction in unnecessary and lengthy hospital treatment
- Improvement in access to paediatric support in the community
- Financial benefit through reduced admissions

Measures and planned trajectory

Reductions in lengths of stay

Reduction in paediatric emergency admissions

Standardised approach to paediatric care across the Bucks, Oxon, West Berks region

Project Charter: Acute Programme - Bucks Pathology Project

Senior Responsible Officer: David Williams
Clinical Lead: Dr Mavis Mayers
Project Manager: John Nelson

Overall Objectives

- Review Bucks Healthcare Pathology Services to:-
- Establish networking opportunities with Oxford University Hospitals NHS Foundation Trust and The Surrey/Berkshire Pathology Network
- Maintain the adoption of new technology in Pathology diagnosis to provide improvement to patient care and the best use of clinical resources within the Trust
- Improve the use of electronic information management to support clinical practice
- Work with potential network partners on recruitment and training initiatives to improve the recruitment and retention of Pathology staff
- Review potential for collaboration on the management of logistics contracts

Deliverables

- Potential Projects working in Networks:
- Develop computer networks that are consistent with the clinical requirements for patient care and support an improvement in turnaround time and the accuracy of clinical data
- Develop joint business cases for managed services to provide high quality technological systems for the laboratories in the partnership with good value for money and transfer of risk
- Develop partnerships to provide Pathology Consultant Services to facilitate provision of clinical advice and ongoing medical education

Milestones

- Carry out an option appraisal on the possible benefits from network projects that could be developed working with Oxford University Hospitals NHS Foundation Trust Pathology Services and The Surrey/Berkshire Pathology Network
- Create business cases for the recommended projects for review by the Trust Board
- Develop a timetable for the projects that is compatible with available resources and ensures continuity of service for the Trust's clinical requirements
- Organise meetings with potential network partners during September 2016
- Deliver completed Template to NHSI by the end of September 2016
- Deliver option appraisal to Trust Strategy Group in October 2016
- Develop timetable for agreed options – November 2016

Critical Success Factors and key risks

- Success Factors:
- Measureable cost reductions in the delivery of Pathology Services
- Key Risks:
- Pathology Laboratory staffing is in serious short supply nationally and potential changes may lead to increased staff turnover and risk to the service.

Scope and exclusions

- Pathology Services provided within the Buckinghamshire Healthcare NHS Trust to the acute care and community environments
- The contract terms for Network projects already in place (Oxford-Bucks Managed Services) will need to be worked in synergy with new projects

Human and other resources committed

- The Project Team is made up from the senior management team within Pathology with support from the Trust's strategic planning group

Benefits

- Potential 15% saving from BHT joining the Surrey/Berks network
- Improve turnaround time for referral testing by developing computer links with partners

Measures and planned trajectory

Verify that the cost of Bucks Pathology Services are no more than 1.6% of the total operating budget of the Trust

Work with potential partners to continue the reduction in the overall costs of the pathology services for the Buckinghamshire community

Seek opportunities to improve the quality of care delivered to patients through value diagnostics

Project Charter: Acute Programme - Procurement Project

Senior Responsible Officer: Bruno Holthof
Clinical Lead: Tony Berendt
Project Manager: Gary Welch

Overall Objectives

- Trusts work collaboratively to share procurement data and resources to improve efficiency, value and deliver cost savings.
- Develop clinically-led procurement across the area to standardise products and suppliers, avoid unwarranted variation in spend – yielding improvements in clinical care, efficiencies and cost savings.
- Inclusion of all Trusts in the Shelford Group procurement work that is being led by OUH (Phase 1).
- Establishment of clinically-led procurement networks to facilitate standardisation (Phase 2).
- Development of an opportunity assessment for a single integrated procurement and supply chain organisation across region (Phase 3).

Deliverables

- An overall project and work management co-ordination and planning function for procurement across the group.
- A common data set and spend analytics across the group to facilitate efficient work planning.
- Development of formal mechanisms and work plans to include Trusts in the Shelford Group procurement work.
- Development of clinically-led procurement networks by working with others (e.g. AHSN) to facilitate standardisation.
- Opportunity assessment for a single integrated procurement and supply chain organisation across region.

Milestones

- September/October 2016 – Initial launch meeting held with group – commence price variance work.
- September/October 2016 – 'rules of engagement' and formal mechanisms agreed to include Trusts in the Shelford Group procurement work.
- October 2016 – Project Manager in place to establish work management co-ordination and planning across the group.
- October/November 2016 - common data set and spend analytics across the group.
- October/November/December 2016 - clinical procurement networks established for initial categories.
- November/December 2016 – workshop held to establish appetite for, and key elements of, a single integrated procurement and supply chain organisation.
- Nov 2016 to Jan 2017 – first benefits delivered from inclusion in Shelford Group work.
- April 2017 - Opportunity assessment completed for a single integrated procurement and supply chain organisation across region.

Critical Success Factors and key risks

- Leadership and commitment of Trust executives.
- Project management resource.
- Clinical engagement/leadership and establishment of effective decision-making - active involvement of key clinicians.
- Common dataset and consistent management information.

Scope and exclusions

- To initially focus on medical and surgical expenditure but to be developed to include all expenditure with 3rd parties.
- To include other nearby Trusts in neighbouring STP footprints.

Human and other resources committed

- Trusts to prioritise and commit existing resources.
- Project Manager(s) required to co-ordinate and lead the development and implementation of the project (est. cost £100k-£150k) and the opportunity assessment for a single organisation (£50k-£100k).

Benefits

- Clinical standardisation and reduction in variation leading to improved clinical outcomes.
- Savings from additional leverage of Shelford Group.
- Efficiency benefits rationalised and co-ordinated procurement and supply chain function.

Measures and planned trajectory

- Savings estimates cannot be made with a great degree of accuracy based on the current information available. However, the expenditure with 3rd parties across the group is estimated to be in the region of £0.5bn-£0.75bn – an additional 1% benefit of working collaboratively across the group would therefore yield £5m-£7.5m.
- Initial analysis of PO data using NHSI new benchmarking tool suggest £1.0m-£4.2m potential savings from resolving price variance alone.

Project Charter: Acute Programme - Specialist Paediatrics

Senior Responsible Officer: Bruno Holthof
Clinical Leads: Karen Steinhardt
Project Manager: Andrew Stevens

Overall Objectives

To achieve clinical and financial sustainability for all paediatric sub-specialties across the Oxford and Southampton Children's Clinical Network.

Deliverables

- Developing a strategic framework for the planning, commissioning and delivery of all specialist paediatric services
- Continuation of implementing Operational Delivery Networks for Cardiac, Critical Care and Neurosciences
- Develop a Rehabilitation regional network
- Implement a Network-wide Transition Programme – transitioning patients from Paediatrics to Adult Services using the Ready, Steady Go model
- Implement a Network-wide Patient and Public Improvement Strategy

Milestones

- Priorities agreed by the Network Board - completed
- Initial scoping meeting for the development of the strategic framework held on 27/07/16
- Clinical and Managerial Workshop to be held October 2016
- Proposals for lead commissioner arrangements for 2017/18 to be agreed with Specialist Commissioners as part of the 2017/18 commissioning round
- Other milestones as per the Children's Network Business Plan

Critical Success Factors and key risks

- Compliance with agreed service models
- Full clinical engagement
- Agreement of effective commissioning and inter-trust managerial and financial arrangements
- Agreement of any planned service reconfigurations

Scope and exclusions

- All paediatric specialist paediatric services delivered across the Oxford Southampton Children's Network

Human and other resources committed

- Oxford Southampton Children's Network
- Oxford AHSN Children's Clinical Network

Benefits

- Improved and consistent quality of care for children across the Children's Network
- Clinical and financial sustainability for specialist paediatric services

Measures and planned trajectory

- Specialist paediatric services quality dashboards
- Compliance with specialist paediatrics service specifications
- Consistency of access, performance and outcomes across the network
- Financial sustainability of specialist paediatric services across the network

Project Charter: Mental Health Programme

Senior Responsible Officer: Stuart bell, CEO Clinical Lead: TBC Project Manager: N/A

Overall Objectives

- To reduce health inequalities (improved life expectancy in the long-term) for people suffering mental illness.
- Create a system for mental healthcare designed to consistently secure the best outcomes for service users and carers, building on innovation across BOB and beyond.
- Ensure that healthcare resources are appropriately allocated and deployed to meet the mental health needs of the BOB population equitably both in relation to other healthcare needs and by national comparators and targets.

Deliverables

Key Transformations in:

Specialised Services: Reducing OATs, Length of Stay and increasing care closer to him in Low and Medium Secure Adult Mental Health Services, Tier 4 CAMHS and Eating Disorders.

Children and Young People Services: Improving access and outcomes in child and adolescent mental health services In line with the Future in Mind plans in place across BOB.

Implement the Five Year Forward View Plans investing in services to meet the commitments of parity of esteem to address significant service gaps and health inequalities.

Develop BOB-wide Specialist Services to improve outcomes for military trauma and mother, baby and perinatal mental health services.

Address Current Service Gaps for ASD and ADHD, Personality Disorder and Transitions.

Milestones

- Low & Medium Secure Services Business Case Approved (Dec '16) and 'Go-Live' April
- Develop proposals and business cases for T4 CAMHS and Eating Disorders by April '17.
- Agree plans for Implementing FYFV for Mental Health 'December '16
- Agree plans for BOB-wide Services and other service gaps (Dec '16)
- Agree plans to address service gaps and demand/capacity pressures (Dec '16)
- Develop BOB-wide MH implementation plan (April '17)

Critical Success Factors & key risks

- Acknowledgement and recognition of the impact of relatively low levels of spending in mental health.
- Sufficient investment and reallocation of funding into mental health to deliver the aspirations of the Mental Health Task Force.
- Collaboration between BHFT and OHFT.

Key Risks:

- Workforce recruitment, retention and re-training
- Engagement of service users, carers and clinicians
- Time to develop strong collaborative plans.

Scope and exclusions

- Covers all CAMHS, adult and older adult mental health services across BOB including specialist, liaison and perinatal.
- Interfaces with specialist commissioning workstream (and other STPs)
- Interfaces with Frimley in relation to MH services in East Berkshire.

Human and other resources committed

- Currently OHFT and BHFT senior management.
- AHSN programme management support could be utilised to manage some of workload.

Benefits

- Reduced demand for more coercive mental health interventions & physical health services (A&E, admissions, GP attendances)
- Increased well being, more effective transitions
- Earlier intervention in the course of mental illness
- Reduced inequality in patient outcomes.

Measures and planned trajectory

- Identification of projected need across care pathways in BOB.
- Identification of service changes and capacity requirement to deliver FYFV.
- Plans with measureable outcomes.

Project Charter: Specialised Commissioning Programme

Senior Responsible Officer: David Smith
Clinical Lead from SCN
Project Manager: Director of Specialised Commissioning.

Overall Objectives

- Lead, facilitate and drive integration and cross-health system redesign for specialist commissioning across STPs .
- Identify areas of specialised commissioning where increased value can be achieved with focus on cancer and interventional cardiology.
- Mitigate further growth in specialised services by identification of alternative pathways which have greater value for patients.

Deliverables

- SCN report on value and outcomes of specialised treatments where there appears to be unwarranted variation within STP.
- Specific focus on cancer services for a recalibration toward earlier intervention and precision medicine.
- Alternative pathways identified by clinicians.
- Patient, service and financial implications identified from potential changes.
- Engagement with local population.

Milestones

- Engage SCN and patients to identify specialised treatments where patient outcomes appear to provide poor outcomes and low value for patients. Initial focus on: Cancer; Cardiology; Neonatal intensive care; Children's services – Jan 2017
- NHSE / STP work across other STPs where there are material flows for tertiary services.
- Identify alternative pathways providing better value for patients. – March 2017
- Demonstrate benefits for patients and improved value for public money (Senate Review). – May 2017
- NHSE Stage 2 review – July 2017
- Consultation on proposals Aug– Oct 2017
- Service changes commence in Feb 2018 with full effect in 2018/19

Critical Success Factors and key risks

- Speed at which new Director of Specialised Commissioning can be in post.
- Ability to identify alternatives to existing provision.
- Support of commissioners across several STPs
- Engagement of patient groups and clinicians.

Scope and exclusions

- Specialised commissioning budgets across the 3 STP footprints; Buckinghamshire, Oxfordshire and Berkshire West; Hampshire and Isle of Wight; Dorset.

Human and other resources committed

- New Director of Specialised Commissioning Delivery appointed.
- STP financial staff resource to work with NHSE Specialised Commissioning to estimate potential benefits

Benefits

- Improved patient experience and outcomes .
- Predicted 3% growth mitigated (£60m)

Measures and planned trajectory

- Reduce number of patients treated out of BOB area.
- Spend on specialist commission budgets for BOB population for specific services being improved.

Project Charter: Workforce programme - Systems Leadership and OD Capability

Senior Responsible Officer: Neil Dardis
Programme Director – Ali Jennings, Clinical Lead: tbc
Project Manager: tbc

Overall Objectives

- Enable systems thinking, collaboration and behaviour change to support new ways of working, integration and innovation across the BOB STP priority work-streams. This will create the engagement and focus necessary to deliver significant transformation in service delivery through our workforce.
- To create a highly effective BOB Local Workforce Action Group (LWAB)

Deliverables

- System Leadership and OD plan which identifies the leadership and OD priorities.
- A series of development interventions which create the shift in mind-set, behaviours and skills necessary to deliver the STP objectives.
- Working with the Senior leaders and programme directors, to create a collective leadership team that works through 'wicked issues'
- The creation of a culture of collaboration and continuous learning across the STP footprint led by senior system leaders who role model collective and collaborative leadership behaviours.
- Evaluation of interventions contributing to the wider NHS evidence of best practice and learning on system leadership and integration.

Milestones

- Formation of the BWAB in August 2016 and an agreed development plan for the BWAB to create the right working culture of collaboration and ways of working.
- Agreement on the process of developing the System Leadership and OD Plan (the programme of work).
- Creation of the System Leadership and OD Plan (the Plan)
- Identification of target audiences for development and creation of learning cohorts.
- A proactive OD learning community developed
- Mobilisation of the Plan including roll out of development interventions and relevant task and finish groups to lead engagement and delivery.
- Evaluation of interventions and impact.

Critical Success Factors and key risks

- Wide-spread engagement and agreement of the Plan.
- Communication with the wider workforce and target audiences for the intervention on the case for change.
- Successful recruitment to and completion of development interventions.
- Insufficient financial resources to fund development.
- Unrealistic timeframes and expectations.

Scope and exclusions

- The Plan will need to connect the leadership and OD strategies/plans of all the BOB stakeholder organisations
- The Plan will suggest the resources required for successful delivery and implementation but will not create delivery on its own.
- Created with , and owned by the OD community

Human and other resources committed

- 1 day per week of Head of Leadership and OD for TVWLA
- Supported by external providers of leadership and OD
- Initial development investment from HEE TV and TVWLA of circa £40K with further funding being sought from national funding sources.

Benefits

- Engagement of staff in the STP agenda
- Optimising the conditions for success for the priority work -streams through the up-skilling of the workforce and enhancement of leadership capabilities across the BOB footprint.

Measures and planned trajectory

- Levels of engagement in the creation of the Plan
- Recruitment to and completion of development interventions.
- Intervention evaluation
- Measurable and visible behaviour change.

Project Charter: Workforce programme – BOB support Workforce project

Senior Responsible Officer: Bev Searle
Clinical Lead: TBC
Project Manager: Adedayo Odubayo

Aim

- Develop a recruitment strategy
- Create an education framework for the personal and professional development of health and social care support workers
- Enhance the capabilities of support staff
- Identify new roles that better serve clients needs

Objectives

- Provide shared and multidisciplinary training
- Increase the number of health and social care support workers in care homes and domiciliary care

Deliverables

- Skills gap analysis in health and social care workforce
- A core set of support worker competencies
- A recruitment strategy for health and social care
- A competency framework with clear development pathways
- An accredited and non-accredited learning programme
- Good apprenticeship schemes
- Strategy to share good practice

Milestones

- Complete detailed project plan - Sep 2016
- Objectives and deliverables agreed by LWAB
- Funding identified and agreed
- Workforce and skills gap analysis – Dec 2016
- Range of support roles scoped
- Identification of training and supervision requirements for new roles
- Develop training and rotation - March 2017
- New roles and pilot sites agreed
- Recruitment strategy for pilot sites completed
- Approval of proposed initiatives by STP partners
- Recruit first cohorts to rotations - June 2017

Critical Success Factors and key risks

Critical success factors:

- Support from organisations involved.
- Project delivering added value to current local initiatives
- Ability to align terms and conditions of employment across health and social care

Risks

- Not all parties agreeing shared support workforce roles
- High housing costs and low unemployment in Thames Valley reducing recruitment.

Scope and exclusions

Included

- Training, supervision and support for existing and new Support Worker roles
- Health and Care sector support workers
- Those in community and care homes

Excluded

- Professionally qualified staff roles

Human and other resources committed

- HEE Project management support
- HEE Workforce development /analytics support
- Each participating organisation to establish a local project team.

Benefits

- An increased and sustainable support workforce with a reduction in turnover
- Reduced agency spend
- Improved satisfaction of staff
- Fewer people being admitted and instead being supported in their own home
- Reduced number of medically fit patients in hospital and recorded delayed transfers of care

Measures and planned trajectory

- Number of support workers
- Number of medically fit patients in hospital
- Number of hospital admissions for social reasons

Project Charter: Workforce programme – Workforce Value Improvement project

Senior Responsible Officer (Executive Sponsor): Mark Power, Director of OD and Workforce, OUHFT
Clinical Lead: to be identified Project Manager: Samantha Parker, OUHFT

Aim

For trusts in the BOB geography to achieve quality and financial improvements through the more effective utilisation and deployment of the region's healthcare workforce.

Objectives

- Establish a contingent (bank) workforce that has the capacity and capability to be flexibly deployed across the BOB geography, in response to prevailing demand.
- Minimise, or eliminate, the use of high cost agency staff across the BOB geography.
- Improve employment 'portability' across the BOB geography.
- Achieve efficiencies in the recruitment and retention of staff from outside of the UK.
- Improve the staff retention .
- Improve staff and patient experience.

Deliverables

- All trusts using one common platform in the provision and deployment of bank staff.
- Overall bank capacity substantially increased.
- Use of agency staff is a measure of last resort.
- Standardised recruitment, rates of pay and other main terms and conditions of employment for all bank staff.
- Development and implementation of a common recruitment framework and model contracts of employment.
- Improved mobility of labour across the region.

Initial Milestones

- Identification of Executive sponsor (ES)
- Establishment of a project group, accountable to the LAWB.
- Agreed objectives and guiding principles.
- Requisite supporting resources identified.
- Comprehensive baseline analysis of existing job descriptions and associated contractual terms and conditions for all main staff groups.
- Analysis of current practices associated with international recruitment to inform the identification of opportunities for efficiency gains.
- Identification of current 'barriers' to cross-organisational deployment of staff.
- Common bank platform established and (where necessary) existing bank contracts migrated.

Critical Success Factors and Key Risks

Success Factors:

- Common bank platform must be established and (where necessary) existing bank contracts migrated.
- Number of existing job descriptions associated with common roles must be substantially reduced and harmonised across the region.
- Achievement of minimal variation in main terms and conditions of employment (including pay).
- Close collaboration in the recruitment and deployment of staff from outside of the UK.

Key Risks:

- Trusts unable to align to a common bank platform.
- Perpetuation of current barriers to cross-organisational deployment/employment of staff.

Scope and Exclusions

- Scope to include:
  - all flexible staffing requirements via staff banks and approved supporting agencies ;
  - all current off payroll arrangements applicable to interims and other contractors;
  - the potential for shared service arrangements.
- The re-negotiation of nationally determined terms and conditions of employment is out of scope.

Human and Other Resources Committed

- Each participating organisation to establish sufficient local resource to support the project activity.
- Expert analytics support to be sought from HEE.

Benefits

- Regional bank capacity increased by at least 25%, with corresponding reduction in overall agency expenditure.
- Number of existing job descriptions associated with common roles substantially reduced and harmonised across the region.
- Minimal variation in main terms and conditions of employment (including pay).
- Overall staff turnover rate reduced by 5%.
- Demonstrable improvements in staff and patient satisfaction.

Measures and Planned Trajectory

- Detailed project plan to be developed in Q2 16/17.
- Key activity to commence from Q3 16/17 for delivery in 17/18.

Project Charter: Digital Transformation Programme

Senior Responsible Officer: Lois Lere
Clinical Lead: tbc
Project Manager: Several PMs via SCWCSU

Overall Objectives

- Delivering integrated health and care records.
- Empowering patient wellbeing and self care through the collaborative design and specification of personal health records
- Ensure exemplar initiatives draw inward investment into BOB to benefit local population e.g. OUH Global Digital Centre of Excellence.
- Maximise benefits of technology across public sector e.g. smart cities, Bicester Healthy New Town Vanguard and broadband
- Enable individual GP Practices to work at scale through technology.
- Supporting governance and security by agreeing an shared approach to patient identity management and information sharing agreements
- To have a secure and agreed method for using health and care data to inform commissioning, research and service transformation being led by AHSN
- Finding opportunities to share learning and best practice and to collaborate where efficiency can be delivered across the STP
- Direct booking from 111 into General Practice

Deliverables

- A costed investment plan across the NHS and Social Care organisations within the BOB footprint.
- An integrated Digital Roadmap and investment case for the 2017/18 planning round
- Development of requirements for design of patient held records. Business case for pilot
- A suite of standard information sharing agreements to include primary care, social care and children's services
- Existing projects register highlighting procurement flexibilities and options for adoption at scale
- Agreed approach sharing locally held integrated care records and for interfacing these with national services provided by NHS Digital
- Read / write interoperability operational in all areas.
- Care plans shared with urgent care
- Information sharing for child protection

Milestones

- Cross BOB Digital Leaders Group established June 2016 - completed
- Agreement of initial priorities July 2016 - completed
- Costed investment plan based on current priorities by end September 2016 - completed
- Collaborative Information Governance Group established September 2016 - established
- 2017/18 investment priorities based on the digital roadmap by October 2016 – completed
- First draft Integrated Digital Roadmap by November 2016
- Agreed SDIPs for technology – December 2016
- Clear priorities for SDIPs for technology created across BOB by December2016
- Connected Care in Berkshire operational – December 2016
- Deliver an integrated Digital Roadmap – March 2017
- Supplier co-production event with AHSN April 2017
- Shared care plans interim solution with urgent care – March 2017
- Buckinghamshire read / write interoperability operational – Sept 2017
- Oxfordshire read / write interoperability operational - tba
- Information sharing for child protection in place – Oct 2017

Critical Success Factors and key risks

- Organisations continue to engage and prioritise delivery of STP digital priorities and collaboration
- Funding for resources included in plan
- Timely guidance and clarity of objectives from NHSE relating to the digital elements of planning and funding streams
- Stability in organisational structures to allow buy-in and planning

Scope and exclusions

Includes :

- Work to deliver the NHSE requirement to access digital transformation funding.
- Implementing digital solutions to enable BOB wide programmes to deliver benefits.
- Ensuring BOB wide funding is used to best effect.

Excludes :

- Meeting individual organisational service requirements

Human and other resources committed

- Workstream Lead
- SCW CSU Digital Transformation Leads (Flexible based on CCG SLA)
- CIOs from NHS Provider, Commissioner and ALB Organisations and Local Authority Directors of IT

Benefits

- Economies in procurement and delivery
- Transactional efficiency to save staff time and cost
- Sharing information across organisations and patients
- Reduced emergency admissions as front line clinicians have access to patient care plans and records.
- Reduced hospital LOS by enabling shared trusted assessments

Measures and planned trajectory

- Many benefits will be realised as part of other programmes.
- Reduced CSU, CCG & Trust management time required and lower cost of services procured.
- Reduced administrative and clinical time spent on sending FAXs etc. Reduced errors and rework
- Delivery of the NHSE 10 universal capabilities and 7 national must do's.
- Percentage improvements in Provider and Primary Care Digital Maturity against 2016 baseline

Project Charter: Primary Care at Scale Programme

Senior Responsible Officer: tbc
Clinical Lead: Michael Mulholland
Project Manager: tbc

Overall Objectives

- To support the transformation of primary care to deliver high quality care through working at scale and coproduction of improved quality of care across the healthcare system though the development of new ways or working and integrated systems of care.
- To identify and develop the areas of quality care for patients already occurring throughout the BOB footprint in primary care and the measures required to scale these through the networks of localities and federations within and across the three local populations.
- To explore across the footprint how new models care might be developed to provide quality primary care for patients, leading to efficiency for the healthcare system and sustainability of GP and primary care across the STP footprint.

Milestones

- Establish working group Nov 2016
- Identify areas which are common to all parts of BOB where working at scale adds value Jan 2017
- Make proposals of alternative ways to deliver services to STP delivery Board Spring 2017

Scope and exclusions

Includes

- All BOB practices and GP Federations
- Services where patients could benefit from shifting provision into the community

Excludes

- Service change which is specific to local populations, as this will be managed in each local area.

Human and other resources committed

- Primary Care representation group
- Resource to support STP / transformation activity beyond current scope - tbc

Benefits

- Services provided closer to home for patients
- Improve quality through integration with community and primary care will release funding currently invested in secondary care.

Deliverables

Establishment of the Primary Care at Scale working group

Identification across the footprint of examples of quality care provision occurring in practices, localities and Federations which can be scaled up

Identification of new models of care provision to deliver higher quality to patients at BOB scale.

Business cases for reallocation of resource to provide more sustainable patient care

Critical Success Factors and key risks

Critical success factors

- Identification of initiatives which add value to work already occurring within local populations.
- Engagement from Primary Care providers both needed for success of projects and delivery of new models
- Adequate project management and clinical resource funding
- Financial Resources needed to pump prime and support transformation – this is not available within the current provider / GP budget
- Sustainable primary Care

Risks

- Disengagement if it is perceived that change is being forced on primary care.

Measures and planned trajectory

- Improved patient outcomes – dependent on services affected.
- Increased number of people not having to travel to hospital
- Funding released which can be reinvested in community and primary care
- Sustainable primary Care

Project Charter: Buckinghamshire System Transformation Programme

Senior Responsible Officer: Co-Chairs of Transformation Delivery Group – Robert Majilton & Trevor Boyd (Healthy Bucks Leaders have overall oversight)
Clinical Lead: Relevant to each programme area
Programme Director: Ann Donkin

Overall Objectives

- Delivery of Bucks Health & Wellbeing Strategy
- System vision – Everyone working together so that the people of Buckinghamshire have happy and healthier lives
- Rebalance the health and social care spend to increase support for Living, Ageing and Staying Well and Prevention and Early Intervention Initiatives.
- 4 Key workstreams:
  - Self Care and Prevention (SC)
  - Integrating the health & social care commissioning & delivery system (IC)
  - Reforming urgent and emergency care (UC)
  - Planned and Specialist care transformation (PC)
- 3 Enabling Workstreams – Estates, IM&T, Workforce

Key Deliverables

- Implement top 6 priorities in the HWB Strategy (SC)
- Design multi specialist community provider teams in community hubs via a single point of access (IC)
- Deliver a joint approach to residential care & continuing health care market (IC)
- Reduce acute hospital utilisation & invest in community and primary care (IC)
- Implement GP Forward View (IC)
- Reduce length of stay and unnecessary use of beds within the acute sector (UC)
- Improve transitional care for those medically fit for discharge (UC)
- Improve performance to upper decile focused on the Right Care initiatives, utilise new models of care and integrated community & primary care to delivery care closer to home (PC)
- Implement cost efficiencies e.g. the carter review

Key Milestones

By the end of 2016/17

- TV Integrated 111 mobilised (UC)
- Development of OOH innovation & scoping (UC)
- Identification of services for provision on a provider network basis (PC)
- Common care pathways agreed to address unwarranted variation (PC)
- Implementation of iMSK lead provider contract (£35m pa contract) (PC)
- Joint appointments for expansion of integrated commissioning unit (IC)
- Refresh strategies for integrated health and care and 7 localities / hubs (IC)
- Agree plan for EMIS system rollout for community services
- Establish community hubs based on GP populations- 3 locality hubs operational Wycombe, Aylesbury & Buckingham (By April 17) c 250,000 population (50% coverage)
- Estate – Finalise One public Estate, SOC for Wycombe Hospital

2017/18

- OOH & UCC mobilisation, OOH clinical triage managed by NHS111 (UC)
- Acute provider agreement on strategy for collaboration (PC)
- Roll out of pathway transformation from RightCare – e.g. Opthalmology (PC)
- Implementation of stream at front door of A&E (UC)
- Joint market and contracting teams for bucks (IC – Commissioning)
- Remaining GP population based hubs by March 18– 4 localities
- Estate – Acute hub redevelopment and community redesign

2018

- Refresh health economic analysis on return on investment (PC)
- Outcomes based contract across wider footprint for MH & LD (IC)
- Comprehensive childhood obesity prevention programme in place (SC)
- Estates – Service moves to PFI facilities

2019

- Single point of access effective and fully integrated teams in place (UC & IC)
- Estates – release elements of retained estate

2020

- Health & social care in a single organisational system

Critical Success Factors and key risks

- Estimated investments required in national imperatives is adequate to achieve operational goals
- Leadership and cross – organisational working
- Clinical engagement / leadership & mapping onto individual programmes

Scope and exclusions

- Covers Buckinghamshire Health (2 x CCGs, BHT, OHFT, SCAS, Primary Care) and Social Care (BCC) as members of Healthy Bucks Leaders
- Transformation focus is on system wide programmes where delivery is improved by joint working, it does not describe everything each organisation does therefore does not mention all elements of operational planning (these will be covered in the detailed plans)
- There are significant flows for the Bucks population into other STPs particularly Frimley and Milton Keynes, Bedfordshire and Luton

Human and other resources committed

- Transformation delivery group is chaired by CCG Deputy Chief Officer & DASS. Programme Management arrangements agreed, system wide Programme Management Software to be rolled out Nov 2016.
- Supporting groups in place: Finance & Information, Estates, Workforce etc.
- Programme Director until November – arrangements being reviewed
- Monitoring of Individual programme capacity part of Delivery Group remit

Benefits

- Transformational CIP/QIPP target of £12m (£5m Integrated Care / Mental Health, £6.5m).
- Supports delivery of "BAU" CIP/QIPP of £66m

Measures and planned trajectory

- 2% reduction in hospital conveyances (H&T, S&T) to divert patients away from A&E (UC)
- Reduce acute emergency admission growth from 2017 by 2% or 0.5% pa (UC)
- Activity increases reduced to in line with demographic growth (PC)
- Maintain adult social care DTOC to 22% per 100,000 population and reduce bed days to 900 per 100,000 pop (IC)

Project Charter: Oxfordshire Transformation Programme

Senior Responsible Officer: Stuart Bell
Clinical Lead: Relevant to each programme area
Programme Director: Simon Angelides

Overall Objectives

- To develop sustainable acute and community services across Oxfordshire that provide high quality care, now and in the future. This should use clear clinical evidence and utilise lessons learnt from other similar health systems
- These proposals should be developed through a meaningful dialogue with the public, clinicians, staff and the wider stakeholder community
- To consider the proposals in terms of the wider STP footprint, considering developments both at scale but also locality level

Deliverables

- Assurance framework (Clinical Senate / PCBC)
- Option Development Process
- Integrated Impact Assessment
- Clinical Senate Review
- Travel Time Analysis
- Public / Clinical Engagement Reports
- Public consultation plan and documentation
- HOSC and Stakeholder Reports
- PCBC
- Consultation Review
- Consultation Business Case

Milestones

Milestone are split into two phases, but are subject to passing each of the tests set out below.

Phase 1 - Northern Acute

- Senate submission 24 October
- Senate review 7 November
- OCCG sign-off 18 November
- NHSE Submission 21 November
- NHSE Stage 2 Review 5 December
- NHSE Decision 16 December
- Start Consultation 3-10 January

Phase 2 - Community Services TBC

- Further work is required to establish a timeline around community services

Critical Success Factors and key risks

CSF

Achieving a meaningful public engagement that can demonstrate influence within the decision-making process

Risks

- Clinical & public support
- Robust process and decision-making

Scope and exclusions

- Phase 1 will include the North Acute (Emergency & Urgent Care, Obstetrics and Paediatrics), principles for Community Services
- Phase 2 will include Community Services
- Elements such as Primary Care / IM&T are enablers

Human and other resources committed

- Oxfordshire CCG and Oxford University Hospitals clinical, senior management and project management support.

Benefits

- Sustainable local health system that can deliver high quality care
- Horton Hospital changes are cost neutral but overall Transformation programme saves growth of £7.895m by 2020/21

Measures and planned trajectory

-

Project Charter: Berkshire West ACS Programme

Senior Responsible Officer: Cathy Winfield
Clinical Lead: Lindsey Barker
Project Manager: Sam Burrows

Overall Objectives

- The Berkshire West Accountable Care System is an initiative to create a new environment of collaboration between NHS organisations inside the Local Health Economy
- The programme will design and implement a new commercial and financial structure which protects provider organisations from the monetary consequences of implementing new models of care
- A multilateral approach will be taken to pathway redesign in an attempt to fundamentally change how patients access services within Berkshire West
- The programme is comprised of GPs, CCGs, Community / Mental Health provider and the local Acute Hospital provider
- Clinical leaders from each of these organisations will drive the design and implementation of these new models of care.

Deliverables

- New contractual arrangements between commissioners and providers which create an environment for delivery of pathway redesign
- The development of the vision for 10-15 service redesign opportunities (these have been defined)
- The establishment of the clinically project groups required to implement and monitor the changes
- The implementation of the service redesign opportunities, funded using the new contractual arrangements
- The delivery of all provider CIP and commissioner QIPP (c. £45m in 2017/18) through the implementation of new pathways

Milestones

- September 2016 – system leaders clinical workshop to discuss, agree and define the pathway level opportunities for implementation in 17/18 and 18/19
- October 2016 – Commence new approach to commercial / contracting agreements and formally apply for ACS system control total + STP sub-division arrangements
- November 2016 – Complete project 'deep-dive' exercise to ensure complete suite of clinical improvement project information is defined for implementation. Publish ACS programme plan + implementation roadmap
- December 2016 – Formally sign new contracting arrangements
- Spring 2017 – Pre-implementation activities progressed and completed
- April 2017 onwards – Implementation of new models of care:
    - Reducing frequent NEL admission
    - New respiratory pathway
    - Enhanced GP / Consultant interface
    - New model for Crisis Care
    - Dealing with on the day demand more appropriately
    - Clinical review of services with low value
    - Transformation of the outpatient function
    - Planned care pathways e.g. MSK, ophthalmology
    - Review of whole system bed stock and usage
    - Redesign of system wide use of diagnostics

Critical Success Factors and key risks

- Leadership and commitment of Trust executives.
- Project and programme management resource.
- Clinical engagement/leadership and establishment of effective decision-making - active involvement of key clinicians.
- Shared & open book accounting
- Regulator approval for joint working on alternative control totals

Scope and exclusions

- To initially contain only NHS organisations operating within Berkshire West as members of the ACS
- There is a shared aspiration that Local Authority organisations may formally join at a later date
- Excludes Berkshire Healthcare's "East" business as this formally resides in the Frimley STP area

Human and other resources committed

- Programme Manager required to drive and co-ordinate implementation
- Support to CFOs for the creation of group accounts
- Existing planning & transformation resource redeployed

Benefits

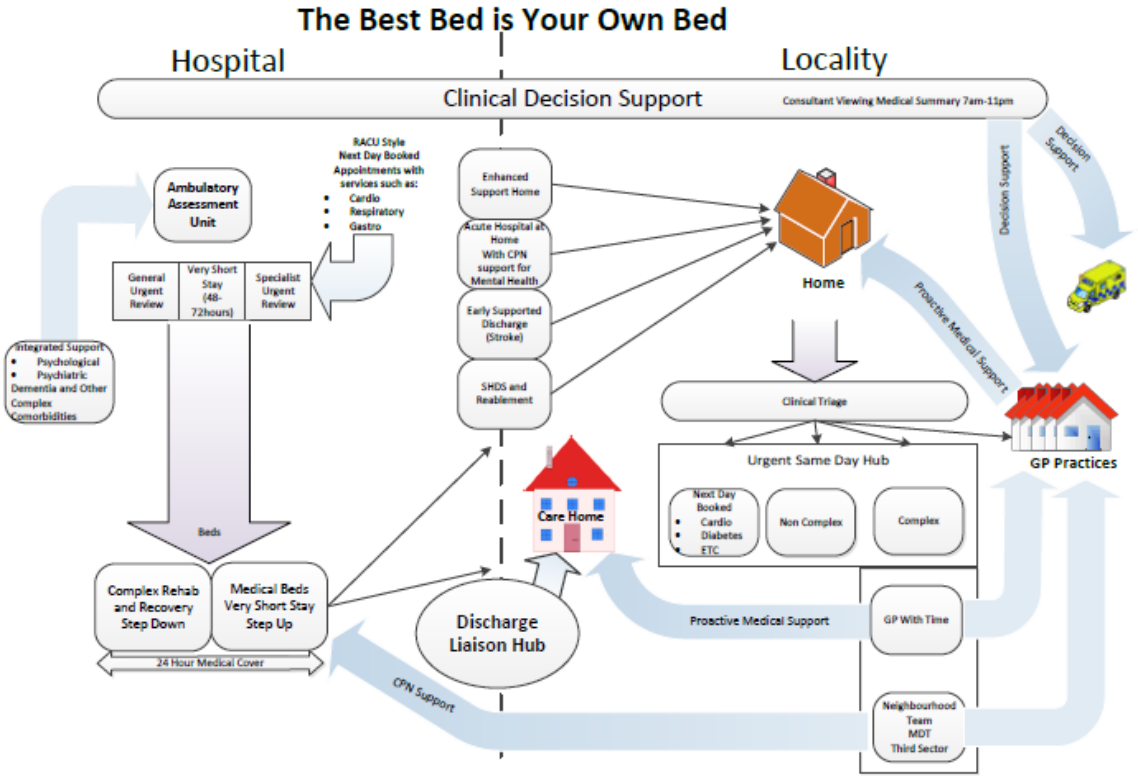
- Delivery of all provider CIP + commissioner QIPP with the aim to full system financial balance
- Improved care quality for patients, particularly those who can be kept out of hospital

Measures and planned trajectory

- Milestone tracker will be created for all projects within the programme so that the trajectory of implementation can be rigorously monitored and delivered
- Cost based accounting system will be implemented across all organisations in order to track delivery of multilateral cost reduction
- Plan for system wide financial balance (c.£45m of cost reduction) from end of 17/18

17. Appendix D: Best practice case studies

17.1 Oxford University Hospitals NHS Foundation Trust – supporting more people in the community rather than in hospital beds



The health and social care system in Oxfordshire had been struggling to solve the problem of delays in transferring patients out of hospital for years. This led to patients who were medically fit to be discharged remaining in hospital for longer periods, risking deterioration of their health and reducing the number of beds available to those with chronic conditions, particularly in winter.

Oxfordshire CCG worked with partners at Oxford Health NHS Foundation Trust (OHFT), Oxford University Hospitals NHS Foundation Trust (OUH) and Oxfordshire County Council to implement an initiative which would rebalance the system. The approach focused on transferring patients who were delayed into beds in nursing homes across Oxfordshire for a short period of time, while they awaited the next stage of their care (mainly home care packages or the organisation of a long term care home). This was managed with a single cross-system approach and a central 'Gold Command' structure which prioritised patients with complex discharge needs to identify available resources more quickly and unblock any barriers or delays.

A multi-agency liaison hub was established to provide a key liaison point for patients and all staff involved in the process of supporting them through their discharge. The hub's multi-disciplinary team (MDT) consists of qualified nurses with acute medical experience and expertise in discharge planning with discharge planners working alongside them, the OUH lead for discharge planning and an administrator. The hub worked closely with staff from adult social care, therapy staff, consultant geriatricians and senior interface physicians to:

- ensure proactive discharge planning for patients who are transferred
- administer arrangements and agreements with nursing homes, social workers, therapists, GPs and hospital clinicians
- manage the logistics of communication with patients and families and escalate any concerns and issues
- maintain a tracking system via a virtual ward on all patients who have moved and their onward destination
- provide day to day support to nursing homes to proactively support patient management.

Excellent multi-agency working along with a recruitment drive for extra home carers, has had a significant impact on the number of patients now delayed in an inpatient bed. Since the end of March 2016, the number of patients delayed in beds across Oxfordshire has been on a downward trajectory with a five year low in the number of patients delayed and waiting in OUH beds recorded in June 2016. This has led to 104 delays for Oxfordshire residents in July 2016 compared to 150 – 160 the same time the previous year.

Cross system working was highly valued by all staff involved, particularly by those who had been involved in previous attempts to work in an integrated way and who commented that this time 'we have got it right'.

17.2 Bicester Healthy New Town

Oxfordshire CCG is a lead partner in innovative plans for a new housing development in Bicester as part of the nationwide Healthy New Towns Programme. Working with partners, including, the local district council, housing associations and the Oxford AHSN, the CCG was instrumental in developing one of just ten bids selected from 114 across the country, which will see health and wellbeing put at the centre of a new housing development in North West Bicester. A shared vision will see the partnership strive to create a healthy community using the built environment as a catalyst for healthy living and technology as a means to supporting the community to live a healthy lifestyle.

This is the only site in the UK being developed to Planning Policy Statement 1 standards, including design for healthy lifestyles. OCCG is at the centre of this bid to support the aim of putting health at the heart of new developments by finding solutions to the health and care challenges of this new century using new models of digital health and designing-in health and modern care from the outset

Artist's impression of Bicester Healthy New Town

17.3 Supporting the childhood flu immunisation programme

For the second year, the Oxford AHSN has supported uptake of the children's flu vaccine through the Children's Clinical Network. In the first year, the vaccine was delivered to 2-4 year-olds via their GP practices. The Network Nurses' focus was on identifying how best performing GP practices achieved a high rate of immunisation uptake and then spreading this best practice to GP practices with lower rates of uptake. This was supplemented with training for GPs, practice nurses and other stakeholders aimed at improving uptake. In addition, in low vaccine uptake areas, parents were provided with information to allow them to see the benefits of immunising their children.

In 2015/16, the cohort of children offered the vaccine was extended to include school years 1 and 2. The vaccine was delivered through a school-based programme, supplemented by GP practices for children aged two to four in all parts of the Oxford AHSN region except Oxfordshire where the programme was delivered entirely by GP practices.

Following a review of the first year's work (2014/15), in 2015/16 the Network Nurses focused on providing a comprehensive flu vaccine information resource, based on feedback that all those involved in promoting, delivering or receiving the vaccine that background knowledge was lacking and access to information and resources was a challenge.

Flu webpages were included in the Children's Network section of the Oxford AHSN website to provide all resources and information on children's flu vaccination to all potential stakeholders from July 2015.

The Network Nurses contributed to over 30 training, promotional and educational

events for health professionals involved in immunisation, including facilitating at a national workshop. Some of this involved delivering 'train the trainer' children's flu sessions in the Oxford AHSN region as well as sessions for a variety of wider stakeholders such as children's centre managers.

In 2015/16, the best practice tips from high achieving practices were adopted for inclusion in national guidance by NHS England's national childhood flu immunisation taskforce. A second round of tips for the school-based flu vaccination programme have also been created, and adopted in national guidance.

The Oxford AHSN Children's Network engaged children in understanding the effects of flu by inviting school years 1 and 2 children to design a poster on the theme of 'What I would look like with the flu'. A calendar was created from the 12 top entries.

Outcomes
The total number of children taking up the flu vaccine in the Oxford AHSN region increased 45.5% from around 87,500 to over 161,000 (this takes account of the new age cohort), though in common with the rest of the country, the overall percentage of children vaccinated has dropped for reasons as yet unknown.

17.4 Improving recovery rates for people experiencing anxiety and depression

Background
In 2014, the Oxford AHSN Anxiety and Depression Clinical Network set out to increase the average recovery rate by 5% points. By June 2015, an average increase in recovery rate of 10% points had been achieved (from 48% to 58%) across the Oxford AHSN region. This means that each month an additional 173 people have been successfully treated for anxiety and depression and are now able to make long-term plans for their lives with greater confidence. The recovery rate in the Oxford AHSN region compares favourably with the national rate which remained constant at 45% during this period.

Challenge identified and actions taken
Based on a review of patients who had not fully recovered, it was agreed that a new approach was needed to further improve outcomes for people experiencing anxiety and depression. This was based on a commitment to continuous performance improvement with patients routinely receiving the best treatment at first point of contact. The Oxford AHSN Anxiety and Depression Clinical Network focused on collecting comprehensive data, accessing high quality research, identifying patient outcome themes and putting the right staff training in place. They built on links with existing networks, particularly IAPT, which see 30,000 patients a year in the Oxford AHSN region. A critical element was regular workshops to share innovation, best practice and latest research – as well as making time for hands-on training.

Outcomes
An improvement of 10 percentage points in recovery rates for people experiencing anxiety and depression has been achieved with a commitment to achieve further

improvements in recovery rates. In the most successful areas the recovery rate increased by 20% points.

17.5 Spreading best practice in dementia care

Challenge identified and actions taken
Memory clinics provide valuable support to people with dementia and their carers. Having identified unwarranted variation across its region, the Oxford AHSN appointed a specialist nurse to work with six memory clinic teams in Buckinghamshire, Milton Keynes and Oxfordshire, aiming to bring them up to the best standard through the Royal College of Psychiatrists (RCP) Memory Services National Accreditation Programme (MSNAP), which provides a structured means of working, embedding consistent high standards in memory clinics.

Three memory clinics in Berkshire, which had already gained excellent ratings, helped their colleagues elsewhere by helping them evidence standards and identify gaps. This resulted in successful cross-fertilisation of ideas and sharing of protocols, encouraging mutual support and a 'learning cascade'.

Outcomes
By January 2016, all six memory clinics had been accredited by the Royal College of Psychiatrists Memory Services National Accreditation Programme, three of which received an 'excellent' rating.

17.6 Spreading best practice in Buckinghamshire

Ophthalmology
A designated suite for age-related macular degeneration was built in south Buckinghamshire offering a one stop multidisciplinary rapid access clinic model to reduce waiting times within current resources and improve patient experience and long term outcomes.

Ambulatory care
A dedicated medical ambulatory care facility was opened to manage 20% of the acute medical cases taken outside of the Emergency Department and without the need to admit patients to beds. This was expanded to a full seven day service in summer 2016 along with the launch of a Rapid Emergency Assessment Community Team in the Emergency Department to fast track patients home without admission.

Stroke
Buckinghamshire have developed an innovative model of stroke care on the Wycombe Hospital site through the development of its Hyper Acute Stroke Unit. The unit is rated by the Stoke Sentinel Stroke National Audit programme in the top 7% for quality in the country. From April 2017, as part of the regions plans to centralise stroke care, the unit will expand to accept 600 more patients from the Berkshire catchment area. This follows extensive stakeholder consultation led by the Thames Valley Clinical Senate.

Better Healthcare in Bucks

Buckinghamshire have implemented 'Better Healthcare in Bucks', a major transformation programme which has resulted in the centralisation of A&E and emergency care services on the Stoke Mandeville site, the consolidation and development of cardiac and stroke services and the introduction of a minor injuries and illness unit at Wycombe Hospital, the trust's major planned care centre. This has provided patients with greater concentrations of clinical expertise for the care they need and supported the ongoing sustainability of urgent and emergency care services in the county.

Diabetes
The Buckinghamshire health and care system has redesigned diabetes services to transfer care out of the acute hospital into more community settings. Pathways for Type 2 Diabetes and prevention/pre-diabetes have been jointly developed by primary and seocndary care teams incorporating virtual clinics offering telephone and email consultations, multi-disciplinary teams reviewing complex patient cases, and the roll-out of an education programme for primary care clinicians. Patient care programmes have been strengthened including specific programmes for BME communities.

Musculo-skeletal service
Musculo-skeletal services are currently delivered through a variety of providers across Buckinghamshire. Providers have worked together through a collaborative process to redesign pathways to deliver better care to patients, whilst aiming to reduce the overall cost to the healthcare economy. An innovative commercial model is being developed that reflects a sharing of whole system costs and risk. In this way, partners are looking to reduce duplication and fragmentation of services for patients and agree a model which sustains services for the long term.

Vascular
The Buckinghamshire health and care system have centralised vascular services with leadership from the Clinical Network. In 2016, major aortic vascular surgery and carotid endarterectomy surgery was transferred from Buckinghamshire Healthcare NHS Trust to Oxford University Hospitals NHS Foundation Trust.

17.7 Mental health care best practice in Berkshire West

Across Berkshire West, there is timely access to specialist mental health services for all ages that is supporting positive patient health outcomes:

- All urgent referrals to specialist mental health services are responded to within one hour and all emergency referrals are responded to within 14 hours of referral
- Mental health services are monitored monthly through performance meetings to ensure delivery of access and wait time standards
- Service development Improvement Plan (SDIP) in place for 2016/17 to improve standards on key mental health services, such as Early Intervention Psychosis (EIP), Common Point of Entry (CPE), Tier 3 CAMHs, CAMHs Community Eating Disorders Service and CAMHs crisis care pilot
- CAMHs CPE now open 8am- 8pm Monday to Friday. Trial of weekend clinics
- Greater use of telephone and moderated online support for families whose children are accessing CAMHs treatment

- CAMHs working with the voluntary sector and local authority services to develop and deliver resources to support families while they are waiting for specialist intervention
- Whole system working to support children and families, for example Autistic Spectrum Disorder (ASD)
- Enhanced perinatal mental health service now implemented
- Expansion of SHaRON.

18. Appendix E: STP communications and engagement strategy to support the Sustainability and Transformation Plan for Buckinghamshire, Oxfordshire and Berkshire West

1. INTRODUCTION

In December 2015, the NHS outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England is producing a five year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency. To deliver these plans, local health and care systems came together in January 2016 to form 44 STP 'footprints'.

The Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP footprint is made up of three Local Health and Care Economies (known as LHEs), which themselves comprise a wide range of service providers, local authorities and a total of seven CCGs. The footprint itself covers a population of 1.8 million people. By its very nature, the BOB STP footprint is a multi-organisational programme – with all the opportunities and challenges that this brings.

This document outlines the proposed communications and engagement strategy for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP footprint. In developing their Sustainability and Transformation, the BOB constituent organisations have agreed that joint work (and therefore the focus of the overarching BOB STP) should be on those areas where the benefits of working at a larger scale can bring added value. By working in this way, they wish to avoid duplicating effort that is happening at a more local level.

This communications and engagement strategy is reflective of this approach – acknowledging that much work has been and will continue to be carried out at a more local level. However, every effort will be made to ensure messages are consistent, co-ordinated and timely - there is a long and well-established history of collaborative working amongst communications and engagement leads and professionals working in the BOB area which will continue. This is further facilitated

by a regional networking arrangement supported by NHS England to ensure best practice and plans are shared and discussed regularly.

These opportunities to forward plan and collaborate in a coordinated way enable all communications and engagement teams in the BOB STP footprint to better manage risks, issues and opportunities

It is noted that STP footprints are not statutory bodies. This means that individual organisations within the BOB footprint remain accountable for ensuring their legal duties are met during the STP design, delivery and implementation process.

This communications and engagement strategy will be shared with communications and engagement leads across the BOB footprint. Governance and the management of risk and issues are described later in this document.

2. APPROACH

2.1 Collaboration: maximising the local and adding value at STP level

Given the multi-organisational nature of STP footprints, it is proposed that the strategic approach to communications and engagement across the BOB footprint operates at the following levels: regional (NHS England South); BOB; place; organisation.

LEVEL	DELIVERY LEAD	FOCUS
Regional	NHS E Head of Communications and Engagement working with all STP comms and engagement leads	Consistency with national messages Regional messaging Supporting collaboration, sharing best practice and co-ordination across the region Assurance
BOB	BOB STP Communications and Engagement Lead	Co-ordination of overarching messages to ensure consistency across BOB footprint in line with the BOB STP narrative Supporting place and organisation leads to ensure they are sighted in a timely way on BOB comms plans and messages to support their stakeholder engagement Communications and engagement plans to support the delivery of BOB specific work programmes – this includes ensuring patients, the public and other stakeholders are fully involved in the development of these work streams as well as any comms and engagement plans Advice and support on implications of BOB specific plans on service change

LEVEL	DELIVERY LEAD	FOCUS
Local population	Communications and engagement leads for: Oxon Transformation Bucks Healthy Leaders Berkshire West ACS Berkshire West 10 NHS 111	Leadership and delivery within their localities of communications and engagement activities to support their place-specific STP activities Ensuring legal requirements around service change are met Ensuring all place specific stakeholders are identified and are appropriately and proportionately kept informed and engaged/involved – this includes their own Boards and those of partner organisations
Organisation	Communications and engagement leads for each BOB member organisation	Leadership and delivery within their organisations of communications and engagement activities - particularly in relation to engaging and involving their staff and service users Ensuring legal requirements around service change are met

2.2 Maximising local insight in developing the STP

NHS organisations have a duty to involve patients and the public in:

- Planning the provision of services
- The development and consideration of proposals for changes in the way those services are provided
- Decisions to be made by the NHS organisation affecting the operation of services.

Notwithstanding statutory obligations, involving and engaging will help to:

- Create understanding of the need for change and the case for developing new models of care to transformation health services across the BOB footprint and within LHEs
- Better inform the development of new models of care
- Enable partnership working and co-production with the public to ensure the successful implementation of any service change projects.

All partner organisations within the BOB STP footprint recognise the importance of informing, involving, engaging and, where needed, formally consulting their communities.

In the same way that this strategy recognises the many layers within each STP footprint, it similarly, recognises that all partner organisations and, in particular CCGs, have established relationships with their local communities and are in regular dialogue with them at a local level. This ‘locality-based’ approach fits better with how many of our local patients and public use services and therefore what they will want to know about and to influence.

Communities have already provided a wealth of feedback on the strategic direction of priority areas – and this has been considered as part of the development of the BOB STP and which will also provide a firm starting point for the development of the BOB specific work programmes and LHE activities.

It is important to acknowledge how this feedback has been considered, to explain how it has been used and how local conversations and engagement will continue to help inform how best to deliver change.

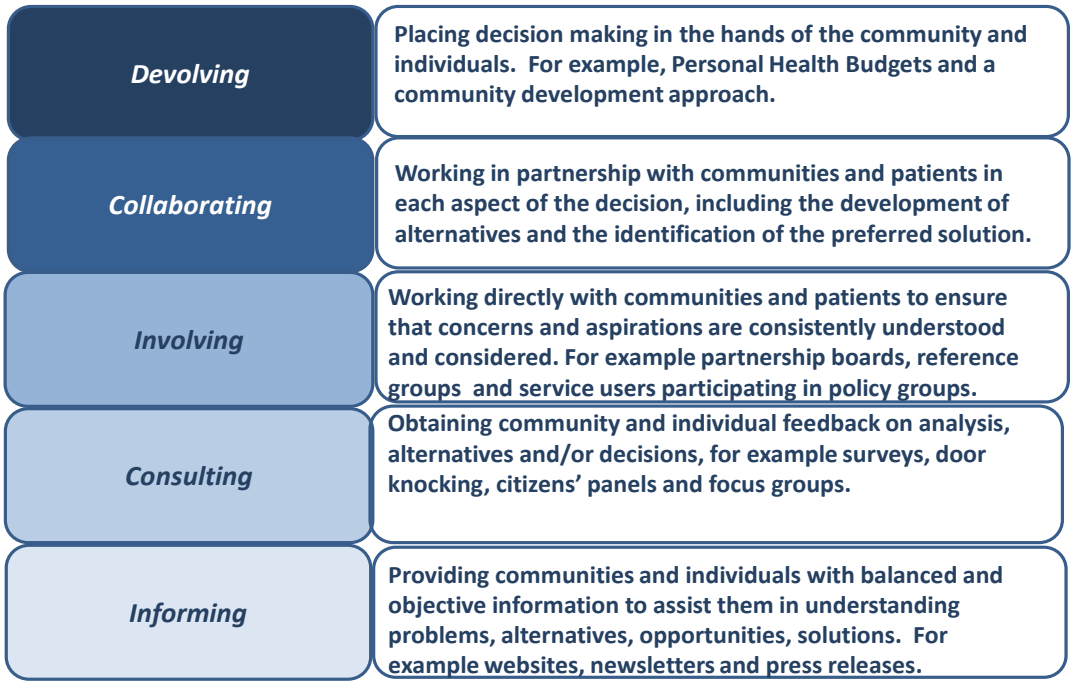
2.3 Working with communities to inform and engage

Organisations working within BOB are committed to achieving their joint STP and to making sure these identified areas are the best they can be – both now and in future years. However, these goals can only be achieved by whole communities working together – by patients, the public, carers, clinicians, stakeholders *as well as* local health and care organisations joining forces to develop, agree and deliver what should be jointly owned goals.

> To achieve buy-in and be able to implement the changes necessary to underpin the long-term future of health and care services, we must ensure that all groups (patients, the public, staff and stakeholders) both understand the opportunities and challenges and have the opportunity to shape the solutions. Where all interested parties are fully involved in decision making, solutions are better than where decisions are taken in isolation.

This strategy recognises that there are many different ways in which people might participate, depending on their personal circumstances and interest, as set out below. This model also shows that there are times when there will be a need to build awareness by informing and others where more active engagement is required. This approach will continue to be used at a LHE level and incorporated into the communications and engagement plans for the BOB-specific work programmes.

(TRANSFORMING PARTICIPATION IN HEALTH AND CARE. NHS England, September 2013)



2.4 Communications and engagement principles

Underpinning our approach to all communications and engagement activities will be a core set of fundamental principles. Our communications and engagement will be:

- **Clear** – we will keep it simple and straightforward. We will communicate a clear vision of the improvements we want to make
- **Consistent** – we will be consistent with our values, our objectives, our strategy and most importantly our key messages
- **Open and transparent -** we will be clear from the start what our plans are, what is and what is not in scope negotiable and the reasons why
- **Two-way symmetrical -** we won't just talk - we will also listen. We want to ensure that we have effective two-way communications and meaningful engagement (including co-production) in place to support our collective ambition.
- **Targeted -** we will ensure we get messages across to the right people in the right way and at the right time.
- **Timely** - we will involve stakeholders as early as possible in the process of engagement and communications
- **Informed -** we will ensure that people taking part in conversations will be

supported by detailed information to help them give informed views and perspectives

3. STRATEGY

3.1 Objectives

1. Ensure people have the opportunity to shape health and care provision, as well as their own health and behaviours

2. Connect the health and social care workforce to the BOB vision, ensuring they can co-design and contribute to the work we do

3. Continue to build effective reciprocal relationships with all stakeholder and partner groups

4. Demonstrate the difference working at a BOB level (for the BOB specific work programmes) is making to the people within the footprint area - focusing on the tangible local, and personal, benefits and being transparent about impact, savings and spend

5. Maintain and further develop a co-ordinated approach to media activities across the BOB footprint to maximise positive and minimise negative coverage, with both online and traditional media

6. Create and maintain an effective online presence that is accessible and informative to the general public, public sector staff and stakeholder groups – including making best use of digital platforms available across BOB member organisations for engagement

7. Ensure any plans or programmes within the BOB STP that require major service change, are planned and delivered according to statutory and legal requirements for public consultation.

3.2 Key messages/the BOB STP narrative

A shared STP level narrative will provide a consistent thread throughout all activities and will explain in broad terms the challenges facing health and social care; what the options are, and the benefits we expect to achieve.

We would test this with patient representatives, the voluntary sector and clinicians to ensure the document is truly co-produced. Engaging with and involving a wide range of clinical, non-clinical and social care staff to develop it means that it is tested and challenged by those with knowledge and expertise in the reality of delivering and receiving care.

As mentioned earlier in this strategy regarding the different operating levels for communications and engagement activities, consistency of message about the aims

of STPs and their long term goals and benefits should be maintained. When Place or Organisational leads want to set the context for their local activities, they will be asked to ensure they are mindful of core key messages, namely:

- There is now a broad consensus on how the NHS needs to change:
  - More action to tackle obesity, smoking, alcohol and other health risks – this means working with people to help them to overcome those lifestyle factors which affect their health
  - Patients having far greater control over their own care – there are many ways in which patients can be helped to manage their own conditions more effectively, for example, if they are given better information and have their own agreed care plan
  - Breaking down the barriers in how care is provided. This means not only health and social care organisations working more closely together but other parts of the NHS working jointly.
- Our STP footprint and our work to develop a plan for the BOB area will focus on the benefits that working across a larger area can bring – we will concentrate on where this will make the most impact and not duplicate the work being delivered in local health and care economies
- The NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them
- Different organisations and people from different locations will work together for the benefit of the whole system
- All key stakeholders have an important role to play in helping us shape these services
- We will encourage people to share their views and make it easy for them to have their voices heard
- We will involve people in the development and delivery of our plans.

Tailored messages will also need to be developed to best meet the audiences and need for each BOB specific work programme. In line with our commitment to involvement and engagement, we will develop and test these with key groups to ensure they resonate, are clear and meet our stated communications and engagement principles.

However, it is equally important that the overarching BOB Sustainability and Transformation Plan itself is clear and accessible – and therefore should be tested and developed with identified key groups, such as Healthwatch or Lay representatives, which are part of the BOB STP governance arrangements.

3.3 Stakeholder mapping and segmentation

Each of our stakeholder groups can broadly be represented in one of the following categories:

- clinical leads
- NHS staff

- public and patients – including seldom heard groups
- MPs
- CCGs
- patient representative groups
- NHS trusts
- local government
- Third sector and voluntary groups

We will segment external audiences and understand their views and behaviours so that information and activities can be tailored to the level of engagement they want, reflect specific interests they have and ensure the most appropriate channels for engagement are used. We will categorise them into four different groups based on their perceived levels of influence and interest with regards to the seven programmes:

Partner: Stakeholders that we need to work in partnership with to deliver the programme. It should be a partnership, highly bespoke, top level, interactive team. This is where key attention should be given.

Involve: Stakeholders who will need to be actively involved in and supportive of the work of the programme. It should encourage working together where appropriate and possible.

Consult: Stakeholders who will need to be consulted on particular areas of the work of the programme. It should provide a two-way and interactive method of communications and engagement – 'we will listen to you and respond'.

Inform: Stakeholders who need to be aware of the programme and kept informed of the main developments. It should be one way, straight forward, targeted and easy to prepare. This strategy is a live document and will take in to consideration that the stakeholders' power and interest may change over time.

3.4 Communications and engagement channels

Across the footprint we will work together as a health and care economy to make use of our existing groups, forums, communication channels and engagement mechanisms to engage with patients, the public, staff and stakeholders so that we reach as wide a group of the population as possible. Examples of existing channels are described on page 11.

In addition to tried and tested existing communication channels we are exploring the following to enhance more local activities:

- Establishing a website for the BOB programme to allow stakeholders easy access to consistent and up-to-date information. A secure section of the site could be used as a repository for project team members, including communications and engagement

- Using technology to map our physical communities – software exists that

allows you to do this quickly and effectively – the results can identify gaps and plans can be put in place to address these

- Mapping our digital communities and put together a plan for engaging with them

- Investing in software (Coveritlive) to enable online meetings – negating the need to hold poorly attended, resource-intensive and costly face-to-face/community meetings

- Working with partner organisations to identify existing consultation exercises which could be extended to include aspects of the STP engagement work

- Organising a multi-agency media briefing running at regular intervals throughout the programme (online to achieve greatest uptake across large geographical area).

Examples of existing communications and engagement channels across the BOB STP Footprint

Patients, the public and carers	Boards/partners	Clinicians/staff	Wider stakeholders
• Public engagement events • Roadshows • Working with PPGs • Healthwatch • Online engagement tools e.g. Oxon Talking Health, the Berkshire West Health Network, Let's Talk Health Bucks • Existing community and voluntary organisations' meetings and channels • Reaching people where they already are: libraries, GP surgeries, pharmacies, hospital etc • Joining up with other local engagement activity as appropriate • Focus groups • Surveys • Newsletters	• Programme governance meeting schedule • CCG Boards • Statutory meeting updates (HOSC, Health and Wellbeing Boards) • Stakeholder specific briefings, meetings and update communications to include Councillors, MPs, neighbouring CCGs and providers	• CCG member briefings, newsletters etc. • Wider CCG and provider staff briefings and comms: o Scheduled meetings o Direct emails o Newsletters/bulletins o Noticeboards o Website/intranet	• Materials to support partners in their cascades, such as briefings, parish newsletter content etc
Communications: print, digital and broadcast media, websites, e-bulletins, social media, 'you said, we did' communications			

4. ACTIVITIES AND WORK PROGRAMMES

4.1 Immediate priorities

Our immediate priority will be to ensure that a public facing version of the BOB STP is prepared and that, across the BOB footprint, we ensure that our target audiences and key stakeholders are aware of our aims and objectives. The timing of this activity will be in line with the NHS England submission timetable - currently expected to be in late November 2016.

Effective publicity for the plan is essential in ensuring the public have the best understanding of the proposed changes and the benefits it will bring. It is crucial to explain in broad terms the challenges facing health and social care; what the options are, and the benefits we expect to achieve. We would recommend the following approach in order to achieve this:

Using the Executive Summary as a starting point, produce a source document to use as the basis for briefing all stakeholders. This should be tested with patient representatives, the voluntary sector and clinicians to ensure the document is truly co-produced. Engaging with and involving a wide range of clinical, non-clinical and social care staff to develop it means that it is tested and challenged by those with knowledge and expertise in the reality of delivering and receiving care.

Once the STP is in a position to begin this outward-facing work, communications products and activities could be delivered as per the following illustration:

Target Audience	**Mechanism**	**Purpose**
MPs/Local Government	Briefing document Short copy	To present the facts to government reps across the STP patch For inclusion in council publications aimed at councillors across the STP patch
Patient representative groups	Briefing document	To present the facts and to seek feedback on the way they are presented to patients/public
Clinicians/staff	Briefing document	To present the facts and to seek feedback on the way they are presented to patients/public

	Intranet copy Posters	To ensure all staff are aware of the plan and what it means in for the local population with whom they work To encourage staff to get the facts about the plan and what it means for the local population with whom they work
Patients/the public	Infographic Easy-read leaflet Digital ad	To present the complex information in a simple-to-understand way To use as a conversation starter or for distribution throughout the local health and social care system to raise awareness and explain the plan. For use with digital audiences, for example on social media, to increase retention of the messages we communicate about the plan.
All	PR and Media work	Briefing journalists will help to ensure they have the facts and are writing informed pieces about the STP. This, in turn, means the wider public is getting the facts.

4.2 BOB-level work programmes

The BOB constituent organisations have agreed that joint work (and therefore the focus of the overarching BOB STP) should be on those areas where the benefits of working at a larger scale can bring added value. By working in this way, they wish to avoid duplicating effort that is happening at a more local level. There are eight areas which will be tackled by planning and delivery at a BOB-level:

- Prevention: child and adult obesity; health inequalities; alcohol and smoking related disease
- Urgent and emergency care
- Acute services
- Mental health
- Specialised commissioning
- Workforce
- Primary care
- Digital interoperability.

Using the communications and engagement principles and objectives described in this strategy, communications and engagement plans, specifically tailored to each work programme will be developed.

The most advanced of these work programmes is within urgent care and the development of an improved Thames Valley NSH 111 service which will offer patients access to a new 24/7 urgent clinical assessment and treatment service – bringing together NHS 111, GP out of hours and clinical advice. The service will be integrated around the patient, helping the caller to get the right care at the right time, in the right location, with a team of clinicians available at the end of the phone in the new NHS Clinical Hub.

During the summer of 2015 an online questionnaire was promoted across Buckinghamshire, Berkshire West, Berkshire East and Oxfordshire and four workshops were held to find out about people's experiences of using the service and seek views about ways it could be changed for the better.

The feedback was used to influence the specification for the re-procurement of an improved integrated 111 Urgent Care service. During the post-production stage further engagement was completed with stakeholders and patients to gain views to shape the delivery of the new service, which will go live in April 2017.

4.3 LHE-specific programmes

This strategy acknowledges that most change (and therefore communications, engagement and consultation activities) will be focussed at LHE level – a 'locality-based' approach fits better with how many of our local patients and public use services and therefore what they will want to know about and to influence.

Buckinghamshire

In Buckinghamshire, engagement work for the Bucks Healthy Leaders group, as part of the five year system plan and the primary care strategy has included:

- patient experience feedback on services
- Community hubs engagement events
- urgent care survey results from across the patch
- seeking input from the Thames Valley Clinical Senate and the Oxford AHSN Academic Health Science Network.

More locality-focused engagement is due to take place over the coming months, culminating in the publication of a local plan. Public consultation will follow, depending on the nature of any proposed changes.

Oxfordshire

In Oxfordshire, the transformation programme has been actively involving key stakeholders (e.g. HOSC since December 2015) and local communities in an extensive period of engagement through wide variety of activities including focus groups, public meetings and a social media campaign designed to inform the public of possible changes to healthcare delivery and seek views on service development. The results of this work are now being fed back to participants ahead of full public consultation on proposed major service changes in the New Year.

Berkshire West

The Berkshire West 10 is the health and social care integration programme which is well established within the local economy. In operation since 2013, the programme aims to achieve the following objectives:

- Strengthen cross-organisational working between partners
- Facilitate joint investments in cross-organisation service redesign
- Design and deliver innovative models of care across the geography
- Provide a forum for learning and knowledge share to enable the 'scaling up' of local successes

Communications and engagement activities aligned to this LHE programme are delivered by communications and engagement leads within member organisations.

The Berkshire West Accountable Care System is a complete transformation of how the NHS organisations within Berkshire West will work and transact with each other. By moving away from a system of contractual transactions and closer to an allocative distribution of monies coming into the local health economy, the ACS seeks to move to a system whereby resources are allocated to the efficient delivery of pathways at cost rather than price. By moving to this new contractual relationship, providers and commissioners will need to share the risk of delivering services across the geography within an overall cost allocation rather than individual organisations being required to protect their own financial positions. A communications and engagement plan is in development.

5. GOVERNANCE AND IMPLEMENTATION

Delivery will take a partnership model, with the BOB STP Communications and Engagement lead working with colleagues across the BOB footprint working together

to prioritise actions and co-ordinate activities. An action plan will be agreed to support this Strategy, setting out at a high level the annual cycle of communications and engagement activities.

It is proposed that a communications and engagement reference group is set up to oversee action plans, agree on priorities and identifying resource needs and opportunities to maximise economies of scale. The group will agree terms of reference and oversee the 'who does what' partnerships.

A detailed action plan of timed stakeholder communications and engagement will be developed to run alongside each programme plan. An activity log will be kept and updated to ensure there is a clear record of what communications and engagement has taken place and any learning takes place through on-going evaluation.

6. ISSUES AND RISKS

With any programme of change, it is essential to consider any issues which present risks to its successful delivery.

The following are key issues which will influence the success of this plan:-

- Public sensitivity and cynicism – people view the programme as a money saving exercise which has no positive effect on health services in their community. Stakeholders need to be openly engaged and involved in the process so that they are able to develop a proper understanding and can become ambassadors for the programme.

- Transparency around decision making - why they were made, by whom, and what influenced the process. Being open and transparent about this ensures people feel decisions are being made with them and lessens the chances of them rejecting something they would ordinarily support.

- Political involvement – the closure or perceived reduction of services has already resulted in the formation of campaign groups with MP and local councillor support. Communication and engagement with local politicians is crucial to ensure they are as informed as possible.

- Fear of change - the staff and stakeholders involved are part of organisations which are in different places and at different points of progress. It is essential to manage expectations around the programme, being mindful of the variation in the amount of change they will experience.

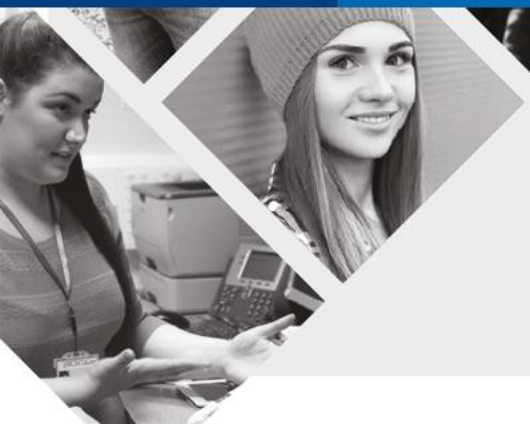
Currently there are a number of potential risks to the success of the project:

- Lack of stakeholder buy-in, co-operation and partnership working
- Changing political landscape
- Inconsistent communication leading to diluted, confused and incorrect messages
- Transformation work in Oxfordshire, ACS work in Berkshire West and Your

Community, Your Care work and how it relates to STP for BOB
- Consultation fatigue
- The “false” boundary of the BOB footprint and the need to recognise other neighbouring footprint plans and in turn, the need for those footprints to recognize ours

As the landscape changes and the programme continues, it is essential to keep reviewing the issues and risks. It is expected that there is a communications and engagement SRO to ensure risks and issues are mitigated and reported accordingly to the STP Operational Group.

A vision and programme for digital transformation in health and care



The **Local Digital Roadmap** for Buckinghamshire, Oxfordshire & Berkshire West

1. Overview and summary

2. Vision and outcomes

3. Aligning to STP goals

4. Programme delivery

5. Capabilities and plans

6. Next steps

Contents

Preface

The last decade has seen a genuine digital revolution in the UK. Information technology is pervasive, enabling, and essential to everything that we do, from shopping to healthcare. This has changed the expectations of both service users and service givers as to what digital technology can do to improve how we deliver care, and this is for the better. However, bringing the advantages of digital transformation to where it matters – where clinician meets patient, where patient meets illness, where planning meets reality – has many challenges.

Health and care across Buckinghamshire, Oxfordshire and Berkshire West is supported by a wide range of organisations, including three acute trusts, two community and mental health trusts, 5 local authorities, a primary care sector of 181 practices, an ambulance service, and a range of independent and voluntary sector providers.

Each of them generally uses a different patient/client record system, none of which can easily communicate with each other. Tracking patients through the system across the organisations for population health and planning how best to put services where, is similarly disconnected. This is entirely normal for the UK health and social care system and indeed for most, if not all, health and social care systems worldwide. This local digital roadmap is about working out how to change that, at least in our area. And if local solutions work well, they can become part of national solutions, or even international solutions.

In the future, patients will be able to read their own health record in the way they choose, enter or upload their own information as they see fit, and decide who else is able to access it. Clinicians and other caregivers – including doctors, nurses, carers, and social services workers – will be able to access all relevant patient information when they need to, when they see the patient, with the patient's consent.

Those planning how to better deliver services in future will be able to access real-time service data across the entire system so that they can analyse whether a current service actually does what it is supposed to, design a better service if it doesn't, and see where the system can work better together.

These are the changes that we want, and the road that we wish to travel, together.

Dr Paul Park, CCIO Oxfordshire CCG (Chief Clinical Information Officer)

1.

Overview and summary

The **Local Digital Roadmap** for Buckinghamshire, Oxfordshire & Berkshire West

Overview

This Local Digital Roadmap for Buckinghamshire, Oxfordshire and Berkshire West presents a vision for digital transformation in health and care across the sustainability and transformation plan (STP). Based on levels of programme activity, this roadmap draws together plans, first submitted in 2016, from the three areas.

This Local Digital Roadmap (LDR) reflects strong foundations across Buckinghamshire, Oxfordshire and Berkshire West (BOB) to create a joint plan for delivery of digital capabilities.

- We will jointly develop and deliver digital programmes where this adds value and can achieve greater benefits for patients and value for money than a local focus.
- We will collaborate across the STP to share best practice in digital health, with delivery programmes in each of the three area.
- Each organisation will make the necessary contribution to strengthen digital maturity across the STP.

We will work together where it makes sense to do so, but also allow localities and individual organisations to pursue plans and developments that are localised to their specific needs.

Digital transformation across BOB will progress under three core themes.

- Delivering the vital technology capabilities required to enable STP service change goals
- Digital maturity in all care settings to achieve paperless working at the point of care.
- High levels of achievement towards the national '10 universal capabilities'.

It is not always practical to reference all terms of organisation, care worker, or service user/patient/citizen in a document such as this, particularly when referencing other published documents.

Readers should note that this roadmap is inclusive of care across all sectors: health, social or other care.

A summary of the BOB Sustainability and Transformation plan can be found online at http://bit.ly/BOBSTP

Digital programme priorities

Based on the core elements of the existing Local Digital Roadmaps for Buckinghamshire, Oxfordshire and Berkshire West, five priorities have been identified for the focus of the STP Digital Roadmap, shaped further through discussion at the STP CIOs Forum.

- **Records sharing / Transfers of Care information**
- **Patient / citizen facing technology**
- **Whole system intelligence & real-time clinical intelligence**
- **Infrastructure & network connectivity**
- **Information Governance (IG)**

In addition, a substantial range of technology development is taking place at provider organisations across the STP footprint.

Each organisation is progressing on elements of digital maturity which complement the five priority areas.

These developments are highlighted in **section 5**. The capabilities in this area include Medicines Optimisation, Resource & Asset management, Orders & Results management.

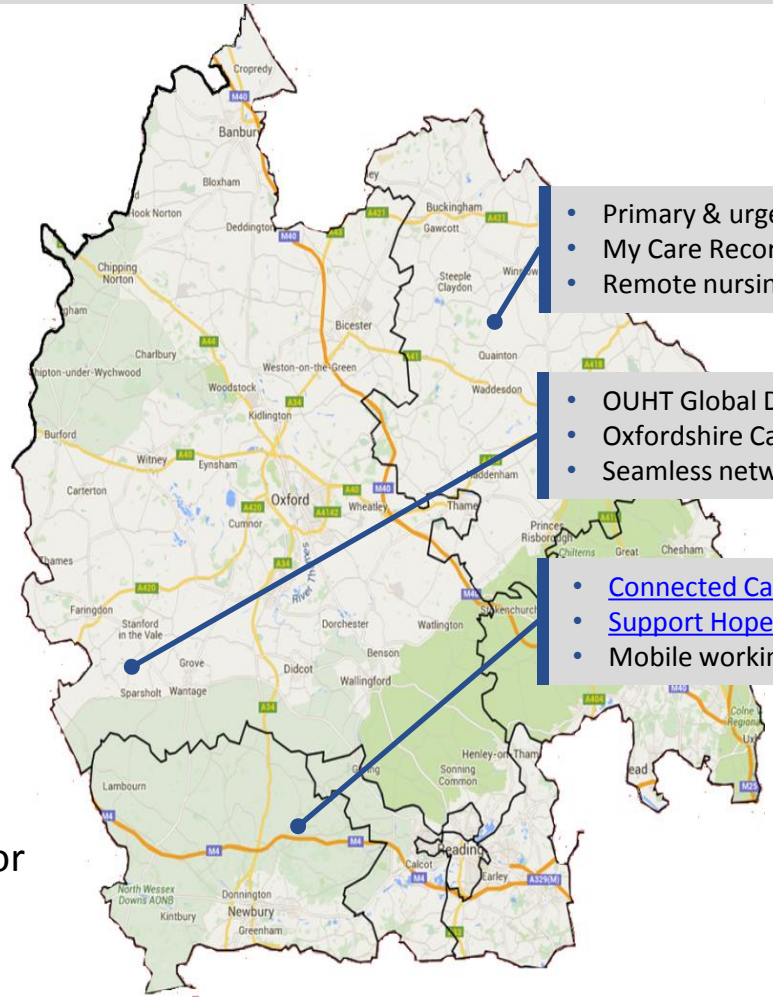
Digital health: Strong foundations

The area has strong foundations in digital health,
with all areas demonstrating leading examples of technology development.

Buckinghamshire, Oxfordshire and Berkshire West

- 1.8 million population
- £2.5 billion budget
- 7 clinical commissioning groups
- 6 NHS trusts
- 14 local authorities (incl. Districts)

BHFT and OHFT have both been identified in a group of only fourteen MH Trusts shortlisted nationally to make submission for Mental Health Global Digital Exemplar status.



- Primary & urgent care access
- My Care Record (phase 1)
- Remote nursing support for care homes

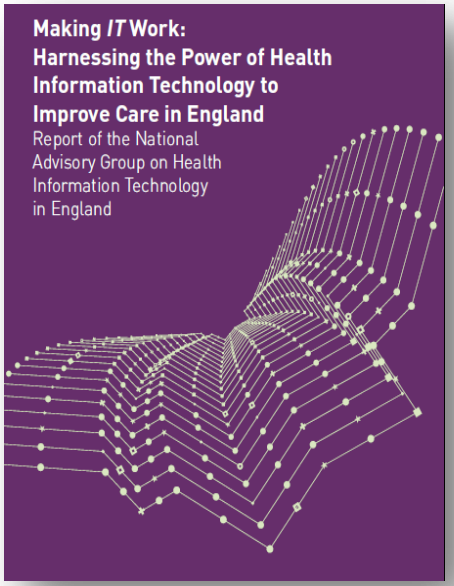
- OUHT Global Digital Exemplar
- Oxfordshire Care Summary
- Seamless network connectivity

- Connected Care
- Support Hope and Recovery Online Network
- Mobile working in community & MH

Driving principles

This roadmap takes on board the principles and recommendations of the 'Wachter Report' - Making IT work: harnessing the power of health information technology to improve care in England

- Digitise for the correct reasons.
- It is better to get digitisation right than to do it quickly.
- When it comes to centralisation, the NHS should learn (but not over-learn) the lessons of the NHS National Programme for IT, getting right balance between local, regional and national solutions.
- Interoperability should be built in from the start.
- While privacy is very important, so too is data sharing.
- Health IT systems must embrace user-centred design.
- Going live with a health IT system is the beginning, not the end.
- A successful digital strategy must be multifaceted, and requires workforce development.
- Health IT entails both technical and adaptive change.

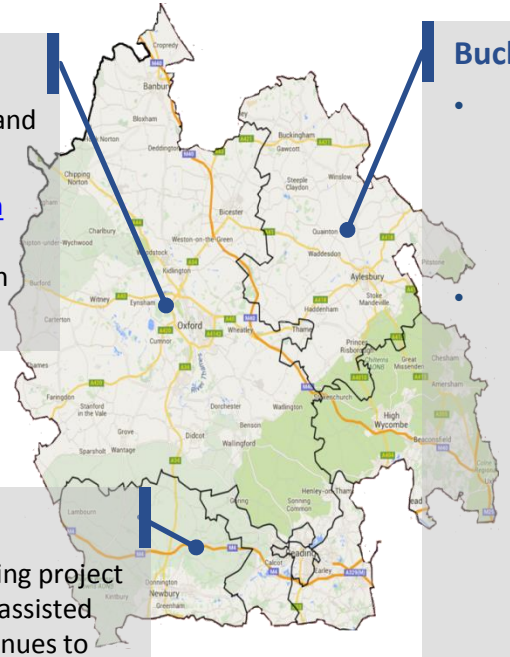


Involving citizens, clinicians, and practitioners

Key to any transformation programme is the engagement of those people who are affected by and will benefit from new technology. Citizens, clinicians and practitioners have all been involved in the creation of the BOB STP local digital roadmap and its components.

Oxfordshire

- Oxfordshire digital projects will have a clinical lead and clinical user involvement
- Oxfordshire Talking Health and Patient Participation Groups have regular opportunities to have their say (similar online engagement tools are in also place in Buckinghamshire and Berkshire West).



Buckinghamshire

- The Buckinghamshire Supported self-care pilot with Digital Life Sciences is co-produced with a number of local patients.
- Buckinghamshire has strong clinical involvement in digital transformation projects :
  - eRS, Patient Online, EMIS Clinical services, My Care Record, Access and Supported self-care with Digital Life Sciences.
  - The Diabetes programme also has formal patient involvement.

Berkshire West

- The Connected Care (Share Your Care) records sharing project has strong patient representation. A patient group assisted with selection of the patient portal. The group continues to meet and has assisted with the development of IG principles and public communications to support the project.
- Over 1,000 patients answered questions about their digital lifestyles and new models of care during engagement activities in support of a new primary care strategy and the re-procurement of GP contracts.

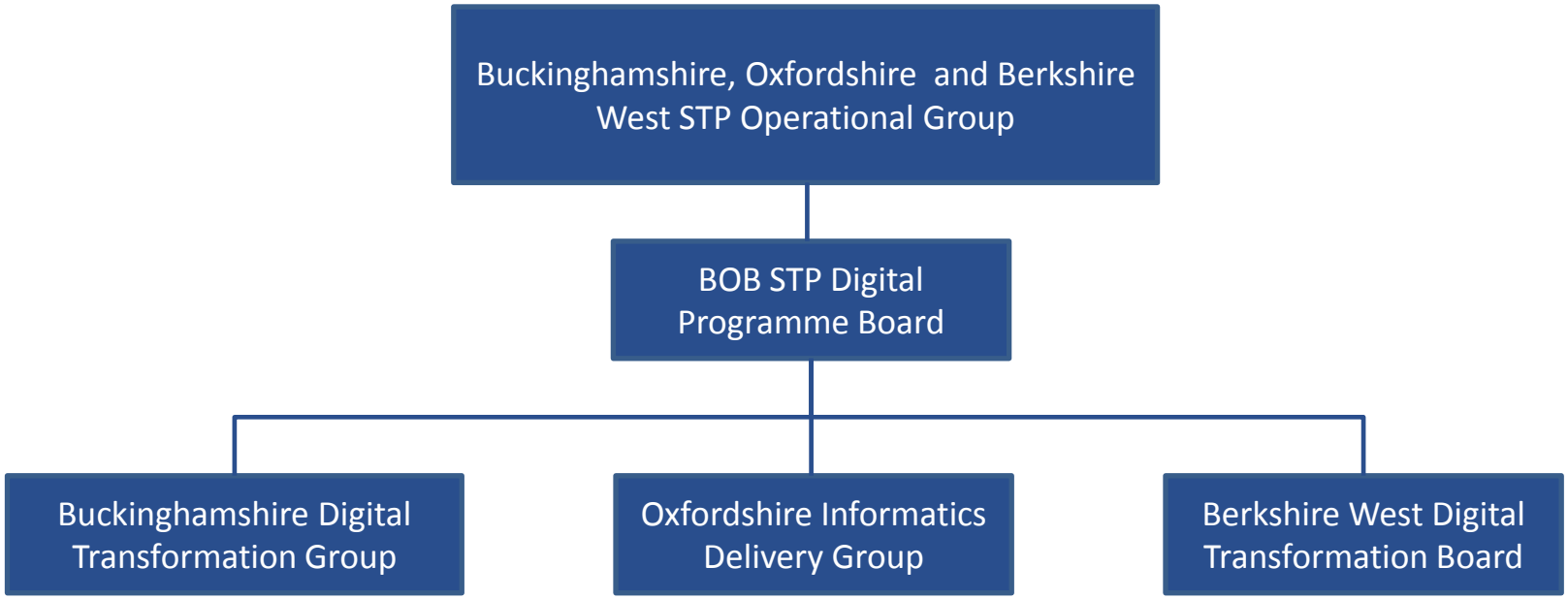
The benefits of digital health

Improved treatment	better use of technology to monitor patients, coupled with freeing up nurses and doctors to talk with their patients.
Efficiencies and savings	eliminating waste will allow reassignment of resources to where they will deliver the best value in terms of public health.
Personalised medicine	tailored treatments based on molecular diagnosis, individual's genomic information / life-style parameters & the patient's values.
Population health	very large studies with the resolution and sensitivity to learn what makes a difference and reliably inform policy.
Healthcare research	bigger data sets and better defined 'deeper' phenotypes deliver superior insights and, ultimately, more personalised treatments.
Society engagement	personal health records and centralised dynamic consent changes perception of the NHS towards a shared social enterprise.
Improved well-being	improved engagement with patients, medical staff, carers and family, brokered by a better connected health system.
Improved outcomes	mobile technology to improve recording of outcomes and tightening the feedback of this data to improved care.

The BOB roadmap reflects the findings and analysis of the Oxford AHSN report Digital Health in Oxford and the wider Thames Valley region, identifying 8 key opportunities for digital health.

Governance

This chart represents the core elements of governance for the STP-wide digital programme. Crucial governance steps exist at each local and organisational level.



Oxford University Hospitals NHSFT	Oxford Health NHSFT	Buckinghamshire Healthcare NHS Trust	Berkshire Healthcare NHSFT	Royal Berkshire Hospital NHSFT	South Central Ambulance Service NHSFT	Oxford Academic Health Sciences Network	Care UK (OOH Bucks)
Buckinghamshire County Council	Oxfordshire County Council	Wokingham Borough Council	West Berkshire Council	Reading Borough Council	Buckinghamshire Federated CCGs 52 GP Practices	Oxfordshire CCG 72 GP Practices	Berkshire West Federated CCGs 51 GP practices

2.

Vision and Outcomes

The **Local Digital Roadmap** for Buckinghamshire, Oxfordshire & Berkshire West

Digital programme priorities

The five prioritised digital work-streams reflect those areas that benefit most from being collaborative. The initial task of each work-stream is to fully develop the draft vision, objectives and scope, outlined below and in the following pages.

Records Sharing for cross-organisational care	Enable health and care professionals to have immediate and appropriate access to all relevant information about a person's care, treatment, diagnostics and previous history. This includes care plans and all necessary transfers of care information.
Citizen facing technology	Support and enable people to be actively involved in managing and making decisions about their care. This provides a strong basis for well-being and prevention.
Whole system intelligence	Health and care professionals across communities, geographic and clinical, have the information and insights they require to run an efficient and effective service. This includes care delivery, planning, targeting, monitoring, auditing, and research.
Infrastructure & network connectivity	A fast, reliable infrastructure, with shared connectivity, at a lower cost. Common ways of working support access to 'home' systems across the footprint.
Information Governance	A common set of processes to appropriately and effectively use information, in line with the expectations of patients and citizens. Information Governance becomes an enabler, not a barrier, to care, planning, targeting and research.

Record sharing

Vision	• Enable health and care professionals to have immediate and appropriate access to all relevant information about a person's care, treatment, diagnostics and previous history. This includes care plans and all necessary transfers of care information.
Key objectives	• Supports multi-disciplinary collaboration across care settings and sites • Users can access all necessary records from their 'home' system, particularly patient medications, allergies and adverse reactions. • Multiagency care plans can be created. • Proactive care plans such as End of Life, Special Patient Notes are available to South Central Ambulance Service, 111, out of hours services, ED's and social services. • All referrals, including 2 week wait, are sent electronically. • No user has to re-enter the same patient/service user data twice. • Users do not have to 'look for important patient data', it should be presented to them in a suitable form such as a flag to indicate critical data is available.
Key requirements	**Each digital footprint have their own solutions based on local strategies and investments. The following outcomes are required to deliver the vision across BOB:** • Provenance and timeliness of people's data is clear to users, data is available in real time if required. • A defined level of system functional maturity that each organisation and footprint must attain in order to 'plug their records in'. • Agreed pathways and compatible clinical processes. • A standardised role based access structure. • Suppliers that will work together. • Agreed consent models and Information Governance.

Citizen facing technology

Vision	• Support and enable people to be actively involved in managing and making decisions about their care. This provides a strong basis for well-being and prevention.
Key objectives	• **Individuals have electronic access to view their multi-organisation health record** supporting them to: manage their health, prevention and care; use an online appointment service; monitor a chronic condition (perhaps using a mobile app); ask a clinician or care worker a question; and communicate with members of their care team, such as their GP. • **Access to general information and guidance** to improve knowledge and health literacy; look up medical jargon; and access prevention advice. • **Take part in multi-agency consultations about their care**. • **Have one point of contact for queries** – even though their care may span several organisations/footprints.
Key requirements	• A comprehensive Personalised Health Record, so that patients do not have to navigate and access multiple provider / primary care portals. • Patient focussed signposting to organisation and disease-specific portals such as mydiabetescare. • Secure access to assure people that only they, or those they give consent to, have access to their data. • Leveraging technologies to promote self-care and prevention for differing age groups including wearable's, smartphone applications and assistive technologies. • Patient held technology incorporated into provider specifications. • Authoritative/legal advice on use of citizen held technology and patient information.

Whole system intelligence

Vision	• Health and care professionals across communities, geographic and clinical, have the information and insights they require to run an efficient and effective service. This includes care delivery, planning, targeting, monitoring, auditing, and research.

Key objectives	• Capability across the STP area to access and manipulate data. This enables sophisticated management and forward planning of the healthcare system to:
	  • respond to immediate pressures
	  • undertake trend analysis and rapid assessment of service changes
	  • apply risk modelling to support targeting for care management
	  • demand and capacity modelling across all settings of care
	  • support audits.
	• Staff have a single view of business intelligence information
	• Patients are targeted with services and care pathways appropriate to their need
	• A rich joined up data repository that is available for agreed research purposes.

Key requirements	• Data architecture agreed
	  • For example, data mart layers and integrated / federated / distributed data warehouse / data lake.
	• Common metrics and interpretations.
	• Capability to apply machine-learning / AI to support risk-modelling and profiling.
	• Integrated reporting solutions to avoid duplication and facilitate intelligence / knowledge sharing.
	• Data quality requirements agreed and monitored
	  • For example, how up-to-date and accurate data must be for analysis purposes.

Infrastructure & network connectivity

Vision	• A fast, reliable infrastructure, with shared connectivity, at a lower cost. Common ways of working support access to 'home' systems across the footprint.
Key objectives	• Networks are connected, giving fast access across all health and social care services. • Users have access to their 'home' systems, regardless of where they connect to the network and whether it is wired, wireless or remote. • Systems are easy to use, working seamlessly when a clinician is with a patient. • There is easy access to the right IT Support • Free public WiFi. • Voice over IP
Key requirements	• Single sign on technologies. • Aggregation of networks across geographic areas and organisations to maximise speed of access and system performance, and reduce costs. • A minimum set of infrastructure standards to ensure security and implement change. • A shared development pathway to deliver consistency of approach. • A resilient architecture with back-up and redundant connections. • A plan and process for identifying and resolving any incompatibilities. • Professional development and education to support 'Digitally enabled users' • IT service is flexible enough to support new models of care. • Support calls quickly routed thanks to integrated and interoperable IT support.

Information Governance (IG)

Vision	• A common set of processes to appropriately and effectively use information, in line with the expectations of patients and citizens. Information Governance becomes an enabler, not a barrier, to care, planning, targeting and research.

Key objectives	• Authorised, legal, justification for
	  • record sharing that underpins digital interoperability across the STP area.
	  • using data across the STP area for business intelligence purposes such as targeting, planning, monitoring, research.
	• Staff know what they can use clinical data for.
	• Patients know what their data is used for.
	• New data use purposes are easy to implement.
	• Partners are confident in each other's appropriate data use.

Key requirements	• An authorised, legal, justification for record sharing that underpins digital interoperability across the STP area, for direct care and for secondary use of data such as analytics, modelling, and risk stratification. • A joined up process for handling subject access requests and patient queries – in support of shared records. • A common, STP-wide, understanding of what clinical data can be used for. • Procedures for new processing requests such as research or further record sharing. • STP public communications include a consistent message about what patient data is used for. • A common consent process.

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3.

Aligning to STP Goals

The **Local Digital Roadmap** for Buckinghamshire, Oxfordshire & Berkshire West

Aligning the roadmap to STP goals

> The goal of digitisation of health systems is to promote what has become widely known as healthcare's Triple Aim: better health, better healthcare, and lower cost (Wachter Report)

The eight STP priorities are reflected in the new models of care emerging in the Buckinghamshire, Oxfordshire and Berkshire West.

- Shift the focus of care from treatment to prevention
- Access to the highest quality Primary, Community and Urgent Care
- Acute trusts collaboration to deliver equality and efficiency
- Mental Health development to improve overall value of care provided
- Digital interoperability
- Maximise value and patient outcomes from specialised commissioning so that digital aspects relating to specialist services are not addressed separately.
- Establish a flexible and collaborative approach to workforce
- Primary Care at scale.

Technology must not be applied for the sake of it, but to play a fundamental role in how health is improved, care is delivered, and productivity gains are achieved.

With this focus in mind, the following pages identify how the Digital Roadmap supports the service transformation priorities set out in the BOB STP, with examples of digital initiatives mapped to the STP.

Shift from treatment to prevention

Technology enables patient engagement and activation in their own health & care, and a more intelligent approach to targeting public health & preventative interventions

	Example 1	Example 2
Records sharing for cross-organisational care	Supporting care professionals to promote targeted health and wellbeing messages based on information in the record, such as social prescribing.	
Citizen facing technology	Patient access to a personalised health record, aiding improved self-care.	Integration with apps, wearables and sensors to combine key data into patient record & enable telecare and 'nudge' health alerts.
Whole system intelligence	Data analytics and risk-modelling to identify key patient groups for upstream preventative care.	Socio-demographic and GIS analysis and mapping to target geographic public health initiatives.
Infrastructure & network connectivity	Patient & public access to WiFi in health & care sites.	Telehealth & care devices for target patient cohorts.
Information Governance	Developing public confidence in how data is used beyond direct care.	

The highest quality care

Supporting a joined up service across primary, community and urgent care, underpinned by records-sharing, phone & web supported triage & access, and care coordination.

	Example 1	Example 2
Records sharing for cross-organisational care	Enabling new integrated models of care, supporting multidisciplinary working across sites & organisations.	Integrated appointment booking, for example community hubs. Automated transfers of care data.
Citizen facing technology	Phone and web-based services to support self-care, and an access route into services	Clear, easy-to-find signposting to services, with appointment booking.
Whole system intelligence	Real time analytics, alerts and clinical decision support to aid patient flow and 'right care' delivery.	Risk-stratification supports case-finding for care co-ordination.
Infrastructure & network connectivity	Care professionals are able to access network from any care setting.	Offline access to care records when there is no connectivity.
Information Governance	Ensuring no IG obstacles for legitimate records access for direct care purposes.	

Acute trusts collaboration

Advancing provider digital maturity (with OUHT at the forefront as a Global Digital Exemplar) to support new models of acute care delivery and back-office efficiencies.

	Example 1	Example 2
Records sharing for cross-organisational care	Records sharing to enable hub and spoke model of clinical services and specialist advice.	Information Exchange interface between areas to share records.
Citizen facing technology	Provide secure messaging, lab results, e-consultations, and appointment scheduling between patients & hospital.	
Whole system intelligence	Data and tools supporting patient flow management.	Combined provider data supporting research and clinical audit.
Infrastructure & network connectivity	Care professionals able to access network from any care setting.	Single-sign on and direct access to patient record across systems.
Information Governance	Common STP-wide IG protocols and agreements to enable legitimate sharing across providers.	

Mental Health development

Developing digital technology to transform the way people look after their mental health, and transform the way the NHS designs and delivers mental health services.

	Example 1	Example 2
Records sharing for cross-organisational care	Enabling new integrated models of care, supporting multidisciplinary working across sites & organisations.	Records sharing provides basis for providing holistic person-centred care including mental and physical health.
Citizen facing technology	Patient portal to support care and communication with service users.	Trial online CBT 'chat' therapy & expand remote / assistive technology apps.
Whole system intelligence	Develop mental health analytics on prediction / prevention.	Using data to support delivery of outcomes based contracts.
Infrastructure & network connectivity	Extending off-line access to care records to enable mobile working.	Expansion of free WiFi across care settings for patient and carer use.
Information Governance	Ensuring no IG obstacles for legitimate records access for direct care purposes.	

A flexible & collaborative approach to workforce

Registration and accreditation of the information and technology workforce, with succession and development plans to retain expertise. Developing clinical leaders and gaining organisational commitment to develop and fund the role of the CCIO. Ensuring staff have the digital skills to meet the future challenges and cross system roles.

	Example
Records sharing for cross-organisational care	Saving time and improving effectiveness by making sure the information required to deliver care is available wherever care is delivered.
Citizen facing technology	Supporting a healthy workforce by piloting digital health and wellbeing tools with our own staff, and creating advocates for digital health - giving staff the skills to promote digital inclusion.
Whole system intelligence	Changing the focus of care from making patients better, to keeping people well – supporting early proactive intervention.
Infrastructure & network connectivity	Empowering a connected workforce, by ensuring access to systems across the health and local government estate, removing current barriers to integrated working and segregation of networks.
Information Governance	Supporting staff, by ensuring information sharing is carried out within the same rules and governance across the BOB STP footprint.

Primary Care at scale

Supporting new models of primary care, in locality and federated groups, and as part of the wider health and care team. Applying digital tools to improve demand management.

	Example 1	Example 2
Records sharing for cross-organisational care	Enabling cross-practice and federated working. For example, extended practice hours and 7 day working.	Electronic referrals with bookable appointment slots.
Citizen facing technology	Web and phone-based access services supporting triage, and improved handling of demand for appointments.	Personal Health Records (PHRs) supporting collaborative care planning and interaction between patients and the care team.
Whole system intelligence	Risk stratification and modelling to support care co-ordination.	Clinical decision support and referral management tools.
Infrastructure & network connectivity	Shared network access across primary care, supporting federated working.	Single-sign on for primary care clinicians to avoid multiple log-ons.
Information Governance	Developing confidence in primary care over how data is accessed for primary & secondary uses, and data-controller responsibilities can be assured.	

4.

Programme Delivery

The **Local Digital Roadmap** for Buckinghamshire, Oxfordshire & Berkshire West

Approach to delivery

The five prioritised work-streams all have a history of ongoing development in the three areas of the STP. To achieve the best impact and value for money, the forward plan for the programme has to take account of the existing landscape of technologies and investments, building on these as appropriate at the STP and local levels.

The next page shows a high level summary of the main current developments for each of the five work-streams, and indicates the direction and focus of the STP-level activity on each theme.

There then follows three 'feature programmes' highlighting these major initiatives:

- OUHT Global Digital Exemplar
- Berkshire Connected Care
- Buckinghamshire urgent & primary care access
- Bids for Mental Health Global Digital Exemplars.

Programme delivery 1

	Buckinghamshire	Oxfordshire	Berkshire West	STP-wide
Records sharing	**My Care Record** phase 1 via MIG, connecting GPs with Acute emergency care, OOHs and Social Care. OBC in development for further phases, which will include mental health services. Heart failure (BHT) initiative to share records with providers, carers and patients.	**Oxfordshire Care Summary** is currently in place. Future development is now focussing on building on the OUHT GDE opportunities with Cerner - a review of system-wide opportunities is now underway to confirm overall system-wide approach, taking into account the full range of local initiatives, including the OUHT GDE and AHSC plans.	**Connected Care** integrated digital care record (Graphnet). Initial go-live in Q3 2016, with further foundation stages through to mid 2017, then extending to Personalised Health Record and Care Planning functionality.	The BOB wide work will have two main foci: 1) connecting local shared record systems so patients crossing boundaries can have their records shared, and with SCAS. 2) Sharing best practice.
Citizen facing technology	Development of digital tools and business processes in co-production with patients and clinicians to redesign Primary Care and Urgent Care access and underpin supported self-care with Digital Life Sciences.	Patient portal functionality is an option to extend to wider use via the OUHT GDE.	Personalised Health Record (PHR) development as part of Connecting Care, with Graphnet & Microsoft, live from mid 2017.	Joint development with PPI of user requirements to achieve equity in the 'citizen offer'. Explore options for commonality of patient portal.
	Existing and planned solutions already in place in mental health (e.g. True Colours).			
Whole system intelligence	Systematic use of templates and reports through EMIS Enterprise to support seamless delivery of Locally Commissioned services and evaluate service changes. Use of ACG tool for risk stratification.	Currently EMIS Enterprise provides ability to analyse integrated primary and secondary care - e.g. for risk stratification to target patients. OUHT GDE provides other opportunities for development with Population Health Management and potentially AHSC initiatives.	Process, platform and principles objectives drafted for local work stream initiation. Eclipse project – LTC risk stratification and analytics in flight	Risk stratification is STP wide. Option to synchronise them and use this as the building block for a bigger intelligence resource – leading to common prediction and planning intelligence across BOB.

Programme delivery 2

	Buckinghamshire	Oxfordshire	Berkshire West	STP-wide
Network infrastructure & connectivity	Currently: all organisations have access to current N3 secure Network; free public WiFi available in all BHT sites. WiFi in all general practices to be completed in 2017. BHT mobile infrastructure upgrade for community teams in 2017/18 HSCN is seen as the next step.	Currently: a joined up network incorporating GP practices, OUHT and OHFT sites, some sharing with local council; Provider WiFi; some free public WiFi. Intention is to move to one area wide procurement (ideally as part of STP wide initiative)	Local work stream established. Drafting a multi-organisational 5 year forward view of infrastructure technology. Primary care single domain and WiFi infrastructure deployed. N3 in all organisations and standardisation on NHS number as patient/citizen unique identifier	Health & Social Care Network – joint procurement. Joining up networks with common ways of working.
Information Governance	Multi-organisational common health and social care Information Sharing Agreements created for My Care Record project. A County wide IG group oversees and advises on IG issues: e.g. authorisation for data sharing agreements and Privacy Impact Assessments.	A common Information Sharing structure has been set up. Used for OCS. A County wide IG group oversees and advises on IG issues: e.g. authorisation for data sharing agreements , consent models.	Multi-organisational common health and social care Information Sharing Agreements created for Connected Care project	Standardise on a common IG framework, Information Sharing Agreements, consent process, patient and public engagement & communications. Strengthen PPI scale up on-going programme on usage .

Buckinghamshire digital patient / citizen platform

Buckinghamshire CCG's, in partnership with Digital Life Sciences, are delivering a digital patient / citizen platform to empower patients to self-care and access local services independently.

The platform supports a 'proof of concept' GP Access Centre to receive and process on-the-day requests for GP and Nurse appointments from patients.

The Access Centre and the digital platform together will provide a means to deliver Locally Commissioned Services, Core and extended hours Primary Care, Urgent, Out of Hours Care and Mental health Services.

In time the platform will link with the My Care Record platform.

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- The proof of concept plans to release clinical and admin time at the GP Access Centre. More efficient management of on-the-day demand allows more time to be spent with long term conditions patients. It also releases time to educate patients about digital offerings, self-care and which locally commissioned services are available to them.
- Providing clinicians, carers and patients with a platform to communicate and share data digitally empowers patients, enables remote care support and broadens self-care. Patients can be directed to digital education materials, at scale and on demand.
- Call and appointment data from pilot sites is beginning to demonstrate standardised demand and capacity data in Primary care. This will inform planning and allow more targeted release of resources when required.
- Feedback is being collected routinely from patients who have used the service.

Buckinghamshire digital patient / citizen platform

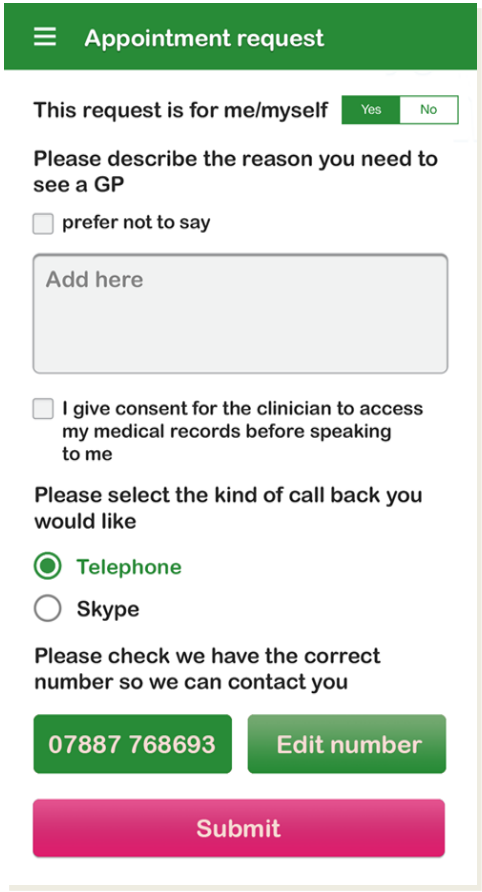
Three central locality practices experiencing high demand, poor patient satisfaction with access and higher than average A&E attendances led to a six month proof of concept of a GP access centre.

Project aims

- Better manage on the day demand
- Improve patient satisfaction
- Reduce unnecessary A&E attendances
- Digitalise patients (get online)
- Centralise admin functions to release admin time

Project status

- Three practices live on system by December 2016
- Patient population = 44,000 people
- Central management of call / online appointment requests.



Requesting a GP call back online.

Buckinghamshire digital patient / citizen platform

Six month proof of concept to provide patients and clinicians with a digital alternative to self and shared care. Converting the paper Care and Support Planning process into a digital process.

Project aims

- Better manage patients out of hospital
- Bring patient & HCP closer together
- Enable better collaboration in patient care
- Digital tools to monitor self-care & share data
- Better access to verified educational material
- Remote support for patients by HCP

Project status

- Dec 2016 - diabetic patients co-produced digital solution
- January 2017 - draft supported self-care online solution for Diabetics and launch to test group
- by April 2017 - full solution launch

Supported Self Care app

OUHT Global Digital Exemplar programme

Oxford University Hospitals Foundation Trust has been selected nationally as one of 12 acute-sector Global Digital Exemplars.

A global digital exemplar will be an internationally recognised NHS care provider delivering exceptional care, efficiently, through the world-class use of digital technology and information flows, both within and beyond their organisation boundary.

It will also be a reference site to other care providers.

The core objectives of the 2.5 year programme are

- Development and delivery of a population health and interoperability solution that can support whole system management of patients and long term conditions with disease registers and an emphasis on ensuring population well-being through patient interaction to their own record.
- Clinical decision support and learning embedded in the workflows to ensure high quality repeatable care delivery.
- Integration of biomedical devices, anaesthetic machines and removal of paper across the whole hospital ceasing to use the paper notes through a combination of on-line clinical documentation and integration as well as some limited scanning.
- Dissemination of the lessons learnt both as blueprints in specific systems for others to adopt and as system agnostic lessons.

OUH programme contributes to the STP & LDR

Oxford University Hospital's 'Go Digital' GDE programme underpins the Trust's strategic plans and is a core contributor to the BOB STP and Oxfordshire LDR.

- Completion of OUH's digital transformation enabling the full hospital record to be accessed by primary care and other colleagues through the pan system longitudinal record.
- Providing a foundation platform available for interoperability across the county; as a starter four disease registers will be constructed to help manage patients with long term diseases across boundaries; this is fundamental to and underpins the LDR.
- Care planning across care settings throughout Oxfordshire can be supported with deep integration into each partners local digital record.
- Assuming the partnership proposals are accepted OUH will assist Royal Berkshire develop its own digital solution cloning parts of what has been achieved in OUH; this will support the West Berkshire LDR and the STP across the whole patch.
- Linkage between the Oxfordshire interoperability platform and the respective platforms for Buckinghamshire and Berkshire will also be delivered with close integration; linkages between OUH, Milton Keynes and Royal Berkshire acute systems will support local clinical networks.
- Lessons from OUH's digital blueprint will be played into STP plans to ensure that lessons are learnt and delivery is expedited.

Berkshire West Connected Care Programme

Berkshire West, in partnership with East Berkshire, are delivering an integrated health and social care record sharing, intelligence analytics and patient/citizen patient portal.

Connected Care is a partnership that spans 18 organisations across health and social care. The East and West programme boards include senior representation from each of the partner organisations involved.

- Connected Care provides comprehensive interoperability and digital data exchange across organisational boundaries. Real time data exchange means that critical information is available to health and social care professionals at the point of care.
- Connected Care will improve clinical effectiveness and patient experience by providing clinicians, carers and patients with a comprehensive view of patient medical/care history, irrespective of source.
- Patient held records (PHR) in Connected Care will enable local people to view and update their record. Coupled with access to accurate real time data from commissioners, health and social care providers (and citizens themselves), the PHR supports patient self-care and streamline current processes. Using the PHR, people can also grant consent to providers of services and carers to view their record.
- Whole system intelligence, including real-time analytics and whole system metrics enables initiatives such as preventative care offered to people identified as being at high risk of an adverse event. This kind of data intelligence could avert costly and unpleasant health problems in future and support planning of services based on local needs.

Connected Care delivery timescale

<< Tranche 1 >>

Provider organisations
- 97% Berkshire GPs
- RBH, BFC, Wokingham

User organisations
- FHFT, SCAS RBWM, OOHs (East & West), BHFT
- 6 GP sites

Estimated end-users
- 500

Capability
- Integrated digital care record platform (CDR)
- Patient Notifications

Direct Integration
- OOHs: Adastra
- BHFT: RIO
- GPs : Emis, Vision
- LiquidLogic

<< Tranche 2 >>

New provider orgs
- Remaining 3% GPs
- BHFT, and RBWM

New user organisations
- 20 GP sites

Estimated end-users
- 1,000

New capability
- Mobile access pilot (OOHs)
- RBH Documents (DS, DLs)
- RBH Radiology Reports
- Enhanced LA dataset
- Patient tracking

Direct Integration
- RBH: Cerner
- FHFT: ED system
- SCAS: Adastra

<< Tranche 3 >>

New provider orgs
- FHFT
- Slough Council

New user organisations
- 40 GP sites

Estimated end-users
- 3,000

New capability
- RBH: Lab results
- BHFT: Documents (DS, DL)
- Bracknell and Wokingham Children's dataset
- Whole system intelligence (CDR)

Direct Integration
- FHFT: EPR system
- RBWM: Paris
- Slough: LiquidLogic

Connected Care subsequent tranches

2016 - 17						2017-18									
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct-Dec	Jan-Mar

Subsequent implementation (tranches 4 – 8)

Integrated dynamic care planning development

Patient portal development in conjunction with Microsoft

(E) Enabling / (S) Supporting universal capabilities

# Tranche	1. Professionals can access GP-held information on GP-prescribed meds, patient allergies & adverse reactions.	2. U&EC clinicians can access key GP-held information for patients previously identified by GPs as most likely to present.	3. Patients can access their GP record.	4. GPs can refer electronically to secondary care.	5. GPs receive timely electronic discharge summaries from secondary care.	6. Social care receive timely electronic assessment, discharge and withdrawal notices from acute care.	7. Clinicians in unscheduled care settings can access child protection information w/ soc. care professionals notified.	8. Professionals across care settings made aware of end-of-life preference information.	9. GPs and community pharmacists can utilise electronic prescriptions.	10. Patients can book appointments and order repeat prescriptions from their GP practice.
1	(E)	(E)		(E)	(E)					
2						(S)				
3							(S)			
4 - 8			(S)					(E)		

Mental Health Global Digital Exemplar Bids

Berkshire Healthcare Trust and Oxford Health Foundation Trust are among 14 mental health organisations invited by NHS England (NHSE) to submit a proposal to be considered as a GDE for mental health services. NHSE are looking to select a small number of Mental Health Trusts who are most advanced in their use of information technology, to develop as national leaders and ultimately to become world leaders at an accelerated pace. The GDE proposals will focus on key areas to advance digital capability.

- Extended use and optimisation of the Electronic Patient Record functionality, enabling
  - Technology to seamlessly transfer service user information at referral, admission or on discharge
  - Use of remote, mobile and assistive technologies to help provide care.
  - Use technology to support the ordering of diagnostics and sharing of test results
  - Receiving automatic alerts and notifications to help me make the right decisions
  - Using insight and intelligence to support continuous service improvement
  - Use of technology to manage assets and resource to drive efficiencies and improve quality
  - Ensure people receive the right combination of medicines every time and reminders about safe monitoring.
- Global Digital Exemplars will become leaders in
  - Innovative new approaches to care redesign
  - Partnering with research organisations to catalyse advances in conducting research and applying its findings
  - Building new digital tools and integrating them into workflow
  - Partnering with IT companies, in the UK and elsewhere, to promote innovation.

5.

Capabilities & Plans

The **Local Digital Roadmap** for Buckinghamshire, Oxfordshire & Berkshire West

Capabilities and plans

Developments in digital capability are planned across Buckinghamshire, Oxfordshire and Berkshire West health and care providers. These developments will increasingly achieve 'paperless working at the point of care', as measured through the domains set out in the national Digital Maturity Index (DMI).

To note in the DMI baseline and planned trajectories:

- Baseline capabilities are generally higher in the 'Readiness' and 'Standards & Infrastructure' elements of the DMI than the core Digital Capability domains
- Medicines Management & Optimisation and Decision Support are the weakest elements of digital capability in the baseline.
- The greatest planned improvement in digital capability is in Records, Assessments and Plans.
- DMI will be reassessed in 2017.
- All Digital Capabilities are planned to be close to or in excess of 70% as measured in the DMI by end 2018/19.

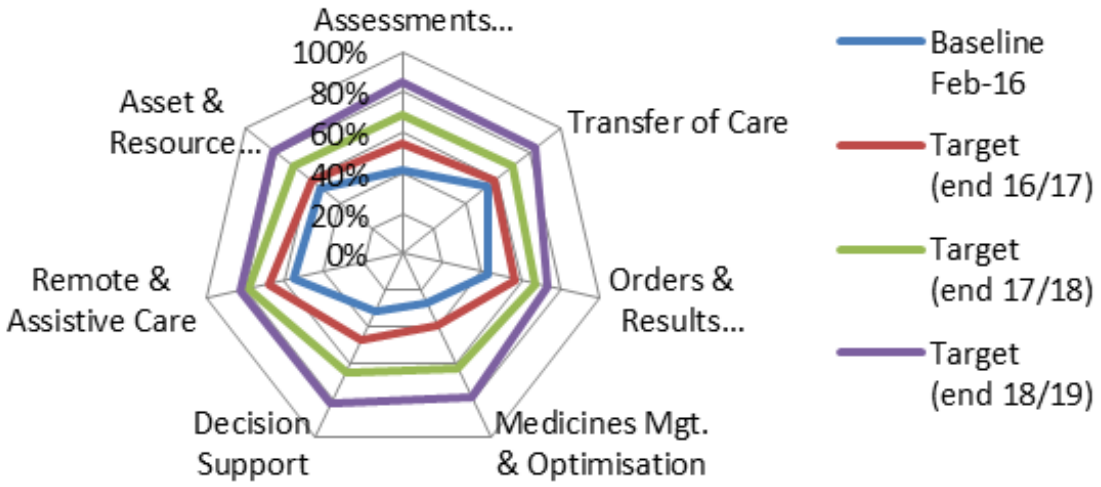
The following slide shows the baseline position for digital maturity in BOB NHS providers, as assessed in early 2016. There follow two slides that demonstrate the planned improvements in digital maturity over the coming 2.5 years.

Digital maturity across trusts

Domain		National	Royal Berkshire Foundation Trust	Oxford University Hospitals Trust	Buckinghamshire Healthcare Trust	Oxford Health Foundation Trust	Berkshire Healthcare Foundation Trust	South Central Ambulance Service Trust
Readiness								
• Strategic Alignment	4/6	76%	60%	80%	80%	85%	100%	56%
• Leadership	5/6	77%	80%	95%	100%	95%	90%	85%
• Resourcing	5/6	66%	45%	70%	70%	75%	95%	75%
• Governance	4/6	74%	65%	70%	80%	90%	100%	75%
• Information Governance	3/6	73%	50%	67%	92%	79%	96%	75%
Digital capabilities								
• Records, Assessments & Plans	3/6	44%	26%	54%	23%	35%	56%	57%
• Transfers Of Care	3/6	48%	42%	92%	30%	35%	59%	61%
• Orders & Results Management	3/6	55%	56%	86%	44%	12%	49%	14%
• Medicines Management & Optimisation	1/6	30%	17%	89%	24%	0%	4%	29%
• Decision Support	1/6	36%	33%	73%	6%	25%	30%	22%
• Remote & Assistive Care	5/6	32%	25%	58%	50%	58%	92%	50%
• Asset & Resource Optimisation	4/6	42%	45%	70%	40%	20%	81%	56%
Standards & Infrastructure								
• Standards	5/6	41%	44%	83%	33%	17%	46%	75%
• Enabling Infrastructure	5/6	68%	48%	84%	61%	77%	80%	75%
			2/14	12/14	6/14	7/14	11/14	8/14

as assessed in Jan 2016; green indicates above national average, red below, blue at or close to.

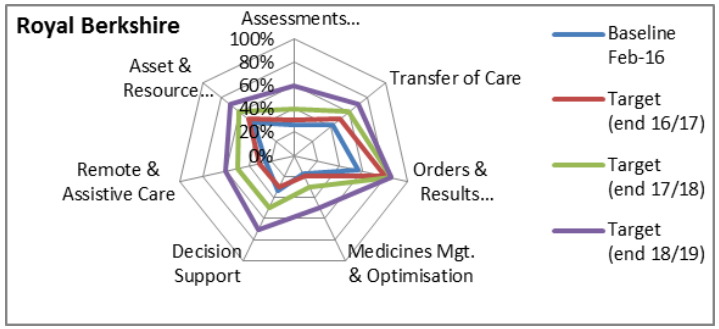
Digital maturity trajectories – BOB level

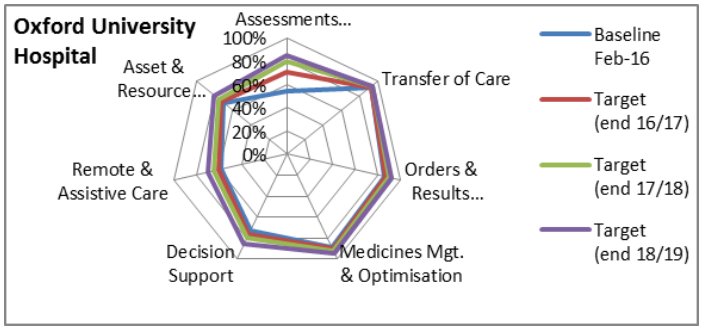


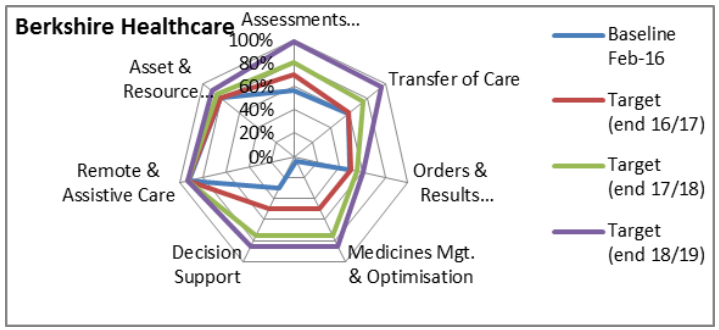
Footprint Summary (Average Provider Score)	National Average	Baseline Feb-16	Target (end 16/17)	Target (end 17/18)	Target (end 18/19)
Records, Assessments & Plans	44%	42%	55%	69%	86%
Transfer of Care	48%	53%	58%	70%	84%
Orders & Results Management	55%	44%	57%	68%	74%
Medicines Mgt. & Optimisation	30%	27%	39%	63%	79%
Decision Support	36%	32%	48%	65%	82%
Remote & Assistive Care	32%	56%	68%	78%	82%
Asset & Resource Optimisation	42%	52%	58%	69%	82%

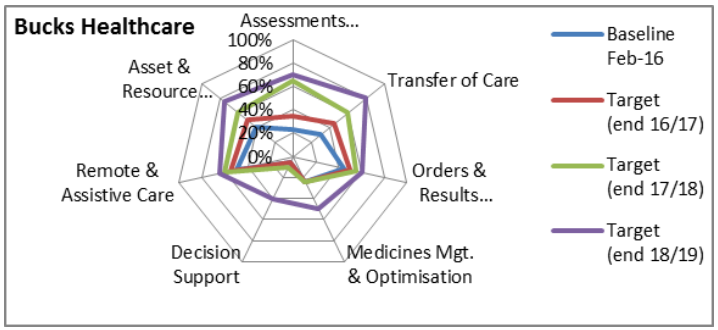
Digital maturity trajectories

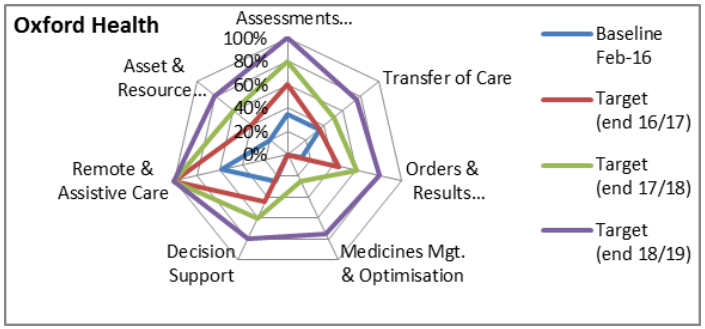
The organisation trajectory summaries reflect the current view and scale of work. There is an underlying plan to deliver increased maturity levels.

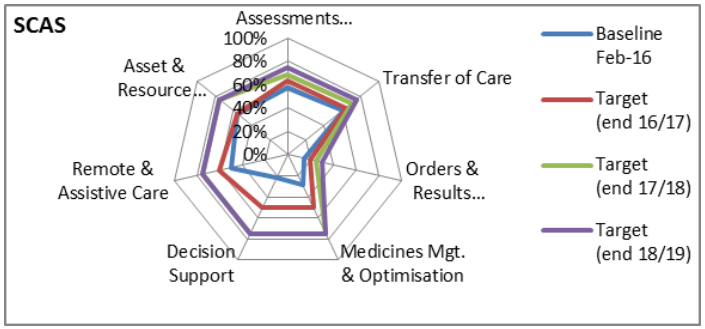












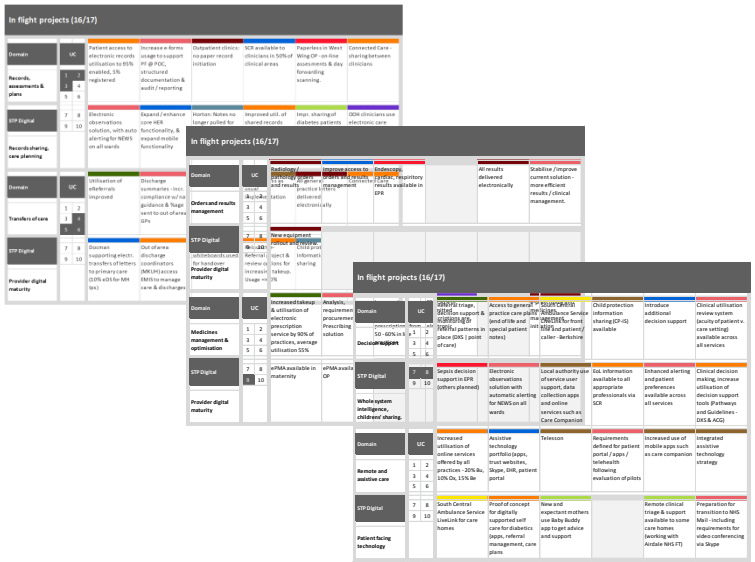
SCAS scores for Orders and Results generally lower as not all elements relevant to an ambulance trust.

Programme plan

The programme plans for the 3 LDR footprints and the BOB STP reflect developments within and across partner organisations.

The following eight pages illustrate the 2016/17 and 2017-19 ‘capability deployment plans’, mapped to the 7 national digital maturity domains, and based on the 3 LDR submissions (excluding the impact of the planned Global Digital Exemplar delivery).

The 2017-19 high level plan indicates the STP-wide programme activities that will be taken forward, subject to adequate investment funding.



Digital capability plans 2016/17

Domain	UC					
Records, assessments & plans	1	2	Patient access to electronic records utilisation to 95% enabled, 5% registered	Increase e-forms usage to support PF @ POC, structured documentation & audit / reporting	Outpatient clinics: no paper record initiation	SCR available to clinicians in 50% of clinical areas	Paperless in West Wing OP - on-line assessments & day forwarding scanning.	Connected Care - sharing between clinicians
	3	4						
	5	6						
STP Digital	7	8	Electronic observations solution, with auto alerting for NEWS on all wards	Expand / enhance core HER functionality, & expand mobile functionality	Horton: Notes no longer pulled for routine appointments	Improved util. of shared records MCR & SCR. Available to soc care & comm pharmacies.	Impr. sharing of diabetes patients info w/ care team. Complete EoL transfer to SCR.	OOH clinicians use electronic care plan to support triage & clinical decisions.
Records sharing, care planning	9	10						

Domain	UC					
Transfers of care	1	2	Utilisation of eReferrals improved	Discharge summaries - incr. compliance w/ nat. guidance & %age sent to out of area GPs	e-Correspondence	RiO business as usual implementation	All general practice letters delivered electronically	Connected Care
	3	4						
	5	6						
STP Digital	7	8	Docman supporting electr. transfers of letters to primary care (10% eDS for MH Ips)	Out of area discharge coordinators (MKUH) access EMIS to manage care & discharges.	Electronic ward whiteboards used for handover	Relaunch e-Referral project & review options for increasing take-up. Usage =>80%	Child protection information sharing	GPs digitally refer urgent cancer patients using eReferral templates.
Provider digital maturity	9	10						

Key: BWF Primary Care | Royal Berkshire NHS Foundation Trust | Berkshire Health NHS Foundation Trust | Local Authority | Multi Organisation | South Central Ambulance Service | OCCG Primary Care | Oxford University Hospitals | Oxford Health NHS Foundation Trust | Buckinghamshire Healthcare NHS Trust | BCCG Primary Care

In flight projects (16/17)

Domain	UC						
Orders and results management	1 2 3 4 5 6	Radiology / pathology orders and results	Improve access to orders and results management	Endescopy, cardiac, respiritory results available in EPR		All results delivered electronically	Stabilise / improve current solution - more efficient results / clinical management.
STP Digital	7 8 9 10	New equipment rollout and review.					
Provider digital maturity							

Domain	UC						
Medicines management & optimisation	1 2 3 4 5 6	Increased takeup & utilisation of electronic prescription service by 90% of practices, average utilisation 55%	Analysis, requirements, procurement of e-Prescribing solution	Increase in utilisation of electronic prescriptions from 50 - 60% in live practices	EPS - 50% of permitted prescriptions are electronic		e-prescribing and medicines management initiation
STP Digital	7 8 9 10	ePMA available in maternity	ePMA available in OP				
Provider digital maturity							

Key:

BWF Primary Care	Royal Berkshire NHS Foundation Trust	Berkshire Health NHS Foundation Trust	Local Authority	Multi Organisation	South Central Ambulance Service	OCCG Primary Care	Oxford University Hospitals	Oxford Health NHS Foundation Trust	Buckinghamshire Healthcare NHS Trust	BCCG Primary Care

In flight projects (16/17)

Domain	UC						
Decision support	1	2	Referral triage, decision support & monitoring of referral patterns in place (DXS | point of care)	Access to general practice care plans (end of life and special patient notes)	South Central Ambulance Service LiveLink for front line and patient / caller - Berkshire	Child protection information sharing (CP-IS) available	Introduce additional decision support	Clinical utilisation review system (acuity of patient v. care setting) available across all services
	3	4						
	5	6						
STP Digital	7	8	Sepsis decision support in EPR (others planned)	Electronic observations solution with automatic alerting for NEWS on all wards	Local authority use of service user support, data collection apps and online services such as Care Companion	EoL information available to all appropriate professionals via SCR	Enhanced alerting and patient preferences available across all services	Clinical decision making, increase utilisation of decision support tools (Pathways and Guidelines - DXS & ACG)
	9	10						
Whole system intelligence, childrens' sharing.								

Domain	UC						
Remote and assistive care	1	2	Increased utilisation of online services offered by all practices - 20% Bu, 10% Ox, 15% Be	Assistive technology portfolio (apps, trust websites, Skype, EHR, patient portal	Telesson	Requirements defined for patient portal / apps / telehealth following evaluation of pilots	Increased use of mobile apps such as care companion	Integrated assistive technology strategy
	3	4						
	5	6						
STP Digital	7	8	South Central Ambulance Service LiveLink for care homes	Proof of concept for digitally supported self care for diabetics (apps, referral management, care plans	New and expectant mothers use Baby Buddy app to get advice and support		Remote clinical triage & support available to some care homes (working with Airdale NHS FT)	Preparation for transition to NHS Mail - including requirements for video conferencing via Skype
	9	10						
Patient facing technology								

Key:

BWF Primary Care	Royal Berkshire NHS Foundation Trust	Berkshire Health NHS Foundation Trust	Local Authority	Multi Organisation	South Central Ambulance Service	OCCG Primary Care	Oxford University Hospitals	Oxford Health NHS Foundation Trust	Buckinghamshire Healthcare NHS Trust	BCCG Primary Care

In flight projects (16/17)

Domain	UC						
Asset and resource optimisation	1	2	Single domain wi-fi and mobile device management (MDM) in place to support federated working	Pilot use of Intelligence Point primary care data to inform planning and commissioning	Use of on-line bed board	e-Consultations	Cerner transition and upgrade	NHS Mail 2
	3	4						
	5	6						
STP Digital	7	8	Improved efficiency through greater interoperability of clinical systems with EPR	e-Rostering implementation completed	Digital appointment correspondence		Virtual pathways	Biomedical device integration with EPR, including infusion pumps (Neuro ICU)
	9	10						
Provider digital maturity								

Key:

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Digital capability plans 2017-19

Domain	UC					
Records, assessments & plans	1 2 3 4 5 6	Patient access to electronic records utilisation to 100% enabled, 8% registered	Digital clinical docs used for all basic nursing and generic medical assessments	All community staff have access to mobile devices to access / update patient information at point of care	Improved utilisation of shared records - MCR / MIG & SCR	No paper record needed at outpatient clinics	Connected Care - majority of secondary care clinicians can access GP-held data
STP Digital	7 8 9 10	Notes no longer pulled for routine appointments - Horton	Carenotes integration with partner solutions	Carenotes uogrades and enhancements			
Records sharing, care planning							

Domain	UC					
Transfers of care	1 2 3 4 5 6	Utilisation of eReferrals improved	Deploy revised e-Discharge summaries	eReferral coverage & use increased. Usage >=85%	Expand support for eRS in key service lines	Care pathways	Child protection information sharing implementation by Local Authorities
STP Digital	7 8 9 10	Connected Care	Digital clinic worklists in widespread use following successful pilot	U18, Urgent care encounters		Deploy e-Admission documentation	EDS sent electronically for 75% MH inpatients
Provider digital maturity							

Key:

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Planned projects (17/18, 18/19)

Domain	UC							
Orders and results management	1	2	All results delivered electronically	Sharing South Central Ambulance Service Discharge summary	Booking for minor injuries unit appointments - Berkshire		Bookings for emergency general practice appointments - Berkshire	Requesting for all non-EPR tests in place
	3	4						
	5	6						
STP Digital	7	8	Reduce paper for requests and results	Additional orders and results management introduced				
	9	10						
Provider digital maturity								

Domain	UC							
Medicines management & optimisation	1	2	Increased take up and utilisation of electronic prescription service by 95% of practices	Deployment of e-prescribing solution - all service areas	e-prescribing and medicines management	e-prescribing and medicines administration	Emergency prescriptions	e-prescribing and medicines administration decision support at Frimley Park Hospital
	3	4						
	5	6						
STP Digital	7	8	70% utilisation of electronic prescriptions	50% of permitted prescriptions are electronic	Development of ePMA functionality			
	9	10						
Provider digital maturity								

Key:

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Planned projects (17/18, 18/19)

Domain	UC						
Decision support	1 2 3 4 5 6	Real time analytics	Early warning systems	Business intelligence - auto reporting and alerting	Improved utilisation of End of Life records	Improved medication support available (a further 50x powerplans / rules)	CP-IS utilisation monitored and plans in place to promote and support usage
STP Digital	7 8 9 10	Advanced decision support introduced					
Whole system intelligence, childrens' sharing.							

Domain	UC						
Remote and assistive care	1 2 3 4 5 6	24/7 digital advice via telephone, web and app supporting same day primary care	eConsultations supporting same day primary care	Increased utilisation of online services - offered by all practices	Expand remote and assistive technology (apps, interactive Trust websites)	Observations capture equipment, eData feeds	Digital support for the management of heart failure patients, following 16/17 pilot
STP Digital	7 8 9 10	NHS mail available to all service areas	Development of patient portal functionality	Heart failure shared record			
Patient facing technology							

Key:

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Planned projects (17/18, 18/19)

Domain	UC					
Asset and resource optimisation	1	2	Extended hours / prime ministers challenge fund	Staff electronic rostering	TIE upgrade and new hardware	Expand asset and resource optimisation	Gastro review and improvement projects
	3	4					
	5	6					
STP Digital	7	8	Create data / income capture interfaces to EPR	RFID - patient tracking deployed (A&E, Maternity and wards)	BCC improvement project		
	9	10					
Provider digital maturity							

Key:

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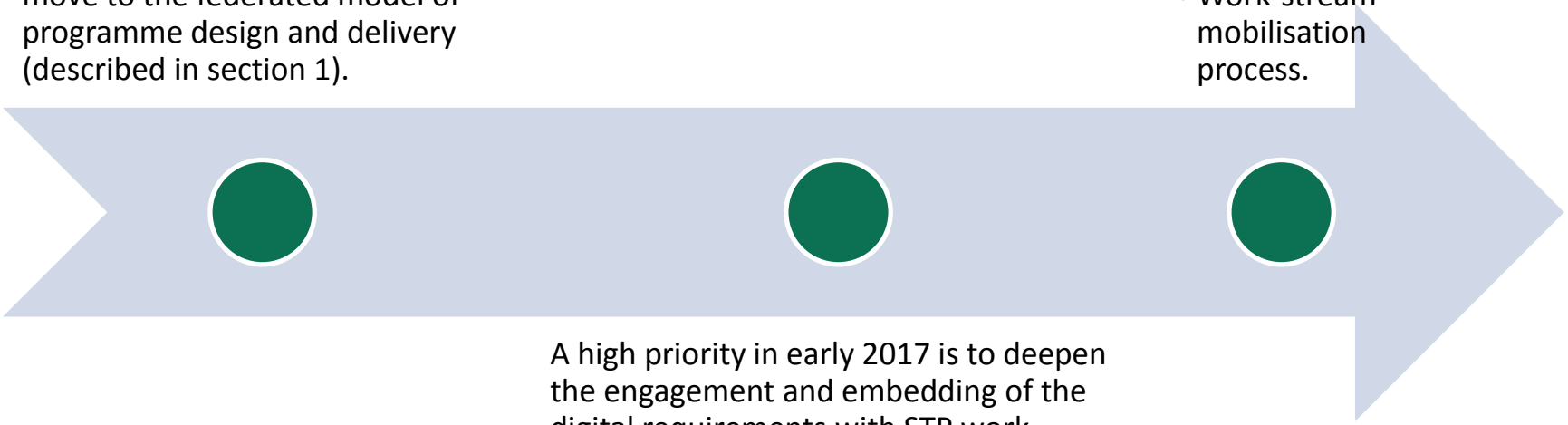
6.

Next Steps

The core elements and priorities of the STP digital programme have been developed in recent months to form a platform from which to move to the federated model of programme design and delivery (described in section 1).

The slides in this final section outline:

- Work-stream leads for each of the 5 agreed STP digital priorities.
- Work-stream mobilisation process.



A high priority in early 2017 is to deepen the engagement and embedding of the digital requirements with STP work-streams, to exploit the opportunities described in section 4.

Extending patient & public engagement as part of wider transformational service changes is needed to support the development of information consent models and the use of data for secondary purposes.

Work-stream mobilisation

Tollgate	Aims	Output		Goal
Phase 1 Initiation	▪ Engage Leadership ▪ Define strategic needs ▪ Define strategic outcomes ▪ Develop strategic business case	▪ Strategic imperatives ▪ Transformational scope ▪ Define strategic outcomes ▪ Outline strategic benefits ▪ Develop strategic business case	*What is driving the change?* *Who and what is impacted?* *What will change?* *What will it deliver?* *How will we make it happen?*	**Executive Charter**
Tollgate Review				
Phase 2 Visioning	▪ Describe the "As Is" ▪ Articulate the "To Be" vision	▪ Vision statement ▪ Future Operating Model ▪ Outline Business Case	*How will the business look?* *How will it operate differently?* *How is the investment justified?*	**As Is Model To Be Model**
Tollgate Review				
Phase 3 Planning	▪ Logical Design ▪ Product and Supplier selection ▪ Identifying Benefits ▪ Defining the Programme ▪ Full Business Case	▪ Logical Design Document ▪ Functional requirements spec. ▪ Product/Supplier selection ▪ Benefit Cards ▪ Benefit Realisation Plan ▪ Full Business Case	*What is the solution concept?* *How the users need it to work.* *Who can deliver the solution?* *What ROI can we expect?* *How to demonstrate returns* *Have we covered all the bases?*	**Outline Solution**
Tollgate Review				
Phase 4 Design	▪ Detailed Design ▪ Benefits Validation ▪ Full Business Case Validation	▪ Design Blueprint ▪ Design Report ▪ Validated Benefit Cards ▪ Revised Full Business Case ▪ Functional Specifications	*What does the solution look like?* *How does the solution stack up?* *What it is going to deliver.* *Is this the right choice to make?* *How will it actually work?*	**Detail Solution**
Tollgate Review				

the current focus for the STP-level digital programme is primarily phases 1-3, noting that many component LDR projects are well advanced into delivery. Working groups with STP wide membership will be working to progress each workstream's vision.

Further programme phases

Further programme phases will be defined in more detail during earlier phases.

7.

Find out more

Find out more

The Buckinghamshire, Oxfordshire and Berkshire West sustainability and transformation plan is currently under development. An updated version will be ready to share by February 2017.

Local public engagement events will continue, including opportunities to comment on the digital future for health and social care. Engagement events will be promoted via each partner organisation's website and other communication channels.

Please share your views at these events and if you have any questions or comments, please email:

- Buckinghamshire queries: ccgcomms@buckscc.gov.uk
- Oxfordshire queries: cscsu.media-team@nhs.net
- Berkshire West queries: ppiteam.berkshirewest@nhs.net