Oxford Health NHS Foundation Trust

Strategic Plan SUMMARY Document for 2014-19

Oxford Health NHS Foundation Trust

Strategic Plan Guidance – Annual Plan Review 2014/15

The cover sheet and following pages constitute the strategic plan submission which forms part of Monitor's 2014/15 Annual Plan Review.

The strategic plan must cover the five year period for 2014/15 to 2018/19. Guidance and detailed requirements on the completion of this section of the template are outlined in Section 5 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good strategic plan should cover (but not necessary be limited to) the following areas, in separate sections:

1. Declaration of sustainability
2. Market analysis and context
3. Risk to sustainability and strategic options
4. Strategic plans
5. Appendices (including commercial or other confidential matters)

As a guide, we would expect strategic plans to be a maximum of fifty pages in length.

As a separate submission foundation trusts must submit a publishable summary. While the content is at the foundation trust's discretion this must be consistent with this document and covers as a minimum a summary of the market analysis and context, strategic options, plans and supporting initiatives and an overview of the financial projections.

Please note that this guidance is not prescriptive. Foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans (Years one and two of the five year plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

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Tel. no. for contact	01865 782 145
Date	

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

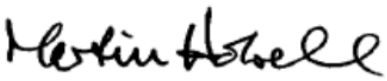
In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Martin Howell

Signature



Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Stuart Bell

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Mike McEnaney

Signature

1.0. Our Strategic Context

1.1. Introduction

This plan sets out how Oxford Health NHS FT (OHFT) intends to deliver high quality sustainable services over the next five years. It builds upon our 2014-2016 Operational Plan. It includes an assessment of the context within which we operate, the challenges we face and the major trust-wide and service-specific strategies we will adopt.

It is essential that we facilitate the development of a model of healthcare that responds to the challenges and takes advantage of the changes in our local health economy. We must work in an integrated way with providers from social care and acute care, the private and the voluntary sector to benefit patients and the whole care system. As an Academic Health Science Centre we can rapidly translate innovations into practice. We must make care a joint endeavour with patients, families and carers, working as partners to achieve the outcomes they want, to treat illness and maintain good health for longer.

The cultural and professional changes that are required are difficult but they have already begun. We must capitalise on some of our excellent work in delivering care locally, the strengths of our children and young people's services and developing early interventions; the new models of adult mental health care and integrated care for people with chronic conditions and people over 75.

We will judge our success not by how well we compete with others but by how well we collaborate with them. We are developing strong partnerships with acute providers, social care partners and the third sector to design a modern, integrated system of care organising services around segments or clusters of patients with similar needs.

We still have further to go to provide truly 21st Century care – most importantly, the integration of the provision of primary care must be seen as central to the whole. We must act as the catalyst to develop strategically thought-through systems that span whole cycles of care.

1.2. Our Vision

As a way to simply articulate the aspirations of our organisation and to help guide our decision-making and planning we have developed the following **vision statement,** so no matter who you are or where you are, we will deliver:

"OUTSTANDING CARE DELIVERED BY OUTSTANDING PEOPLE"

The following table summarises how staff, patients and carers have defined our vision:

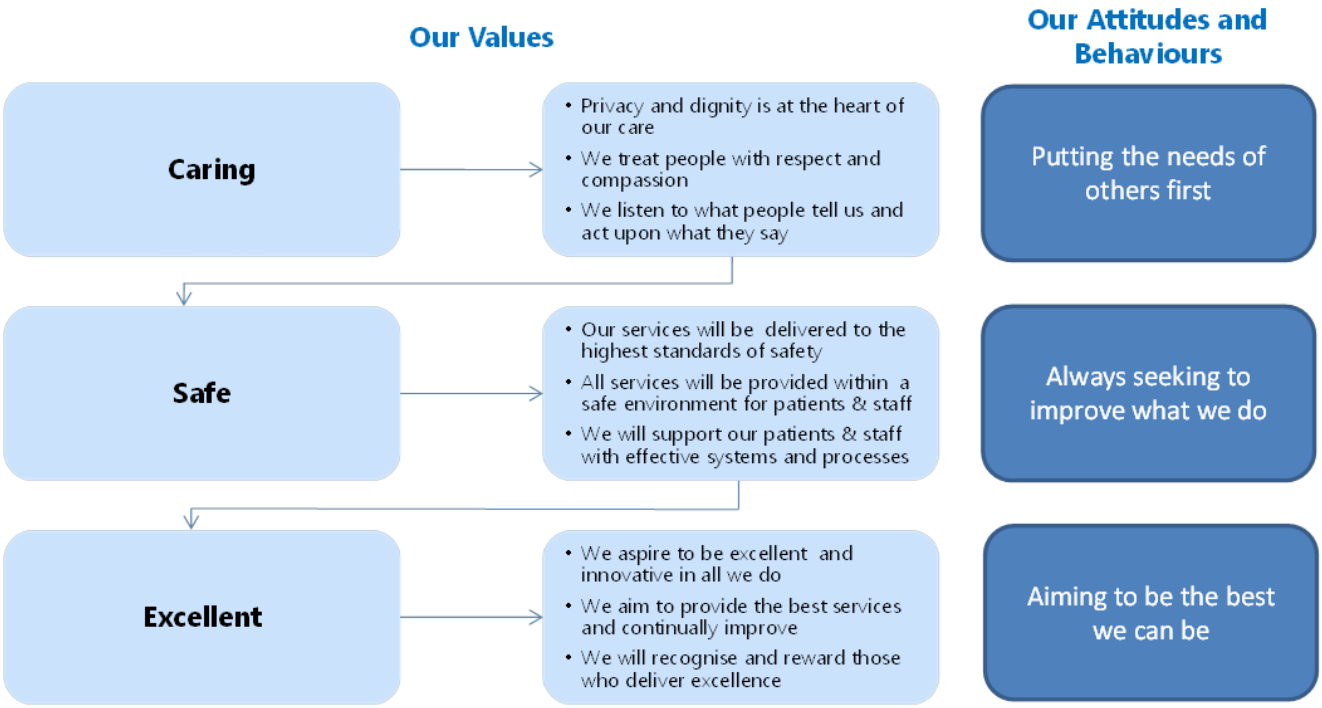
Outstanding Care	Outstanding People
• Keeps you safe • Is kind, compassionate and courteous • Treats everyone with respect and dignity • Respects people's individual choices • Involves patients and carers in decisions • Gets you better as quickly as possible • Has a named care coordinator • Is communicated simply and effectively • Is flexible to achieve the outcomes that matter most to patients and carers • Is consistent, convenient, accessible and friendly • Is always learning, responding to feedback and improving • Exceeds all of our expectations • Has an outstanding reputation	• Listen and respond to people's needs • Treat everyone with respect and dignity • Explain things clearly and simply • Are compassionate, caring and courteous • Build good relationships with patients and carers • Do what they say they will do • Work well in teams • Are always learning, full of innovative ideas and open to ideas • Do everything they can to deliver results for patients and carers • Have skills to work in a complicated system with people from different organisations or cultures • Share the values of our organisation and are true to them • Feel personal responsibility and accountability for doing the best for patients and carers • Are experts in what they do and confident in their skills, competencies, experiences and knowledge • Are resourced and supported appropriately

1.3. Our Mission is to

> Provide people with access to the right service, at the right place and at the right time, to achieve the health outcomes that they want to achieve. By working with them, their families or their carers, and in partnership with other care providers, everyone's experiences will be excellent and we will create a care system that is sustainable.

1.4. Our Values

We have developed a set of values that link to the behaviours we expect everyone who works for us, or with us, to demonstrate and deliver our mission. All staff recruitment is now based around our values.



1.5. Our Strategic Aims

Our four strategic aims (below) describe what we want to accomplish by implementing our strategic plan:

1. To continuously improve the quality of services so that they are safe, patients and carers have excellent experiences and they achieve the outcomes they want.
2. To work as partners in health and social care to increase the value of services, making ourselves and the system sustainable.
3. To fully involve and carers in their care and make information available for everyone responsible for care delivery, when and where they need it.
4. To have an international reputation for teaching, training and research; translating innovation and putting technology into practice.

We will support our populations to achieve and maintain the outcomes they want by working in partnership with others across the care system. We will continue to play a pivotal role in training and educating the workforce to deliver high quality care that meets the changing needs of our populations. Our part in translating innovation and research into practice as part of the newly designated AHSC[1] and as hosts of the CLAHRC[2] and active members of the Oxford AHSN[3] will be fundamental to the sustainability of our Trust and the health and social care system.

[1] Academic Health Science Centre
[2] Collaboration in Leadership and Applied Health Research Centre
[3] Academic Health Science Network

2.0. Future Trends and Themes

It is an exciting time to be involved in health and social care, both at home and abroad. The challenges and uncertainties we face are wide-reaching and require us to play an essential role in leading fundamental changes in the way we help people to stay well or recover from illness. We recognise the opportunity to lead this change by integrating not only the physical and mental health services we provide but by working in new partnerships. In doing this we will develop new models of care that span entire pathways defined by the needs of groups of patients with similar needs.

The following trends and themes will influence the development of our strategic plans over the next five years:

- **The Global Context-** Political, economic, social and environmental challenges, including rapid growth in knowledge and technology, a shift in economic power, rise in global temperatures and sustainability of key resources, offer huge opportunities to innovate and improve.

- **The Financial Context -** Near zero growth in health and annual cuts in social care budgets are expected to continue. Our challenge is to maintain quality of service and meet the rising demand. Our reference cost of 88 demonstrates that we provide already efficient care which makes delivering the challenging cost reduction even more difficult. Under block contracts we receive no payment for the continued increases in activity, and a lesser proportion of the health funds were allocated to Mental Health and Community Services in Oxfordshire.

- **Demography -** The population in England is growing, ageing and becoming more diverse, offering significant challenges. Those aged over 85 are currently the highest consumers of health and social care and also receive significant amounts of informal care. Predictions suggest that this group will grow and it is likely that their demands for health and social care will be large. However some of our deprived populations experience significant inequalities, and tend to have shorter lives and live a greater proportion of their lives in poor health.

- **Issues Affecting Health and Disability -** Factors other than health care, such as individual characteristics, education, employment, lifestyle and physical, social and economic environments, also contribute to population health.

- **Healthy Behaviours -** Major improvements in the health of populations can be achieved if individuals choose to adopt healthy behaviours. Disadvantaged groups are more likely to have a number of unhealthy behaviours – smoking, drinking, low consumption of fruit and vegetables and low levels of physical activity. If current trends continue, these populations are likely to carry a large burden of avoidable illness in the future and health inequalities are likely to continue to grow.

- **Future Patterns of Disease -** The prevalence of multiple chronic diseases is expected to rise in the coming years, due to the growing number of older people, increasing risks factors such as obesity, and medical advances. Their care needs will significantly rise. The greatest opportunity to impact on health inequalities and to reduce the burden of chronic disease will be changing population lifestyles supported by effective chronic disease management and prevention measures.

- **Medical Advances –** Innovation in medical sciences will revolutionise our ability to predict, prevent, monitor and treat a large range of conditions. Our involvement in major clinical-academic partnerships is critical in enabling us to rapidly adopt, disseminate and profit from them.

- **Information and Communication Technologies -** New technologies offer so many opportunities to improve the care we offer people, improve productivity and reduce the gap between our available resources and growing demand. Technology can put more power in the hands of patients, carers and families and we must use these new technologies to benefit patients, to challenge our current care processes and to change. These technologies can help us to go beyond the traditional physical, cultural or geographical boundaries of care settings.

2.1. OHFT's Strengths, Weaknesses, Opportunities and Threats

During the course of developing our strategy we have identified various strengths, weaknesses, opportunities and threats that have influenced the development of our plans for the next five years:

Strengths	Weaknesses
• Our financial track record over recent years is good. • We deliver services at a lower cost than the national average - our FY13 reference cost is 88. • We have built a good reputation in providing several specialist services. • Our services span the entire care cycle from home and community care through to specialist inpatient services, over a wide geographical area. • We have strong working relationships with commissioners across five counties. • We have organisational change experience, and experience in delivering both physical and mental health care. • We have two new state of the art buildings (Whiteleaf Centre & Highfield) and a large existing asset base. • We have well-developed governance structures. • We offer multi-faceted professional training. • Section 75 agreements with local authorities were renewed, highlighting good working relationships with social services. • We have a high level of involvement of patients in care design and delivery in some services such as CAMHS. • We work in partnerships with academic institutions especially University of Oxford and Oxford Brookes. • We saw successful delivery of innovative models of urgent care such as EMUs (Emergency Multidisciplinary Unit) in Abingdon and Witney. • We implemented changes in mental health service provision to shift care closer to home, growing community care, backed up by inpatient services. • We have a burgeoning clinical and academic leadership	• Staff survey findings tell us that we must improve engagement between senior leadership teams and frontline staff. • The organisation still has some way to go to develop a culture of being part of one OHFT team. • We must consider how governance processes, policies and procedures can speed up decision-making and local innovation. • Some of our estate and facilities are old and in poor condition, which does not contribute to a therapeutic environment for patients of staff. • Recruitment can be challenging due to the high cost of living in our region. • There are still some examples of artificial geographical barriers and variation in Oxfordshire and parts of Buckinghamshire. • We can make better use of charitable funds to improve patient care. • We need to learn from some staff how we can better support them in their jobs to reduce turnover.

Opportunities	Threats
• To improve care by sharing successful service models geographically and by working with general practice to coordinate care of patients in the community • To develop clinical leadership throughout the organisation following service re-modelling • To learn from patient and carer involvement • To translate innovation into practice, share best practice and attract best staff through working as part of AHSN, CLARHC and AHSC • To develop a culture of learning and continuous	• Growing needs of growing populations, with high expectations in terms of access to health services close to homes. • The national efficiency target of at least 4% per year reduces our income on existing contracts, and there is no additional payment for the continued increases in activity on our block contracts. • A lower proportion of the health funds being allocated to mental health and community services in Oxfordshire, despite increasing demand

Opportunities	Threats
improvement through the routine and systematic measurement and benchmarking of patient outcomes • Performance management should recognise and reward excellence as well as penalise bad performance. This should be based on how we work as teams and what outcomes we achieve for patients (as teams). • The challenging financial context that we operate will force the whole system to change and innovate. • Outcome-based contracts will lead to change in system-wide incentives, encourage further integration and require systematic measurement of outcomes that matter to patients. • We are developing our own Electronic Health Record to enable better patient care, improve information systems and work with Information teams to provide excellent information for continuous improvement.	• Vulnerability of some providers in terms of quality or financial performance may destabilise local care economies. • Need to develop effective and clear working relationships between new structures such as Clinical Commissioning Groups, Commissioning Support Units (CSUs), Health and Wellbeing Boards, and HealthWatch • The most appropriate use of the Better Care Fund and alignment of incentives to encourage integration and achieve the best outcomes. • The configuration and participation of Primary Care • Cultural and organisational barriers between different sectors and providers. • Tendering of parts of the care cycle may lead to disintegration of services and cherry picking for independent providers of lucrative services. • Availability of suitable and appropriately trained staff.

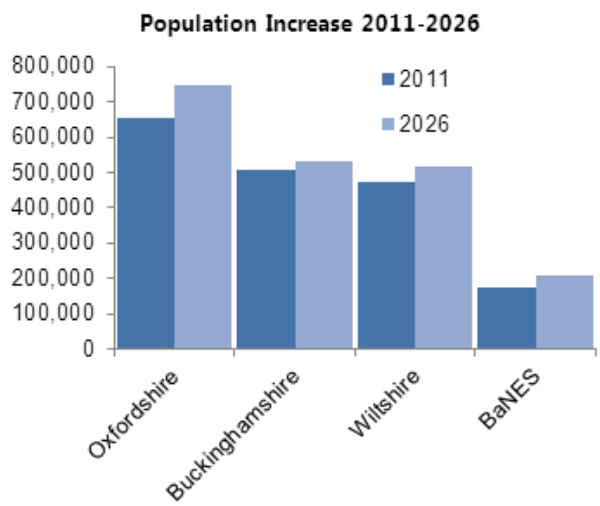
3.0. Market Analysis and Context

3.1. Demographic and Healthcare Trends

OHFT provides community and mental health services for children and young people, adults and older people across Oxfordshire, Buckinghamshire, Wiltshire, Swindon, Bath and North East Somerset (BaNES), which have a combined population of 1,807,315 (2011 Census data).

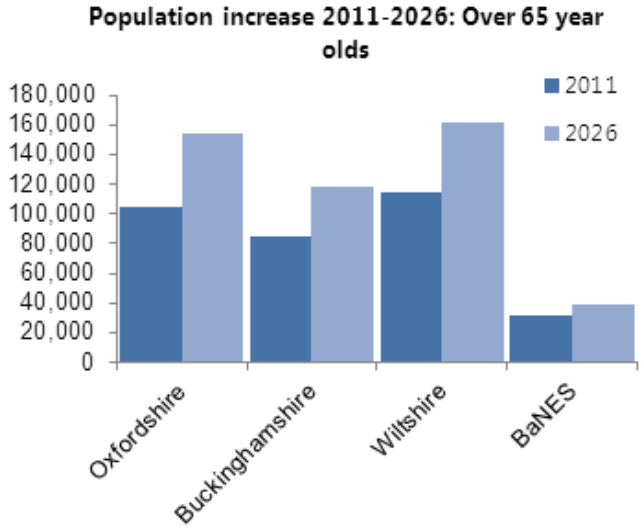
These areas are largely rural. Oxfordshire is the most rural county in the South East, as over 50% of the population live in settlements of less than 10,000 people. Nonetheless there are also highly populated urban areas in these counties. Oxford's city population, for example, grew by 12% from 2001-2011, and is estimated to reach 165,000 by 2021, and Milton Keynes and Aylesbury in Buckinghamshire are predicted to see a similar growth. The rural nature of these areas influences how OHFT designs its services, particularly given the move towards the provision of community services.

All four counties are considered fairly prosperous. In 2010, the counties were ranked according to the indices of multiple deprivations (IMD). Out of 149 local authorities, these four areas were amongst the least deprived: Buckinghamshire ranks as the 8th, Oxfordshire the 12th, BaNES the 15th, and Wiltshire the 18th. However, small pockets of deprivation do exist, which typically experience worse outcomes in terms of health, education and income.



Oxfordshire, Buckinghamshire, Wiltshire and BaNES will experience population growth over the coming years, which will increase demand on our services. By 2026, Oxfordshire's total population is forecast to grow by 14%, Buckinghamshire's by 5%, Wiltshire's by 18.2% and BaNES' by 12%.

The ageing population is increasing in particular across all four counties (below). The consequence of this is an increased demand for health and social care services, a higher prevalence of chronic disease and need for carers.



Increasing life expectancy and a decrease in birth and death rates has resulted in a large growth in the proportion of older people and a predicted decrease in the working age population. Life expectancy in all four counties is high compared to neighbouring areas and the national average, and will continue to increase. The trends would also suggest that disability-free life expectancy is also increasing.

All four counties are less ethnically diverse than the UK average. According to the 2011 Census, 79.8% of the English population was White British. In Oxfordshire, Buckinghamshire, Wiltshire and BaNES the figures are 83.6%, 81.1%, 83.4% and 90.1% respectively. The ethnic composition of these counties is, however, becoming increasingly diverse. Wiltshire CCG has highlighted a concern that there is an unknown demand for services from minority groups and hence unmet need. Thames Valley Local Area Team stated in their strategic plan that some communities enter the health and social care system late and there are consequently higher levels of unplanned acute admissions.

Oxfordshire, Buckinghamshire, Wiltshire and BaNES are, overall, healthy counties. Fewer people say that they suffer from a limiting long-term condition compared to the national average. The Department of Health has estimated that the number of people with multiple long-term conditions seems to be rising, and it is anticipated that it will rise from 1.9 million in 2008 to 2.9 million in 2018. Those with one or more long-term condition use a substantial proportion of health care services (50% of GP appointments and 70% of hospital bed stays), and 70% of hospital and primary care budgets is directed towards their care (NHS England).

Throughout these counties there are continuing issues around childhood obesity, which mirror the upward trends in adult obesity throughout the country. It is estimated that by 2050 60% of adult men, 50% of adult women and 25% of children will be affected by obesity (Foresight 2007). This is likely to lead to a rise in diabetes, heart disease and stroke.

3.2. Key Findings From Across the Local Health Economy (LHE)

<u>3.2.1. Joint Health and Wellbeing Strategies</u>

The Joint Health and Wellbeing Strategies for our areas highlight several challenges to the health and social care system. They use a variety of national data (e.g. 2011 census) and locally produced data. The Joint Strategic Needs Assessments (JSNAs) of the areas in which we work share very similar priorities, which are broadly summarised in the graph [right].

<u>3.2.2. Clinical Commissioning Group (CCG) Priorities</u>

Our findings regarding demographic and healthcare trends closely align to the CCGs' findings. The graph below shows the themes and priorities which characterise the CCG's approach to addressing their identified challenges:

Oxfordshire CCG

- Clinicians & patients working together to redesign how we deliver care
- Reducing health inequalities by tackling the causes of poor health
- Commissioning Patient Centred High Quality Care
- Promoting integrated care through joint working
- Supporting individuals to manage their own health
- Delivering more care locally

Wiltshire CCG

- Staying healthy & preventing ill health
- Planned care
- Unplanned care & frail elderly
- Mental health
- Long term conditions (including dementia)
- End of life care

BaNES CCG

- Increasing the focus on prevention, self-care & personal responsibility
- Improving the coordination of holistic, multi-disciplinary long term condition management
- Creating a stable, sustainable and responsive urgent care system
- Commissioning integrated safe, compassionate pathways for the frail elderly
- Redesigning musculoskeletal pathways to achieve clinically effective services
- Ensuring the interoperability of IT systems across the health and care system

Aylesbury Vale & Chiltern CCGs (Buckinghamshire)

- Improve the health & wellbeing of Buckinghamshire people. Keeping people happy and healthy with better quality health & well-being available for all.
- Provide seamless support with no distinction between services, where we all work together & everyone plays the part. Using the combined strengths of organisations, communities & people's solutions.
- Deliver quality across the whole system. High-quality personalised care based on a consistent, common assessment of a patient's healthcare needs.
- Enable people to take greater responsibility for self-care. Ensuring integration between what GPs do and what people & their families do themselves, as well as between primary and secondary care, health and social care, & physical and mental health.

3.3. Commissioning Intentions

Commissioners have developed their strategic plans within a context of significant financial challenge and growing needs for health and social care. Meeting the highest standards of quality in terms of safety, experience and outcomes within a financially challenged environment is driving the strategic directions for everyone in the LHE. Another challenge is the increased requirement for commissioners to comply with competitive tendering rules. Although individual commissioners have interpreted the rules differently, we have seen a recent increase in the number of services that have been put out to tender. This provides a risk to our business in terms of the internal resource required to respond to tender processes and the risks of disintegrating care. We must work together to find ways of continuing to provide high quality integrated care at lower costs, and commissioners need to consider the risks of adopting a 'rules-based' approach to contracts.

As part of their five year strategic planning, CCGs have worked with Local Authorities to develop their Better Care Fund (BCF) schemes which will be in place from FY16. The BCF is a single pooled budget designed to deliver better integrated health and social care, and will require CCGs and Local Authorities to work together to develop a new shared approach to delivering services and setting priorities. This redirects funds that are currently committed to existing core activities. The impact on OHFT services is not yet clear, but the revenue funding that will transfer to the BCF from Buckinghamshire CCGs is circa £26m and from Oxfordshire is circa £33m.

3.3.1. NHS England (Forensic, CAMHS, Eating Disorders)

NHS England commission a range of specialised services as well as directly commissioned services from OHFT. Their published commissioning intentions for 2014-16 include a focus on value for money; using CQUIN schemes to improve outcomes; ensuring consistent access to effective treatments; and carrying out a systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate, to address clinical or financial sustainability issues.

Work has been ongoing for the last two years to develop and implement national service specifications and measure existing services against these, and put action plans in place where current services do not meet the national specifications. Whilst the services that OHFT provide do largely meet the specifications, there may be an unexpected consequence for innovative services for which there are no national specifications, such as our Forensic pre-discharge unit. It is unclear whether these services will be commissioned by NHS England going forward or whether they will revert to CCG commissioning.

The commissioning of services in lots rather than as part of clinical pathways leads to a fracturing of clinical pathways and potentially multiple providers at different tiers. This particularly affects our CAMHS services, as the move to specialist commissioning led to an increase of inpatient admissions. Eating Disorder services are also commissioned in lots with different requirements. Specialist Eating Disorder Service (adults) beds are commissioned by NHS England, whereas specialist community Eating Disorder services are commissioned by local CCGs. At times there is increased demand and patchy local services in some part of country, which will impact upon the services.

The capacity review and plans to move to national pricing may also impact on our income in future years, but whether this will be beneficial or adverse will not be clear until the review has been carried out and more detailed plans for the move to national pricing are made available.

3.3.2. Oxfordshire

Oxfordshire CCG is facing a very challenging financial situation. They ended FY14 with a surplus of £0.3 million, avoiding the forecast £6.1 million overspend. However FY14 was a difficult year financially and they are currently negotiating a deficit plan with a recovery trajectory over several years. Whilst the work undertaken to move towards outcomes-based commissioning was collaborative, the negotiation process to agree the contract which will determine the funding available has been challenging. This has been partly due to a lack of parity of esteem for mental health and community services, with additional reductions being applied above the national deflator. Oxfordshire CCG's stated strategy is based on providing services closer to home in community, primary care or home settings. Some of the reduced investment may be expected to be achieved through outcomes-based commissioning and efficiencies from revised pathways and contracting models.

3.3.3. Buckinghamshire

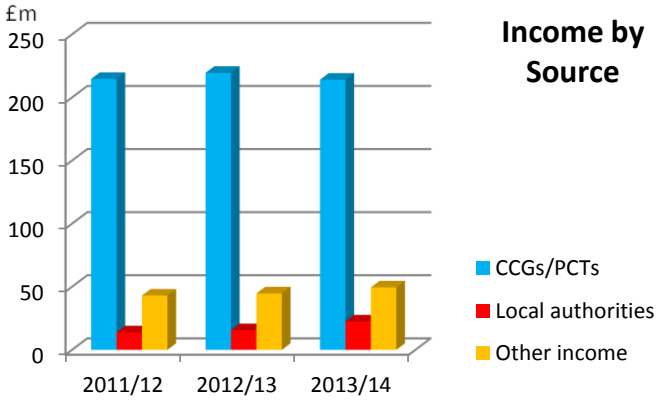
Buckinghamshire CCGs appear to be facing a tight, but manageable financial position, however they do need to find efficiencies to be able to implement their strategy whilst remaining in financial balance going forward. They appear willing, where they can, to invest in projects that will deliver future savings, and we have begun to discuss collaborative working to support the whole economy. There is a Psychiatric In-reach Liaison (PIRLS) scheme in place for FY15 (with an additional £200k investment from Buckinghamshire CCGs and County Council for FY15, on top of £275k for FY14) and we anticipate developing other similar schemes in the future. Buckinghamshire County Council (BCC) currently commission CAMHS community services from OHFT, which they intend to tender during 2014. BCC are intending to structure the tender in lots that separate the provision of tiers 2 and 3, and so OHFT's approach is to partner with the third sector in order to provide the most efficient service along the entire pathway.

3.3.4. Wiltshire and Bath and North East Somerset

OHFT's main CAMHS contract is a joint one between Wiltshire and BaNES. The CAMHS tier 2 contract is separate, and we also have contracts with Swindon and deliver Specialist Eating Disorders services for Wiltshire. Wiltshire County Council is intending to put their children's services out to tender which offers us an opportunity to develop our model further in Wiltshire.

3.4. Funding Analysis

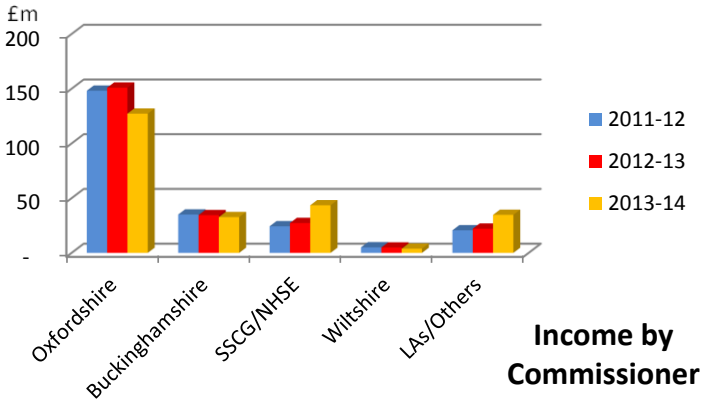
The Trust's income based on historic trends for the last three financial years is summarised in the charts below.



Income by Source

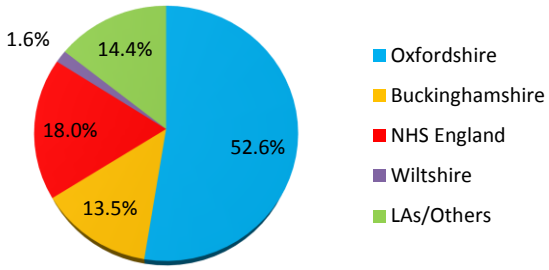
Approximately 83% of the Trust's total income is received from commissioners for patient services. Commissioned income from CCGs reduced in 2013-14 due to national changes in commissioners, which saw some funding transfer from Primary Care Trusts (PCTs) to NHS England and Local Authorities. In addition, the responsibility for services commissioned by Specialist Services Commissioning Groups in 2013-14 transferred to NHS England along with the associated funding.

In 2013-14, 53% of commissioned income was derived from Oxfordshire services. 85% of commissioned income was derived from services provided in Oxfordshire and Buckinghamshire, including from NHS England.



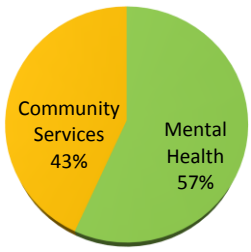
Income by Commissioner

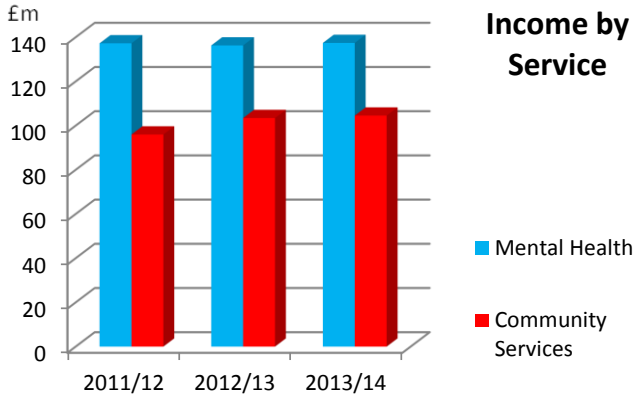
FY14 Income by Commissioner



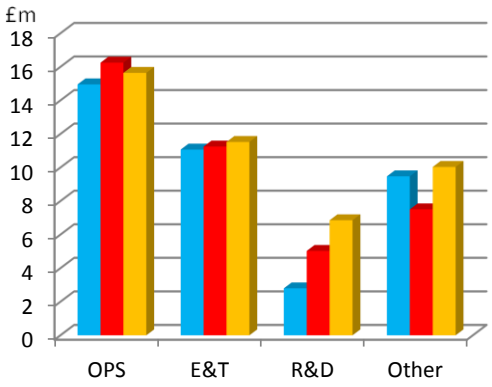
Income received in relation to mental health services has remained relatively constant during the last three years, whilst income received in relation to community services has increased by approximately 9%. In 2013-14, 57% of commissioned income related to mental health services, and 43% related to community services.

2013-14 Income by Service





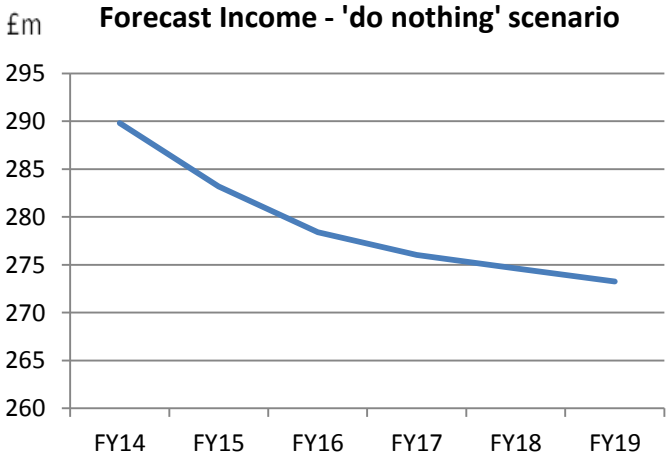
Income by Service



Other Income

Other income refers to income received from non-patient services. The main source of other income is pharmacy sales by the Trust's Oxford Pharmacy Store, income for education and training purposes, and in relation to research and development activities. Other income also includes services provided to other NHS bodies, charitable funds contributions and profit on disposal of assets. Income for research and development has been steadily increasing year-on-year since the launch of the Oxford Academic Health Science Network (OAHSN) and the Oxford NIHR CLAHRC (Collaboration for Leadership in Applied Health Research and Care).

3.5. Forecasted Activity and Revenue



The Trust's forecast income in a 'do nothing' scenario is shown in the chart (left). The key assumption is that there are no significant changes to the income the Trust receives for the services it provides.

This shows that Trust total income would reduce year-on-year. The primary reason for this is the assumption that the 4% national efficiency requirement will continue to be applied, resulting in a net deflator. The 4% efficiency requirement would reduce income in real terms by circa £55 million over the next five years.

The deflator assumptions (right) have been applied to commissioned income based on the NHS England five year strategy. This would result in a £16.6m (5.7%) net reduction in income over the five year period from 2013-14 to 2018-19.[4]

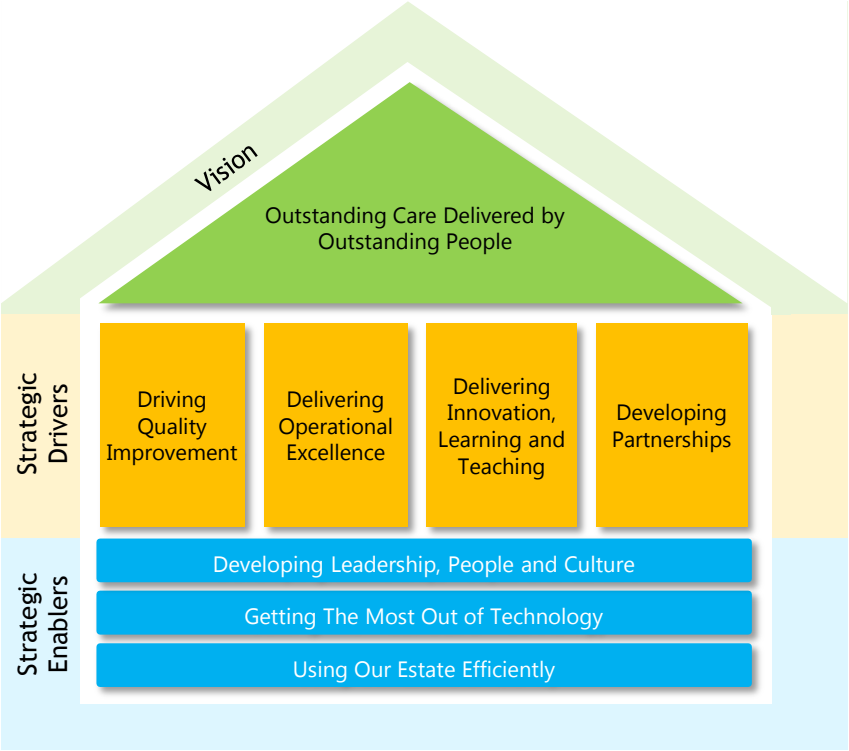
FY15	FY16	FY17	FY18	FY19
-1.8%	-1.8%	-1.0%	-0.6%	-0.6%

3.6. The Provider Landscape

The following map shows the main NHS providers in the surrounding counties:

[4] A deflator is a net reduction in income following uplift for inflation offset by reduction because of the 4% efficiency savings requirement. For example, in FY15, the efficiency savings requirements resulted in a 4% reduction in income, which is offset by 2.2% uplift for inflation and other cost initiatives, therefore leaving a 1.8% deflator.

4.0. Our Strategic Framework

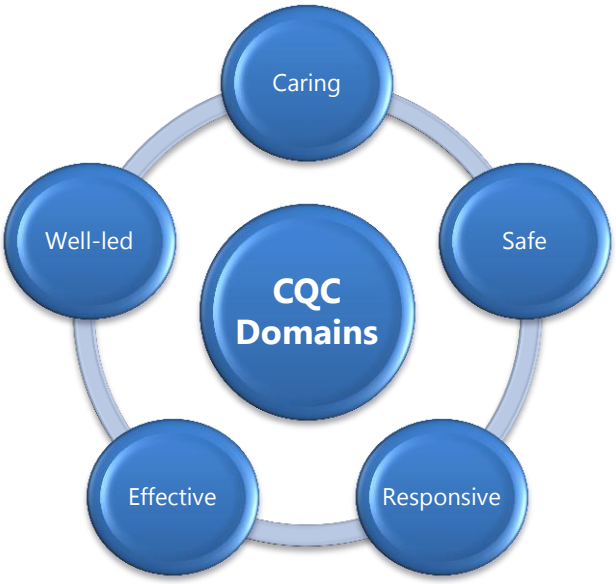


We are continuing to use our strategic framework to provide structure in the development of our plans and align them and our objectives with our strategy. This framework helps us to organise our plans, using a consistent method and language throughout the organisation.

It allows us to use the goals and objectives of the strategic drivers and enablers to organise our individual, team and directorate plans and align them with the Trust's strategy. Plans from across the Trust are incorporated into the Trust-wide integrated business plan and are reported on to the Executive and Board every quarter.

Driving Quality Improvement

4.1. Our Quality Strategy



Our priority is to provide high quality services for patients and our resolve has been further sharpened following the findings of the Berwick, Francis and Keogh reports. Our minimum expectation is that patients are safe and protected from harm and it is essential that we are systematic in our reporting, reviewing and learning from incidents throughout the organisation. It is all of our responsibilities to be curious about this information and to create a culture of improvement.

Our Quality Strategy reflects the Care Quality Commission (CQC) domains [right]:

By measuring the outcomes that matter to patients and their associated costs we will deliver the best value, most sustainable care. Our remodelled services provide an ideal platform to define and measure outcomes for patient conditions in terms of health status, patient functionality and sustainability. This, combined with the patient level costing tool that we continue to refine, will help us to understand the cost of delivering the right outcomes and support further collaborations and service improvements.

It is clear that for us to deliver high quality care we must have the right staff and staffing levels. We have a number of initiatives as part of our quality plan to support our medical, nursing and associated health professionals through training, rewarding and retaining caring, compassionate and high calibre staff to meet the complexity, demands and numbers of patients.

The following four priorities have been identified following consultation with staff, patients, commissioners and other stakeholder groups:

1. **Workforce**: ensuring we have the right number of staff with appropriate training and experience, supported by clinical and managerial leadership, working effectively within teams.
2. **Data**: ensuring we have reliable, accurate and relevant data on the quality and safety of our services.
3. **Service remodelling**: continuing the service redesign and pathway remodelling programme, specifically focusing on its quality benefits in terms of improving outcomes, safety and experiences.
4. **Staff engagement** with the quality agenda: ensuring a focus on quality from the front-line to the board, improving quality management processes, and strengthening links between the Board and staff

The main **quality improvement priorities** will be:

1. **Improving Patient experience**; to implement the new patient experience strategy and to deliver mechanisms for soliciting patient feedback, capturing patient stories and using this information to improve services.
2. **Outcomes Measurement** focused on what measures are important to patients and enable us to assess the impact of the care we provide as well as the way in which we provide care.
3. **Preparing for the new-style CQC inspections**

4.1.1. Safer Care

Our Safer Care programme is a highly systematic approach to identifying and reducing harm to patients. Using a project approach, measures are developed for each harm reduction project to determine accurately the existing level of harm and assess the impact of improvements on the outcome and process of care. OHFT's safer care programme is supported by a group of thirteen NHS trusts in the region. They aim to reduce death from self-harm and unexpected causes, reduce unplanned absences, incidences of violence and aggression and medication errors, improve VTE risk assessment and management, patient and carer experience and assess staff perceptions of patient safety.

4.1.2 Suicide Prevention

We will build on previous successes and develop our suicide prevention work. A project lead is now in place, protocol will be developed (particularly for serious incidents following suicides and near misses) and training will be organised for clinical staff. We will develop suicide awareness and prevention strategies in teams across the Trust and review the impact on practice, benchmarking against other providers for common indicators.

4.1.3. Nursing Strategy

To ensure we treat all our patients with compassion, dignity and respect at all times, an endeavour supported by our core values, we must embed these values in our culture and use them to influence how all our staff work. We are meeting the Department of Health's 'Ten Dignity Standards' and working with patients, carers and our staff to re-launch our Trust privacy and dignity promises. We are currently developing a nursing strategy, based on the national strategy 'Compassion in Practice'. It is important that everyone works together to share best practice. We will therefore use patient and staff feedback to continually refine the work we do to ensure that dignity and respect remain at the heart of our care.

4.1.4. Patient Outcomes

We will improve patient outcomes by creating relevant outcome measures against which we can start monitoring and reporting on the effectiveness and quality of our services. We will work with commissioners to ensure that KPI's and service specifications reflect the service user needs, demand and requirements of service delivery. Better use of evidence-based practices will help to ensure that patients have the best outcomes. Specific examples include developing outcome measure apps in the Children and Young People's directorate with the help of our commercial and university partners. We must maximise patients' opportunities to self-care and manage their own condition.

4.1.5. Patients and Carers

Our teams will work closely with patients and their carers to achieve the health outcomes they want. We will deliver joined up care provided by integrated teams, actively involve carers in care planning, work with the carers reference group in Adults services to develop joint working and single involvement and engagement strategy and processes and work in partnership with both local authority and the voluntary sector to improve the knowledge and skills of formal and informal carers in relation to pressure ulcer prevention.

We endeavour to involve patients and their carers in everything we do, as understanding people's experiences of our services allows us to continuously improve. We provide multiple opportunities to provide feedback and we value the views of the diverse range of people who use them. We invite former and current service users of adult mental health teams to talk to clinicians and managers about how we run our services. Children and young people are greatly involved in the planning, development and evaluation of services, and have contributed to the design of the Highfield Unit and the national pilot of children and young people's IAPT (improving access to psychological therapies).

4.1.6. Patient Experiences

We will continue to implement our patient experience strategy (introduced in 2013) in order to maximise how we capture patient feedback and act upon it to improve our care environments. The aim is to provide every patient with an opportunity to give feedback and use it to make improvements to our services. We will share with the patients and public how their feedback has contributed to improvements and give our staff the support and resources to gather and act on feedback effectively. This will entail creating a webpage to share feedback and actions taken, developing team and clinician level feedback and rolling out the Friends and Family test across all services.

Delivering Operational Excellence

4.2. Our Operational Strategy

4.2.1. Organisational Structures and Leadership Arrangements

Care Pathways	Children & Young People	Adults	Older Adults
Maternal Health	✔	✔	
Neuro-developmental	✔	✔	
Children's complex & multiple needs	✔		
Eating Disorders	✔	✔	✔
Long Term Conditions	✔	✔	✔
Psychosis	✔	✔	✔
Mood Disorders (Bipolar, Anxiety, Depression)	✔	✔	✔
Personality Disorders	✔	✔	✔
Addictive Behaviours	✔	✔	✔
Complex Conditions / Frail Elderly			✔
Dementia			✔
Palliative and End of Life Care	✔	✔	✔

Services were re-modelled in 2013/14 in order to deliver integrated health and social care services that are efficient and appropriate and maximise the opportunities and benefits of local twenty-four hour, seven day a week multidisciplinary care.

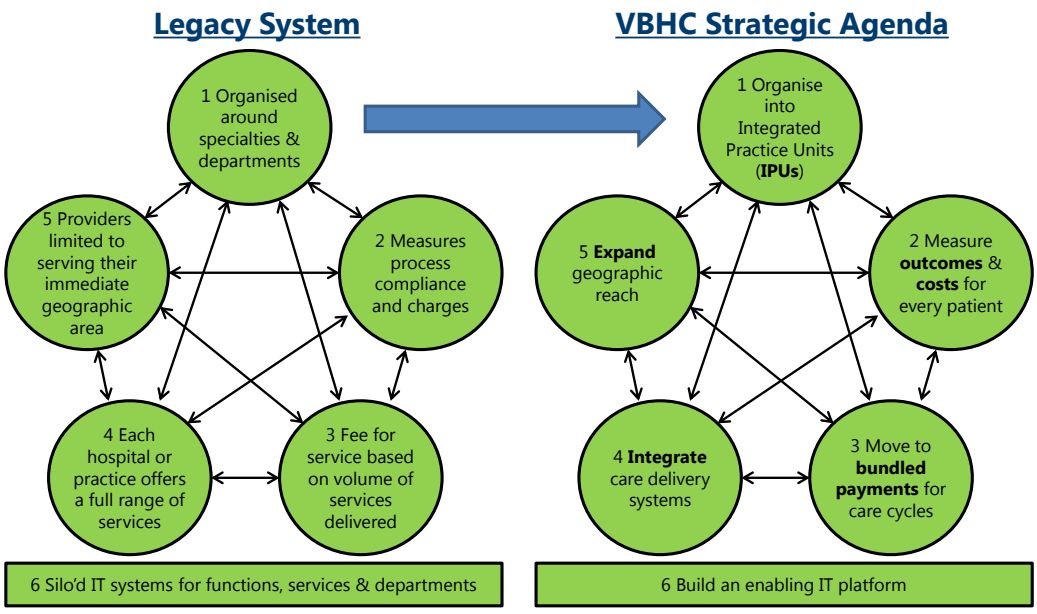
Twelve overarching care pathways have been developed as part of this work with provision of out of hours care and emergency multidisciplinary assessment and treatment cross-cutting throughout.

Our strategic plans aim to organise care around segments of patients with similar needs to ensure that they receive the right expertise at the right times by working with other providers of health and social care.

As we re-model our services we have re-structured our operations, moving from four divisions to three directorates – children and young people, adults of working age and older adults. The new structures have been developed to be fit for the future based on several shared principles. There will be sufficient senior leadership capacity at all levels in each directorate (clinical and operational) to lead the development of 21st century care closer to home and the ability to deliver integrated care. We will lead system improvements and further integration in Buckinghamshire and Wiltshire, and continue to respond to business development and tendering opportunities, recognising this as a function of operating within the existing care market. We will support the development of consistent clinical leadership and the ability to capitalise on rapidly translating innovations into practice through strong clinical and academic links in Oxfordshire. Patient and carer feedback processes will be embedded and clinical and managerial leadership has a shared responsibility for making the best use of this as a rich source of information for improvement. We will make systematic use of streamlined tools and processes that optimise the clinical and operational review of quality and performance. We will deliver value in terms of achieving the best results for patients through effective use of resources within our organisation and throughout the whole cycle of care.

4.2.2. Delivering Value

We are developing and standardising our approach to delivering value in care that underpins all of the changes that we plan to implement in the coming five years. The changes we make in care provision must be fundamental and each directorate is using the value-based healthcare framework. (*Source: Michael Porter & Thomas Lee, Harvard Business Review, October 2013*)



The work to deliver value has begun in all of the Directorates with clinically-led teams following similar steps outlined in the framework.

Within the existing care pathways clinically-led teams are identifying segments of patients with similar needs and considering how services are currently organised to meet their needs. We are identifying outcomes measures that will be routinely monitored and used to drive improvements. These outcomes will be a combination of existing ones from mental health clusters, IAPT outcomes framework or others as well as new ones that are co-produced with patients and carers. The culture we aim to create is one of routine, systematic and relentless measurement of the outcomes that matter to patients to drive continuous improvement in care delivery and partnership working.

Current and desired processes for delivering care for these patient segments are being mapped considering the time and resources that are required to deliver the outcomes. We have our own patient-level costing tool that is helping to understand not just what we are paid for services but the real costs of delivering care for individual patients. With a clear understanding of desired outcomes, processes and costs we are able to make evidence-based decisions about how best to organise care more efficiently.

In the long-run the integration of federated models of primary care and shift in payments away from capitated, activity-based or block contracts to outcome-based contracts will support this transformation.

Delivering Innovation, Learning and Teaching

4.3. Our Strategy for Translating Innovation into Practice

We must ensure that the populations we serve get the most benefit from our involvement in academic research networks and translate their learning in to tangible changes to our services. We will capitalise on these partnerships to ensure that our patients benefit from innovative new treatments. We are developing a research and development strategy which aims to increase recruitment of participants on to trials, and to increase the impact of our research and publications. Our Clinical Record Interactive Search (CRIS) system will enable us to further expand our research capability by improving our ability to identify and recruit potential study participants.

4.3.1. Oxford Academic Health Science Network (AHSN)

OHFT is part of the Oxford AHSN, which covers a population of 3.3 million living in Berkshire, Buckinghamshire, Milton Keynes, Oxfordshire and Bedfordshire. We aim to focus on the needs of the local population, speed up the adoption of innovation in to practice, build a culture of partnership and collaboration, and create wealth. The AHSN has three major work programmes that our services are involved in, which are Best Care (clinical networks, continuous learning and sustainability), Clinical Innovation Adoption, and Research and Development. These are supported by two themes (informatics, and patient and public involvement, engagement and experience). Our membership of the AHSN, especially the clinical networks[5], will enable us to rapidly adopt and share innovations as well as facilitate growing collaborations with industry partners.

4.3.2. Collaboration for Leadership in Applied Health Research and Care (CLAHRC)

OHFT hosts the CLAHRC, which is a collaborative partnership between health and social care providers, commissioners and local authorities and University of Oxford and Oxford Brookes departments focused on improving patient outcomes through the conduct and application of applied health research. The key themes the Oxford CLAHRC will be exploring over the next five years are early intervention and service redesign across organisational boundaries, health behaviours and behavioural interventions, patient experience and patient-reported outcomes (assessment and impact on services), better management of psychiatric comorbidity in the medically ill (developing integrated care) and optimising the health of people at risk or with chronic disease through self-management.

The CLAHRC aims to recruit to new clinical academic posts in applied health research in the NHS, and build new research groupings to inform their research and implementation work (Mar-14 – Mar-15). It then aims to provide evidence of the clinical and cost effectiveness of new service developments addressing key public health priorities, such as reducing admissions to acute hospitals in the frail elderly with multiple co-morbidities (Mar-15 – Mar-16). Longer term, the focus is on building the research capacity of the local NHS to support evidence based commissioning and service development, and building an infrastructure to enable the responsiveness of services to patients' reports of experiences and outcomes at the local level (Mar-17 – Mar-18).

4.3.3. Oxford Academic Health Science Centre (AHSC)

OHFT is one of the partners in the newly designated AHSC, alongside the University of Oxford, Oxford University Hospitals NHS Trust, and Oxford Brookes University. This designation is a reflection of the institutions' strengths in scientific research, clinical and training expertise and ability to translate research to address 21st-century healthcare challenges. The prestige and opportunities to share learning and innovate with international and local partners from within and outside healthcare cannot be underestimated. As we develop as an AHSC we will ensure that our services maximise the advantages that this offers.

[5] Children, Dementia, Depression and Anxiety, Diabetes, Early Intervention in Mental Health, Imaging, Maternity, Medicines Optimisation, Mental and Physical Comorbidity, Out of Hospital Care

Developing Partnerships

4.4 Our Strategic Approach to Partnership Working

Our approach to continuing to provide sustainable care over the next five years relies on our ability to act as a catalyst for whole system change. We have experience of leading changes and modernising the provision of mental health, providing greater access closer to home and collaborating with multiple health and social care providers. Working as a system is the paradigm which drives our attitude to competition. As it currently stands, competition is conceived in a way that is fundamentally out of kilter with the true nature of most healthcare. It is more often than not manifesting itself as a powerful dysfunctional disincentive to progress.

We will judge our success not by how well we compete with others but by how well we collaborate with them. We are developing strong partnerships with acute providers and social care partners to design a modern, integrated system of care for older people in Oxfordshire. Similarly our model of care for adult mental health services will deliver greater value by working with voluntary sector partners, as well as others, to deliver better outcomes at lower costs.

We still have further to go to provide truly 21st century care – most importantly, the integration of the provision of primary care. Primary care is still seen as being separate and on the periphery rather than as central to the whole.

Over the next five years, OHFT intends to strengthen partnerships through our involvement in the AHSN, CLAHRC and AHSC, collaboration with the third sector and County Councils to improve the transitions from acute mental health services into residential placements and meet the needs of mental health service users from an employment, accommodation and wellbeing approach. We will collaborate with OUHT to provide effective, person-centred integrated care for older people with complex co-morbidities through vertical integration of the urgent care pathway, and develop community CAMHS services' partnerships with other health providers and the third sector to increase the pathway potential and address the transition problems into adult care. We must proactively seek opportunities to develop research collaborations with other providers.

4.4.1 Adult Mental Health Pathway

The provision of adult mental health continues to evolve and we remain at the forefront of driving greater integration in Oxfordshire and Buckinghamshire. The new integrated pathways of care are using a recovery approach across all partner services to support people to stay well for longer. Strong partnerships with third sector organisations will deliver more flexible, needs-led approaches to mental health. The integration of mental health care aims to support people to carry out normal day-to-day activities in the process of recovery and reintegration in the wider community and provide integrated recovery focussed mental health services providing assessment and treatment based on clusters as well as addressing housing, employment and well-being needs. We must support self-care and informal peer support networks to enhance service user independence and recovery. We will achieve efficiencies of cost and impact through the implementation of services delivered for patient segments with similar needs harnessing the skills of individual organisations into a collective approach. We will deliver value in terms of achieving patient outcomes and meeting increasing demand within sustainable financial resources.

We have long-standing section 75 agreements with local authorities strengthening our ability to deliver integrated health and social care. We also have long-term agreements in place with commissioners and locality GPs that support us to deliver care based on the established care clusters, encouraging greater collaboration to achieve the best results for patients and carers. We intend to further develop services, such as mental health liaison and linked wards, into acute hospitals as we are already doing with Buckinghamshire Healthcare NHS Trust (BHT) and Oxford University Hospitals Trust (OUHT).

4.4.2. Integrated Older People Pathway

As part of Oxfordshire Outcomes-based Commissioning programme a major new proposal for delivering an integrated urgent care pathway has been developed. This pathway will support all adults with complex co-morbidities who have

urgent care needs (excluding major trauma, myocardial infarction [MI] and acute stroke) and will meet the needs of those over 75 years of age. The services that are included in this work are in four distinct categories: services directly provided by OUHT and OHFT; critical services provided by partners essential for inclusion such as services provided by OCC; services where increase contractual control is required such as patient transport and end of life care, and critical partnerships with the third sector.

Furthermore, there will be significant interfaces with emerging strategies for primary care, such as GP federations, for the management of long-term conditions and extended hours; future developments of 111 and the extension of telecare, telehealth and near patient diagnostics in community settings.

As we implement and broaden our partnerships within the sector it is essential that we are able to realise not only benefits in terms of patient outcomes but also benefits in terms of sustainability. We must strive to deliver great care with fewer resources. We will ensure that we are able to maximise the potential of technology and develop local community hospitals able to diagnose, treat and support people to stay well for longer outside of acute settings. In addition we must make sure that the mental health inpatient facilities that we use are fit for 21st century care.

Developing Leadership, People and Culture

4.5. Workforce, Learning and Development Strategies

We have a comprehensive workforce, learning and development strategy in place to support our plans. We want all our staff to be caring, safe and excellent in their day-to-day work. The strategy looks at how the organisation can attract and then retain the best staff, through efficient recruitment processes and workforce planning, and focuses on staff development, engagement, rewards and wellbeing.

4.5.1 Clinical Leadership

It is vital that effective managerial and clinical leadership is embedded in pathways to lead the delivery of better value care, and this is a key priority following the Francis and Keogh reports. Clinical leaders will lead the development and implementation of plans, along with their management counterparts, to ensure that they do not compromise patient care or safety, are evidence-based and appropriate.

We will develop our teams and clinical leaders by working in multidisciplinary teams to ensure rapid community response seven days a week as a viable alternative to admission, except where clinically appropriate, and work in a way that is based on patients' needs and the pathways of care rather than traditional organisational boundaries.

We will use the work of Professor Michael West to support the implementation of Aston University's team-based working. This approach is based on the research evidence that effective team based working is directly linked to the delivery of a number of indicators of high quality care, including staff satisfaction, patient satisfaction and positive clinical outcomes. OHFT will continue its programme of work to deliver team-working training to all managers in the Trust, with the aim of training 250 managers in 2014-15. A dedicated team will develop employees' skills, knowledge and confidence to apply their learning in practice, and aim to ensure that 100% of managers who attend the training feel equipped to improve team effectiveness. The goal is that effective team working becomes business as usual.

4.5.2. Engaging our Staff

We had a good response to the most recent staff survey and it has provided us with a rich source of information about the good aspects of working for OHFT as well as the areas that we need to be better. We have analysed the findings and broadly categorised them into four areas for attention and improvement:

- **Communication** – making communication between senior management and staff more effective, ensuring staff are informed about what happens in the organisation, the good and the bad.
- **Acting on feedback** – developing ways to ensure that senior managers can act on staff feedback and staff are able to comment about changes as well as reported errors, near misses and incidents.

- **Valuing staff** – finding new ways to demonstrate that the organisation values everyone's work; involving staff in important decisions and ensuring that we are a fair and equitable employer.
- **Working environment** – ensuring that there are enough staff for everyone to do their job properly; and having policies, procedures and environments that are general good for everyone's health.

We want to understand what this information is telling us and we are using it as we develop our strategy and approach to leadership and team-working in the Trust. We are establishing better ways of engaging our staff across all our services and localities to find out what is important to them in their day-to-day work and how we can improve as an organisation. This work links to our workforce strategy which aims to retain the best staff, and the work we are doing to develop our leaders and teams. We must create a culture where information and feedback is seen as essential for improvement and communication is more than transmitting information one-way. We will work on this throughout the organisation to create a collective leadership that continuously improves the quality of care for patients.

4.5.3. Communication Plans

The following five-year objectives will be delivered through activities set out in our communications plan:

1. Develop and deliver effective communications through targeted activities that engage staff, partner organisations, commissioners, patients and public about OHFTs strategy, vision, values and objectives.
2. Develop and implement effective two-way communication tools where we listen, learn, respond and improve.
3. Maximise opportunities to promote OHFT to external audiences.
4. Improve OHFT's digital presence.
5. Increase media coverage by optimising existing opportunities and through targeted campaigns.
6. Increase communications support for transformative healthcare delivery, promoting patient and public engagement in care as a collective endeavour and responsibility.

Our five-year communications strategy will help us to:

- Encourage more people to become engaged with and supportive of OHFT.
- Put effective two-way communication at the heart of everything we do.
- Support delivery of the most effective care to patients.
- Enhance our reputation.
- Develop innovative ways of making the best use of communications technology.
- Build a culture that celebrates partnership and shares success.
- Establish OHFT as a recognised and trusted brand.
- Help OHFT attract and retain the best staff.
- Ensure all communication reflects our core values – caring, safe, and excellent.

Getting the Most out of Technology

4.6 Our Information Technology Strategy

We have developed an information technology strategy that outlines key initiatives over the next five years. Our IT services will be redesigned and developed to ensure that they assist the Trust to achieve operational excellence in everything it does. We will improve our management of information by focusing on the timely availability of high quality information and knowledge that supports decision making. Significant cost improvements will be achieved primarily through service transformation assisted by ICT solutions and innovations. We need to grow in terms of service provision and our geographic operational area by embracing innovation in the design and delivery of services, as well as by cultivating strategic alliances with other care providers and academic institutions.

There are several key initiatives that will support this overarching strategy. We aim to provide our staff with timely access to the information they need, when and where they need it, to deliver care. Pathway care delivery models will be fully supported so staff can seamlessly access the clinical systems and information they require to make critical

decisions and the need for duplicated entry is removed. Comprehensive information will be available from a single source, and used to assess the performance of the Trust and support clinical and business decision making.

Mobile working initiatives will allow staff to work beyond the boundaries of a traditional office-based environment, using a safe, secure and reliable ICT network infrastructure. There is an opportunity to work differently using mobile and telehealth solutions, which should support more efficient service delivery models. Use of the Internet, 'Apps' and multimedia will enable the delivery of high quality communications to and from all Trust stakeholders, especially those hard to reach groups. Staff will receive the IT training they need, have access to the appropriate devices, systems and software, and be supported to use them confidently.

We are moving from a centrally funded 'one size fits all' model to a locally funded 'connect all' model for **Electronic Health Records (EHRs)**. The demise of national contracts for EHR and possibly ESR has allowed us to procure bespoke Trust solutions. We have successfully procured a new EHR system and will work to implement it across the Trust from FY15.

Using Our Estate Efficiently

4.7 Estates Strategy

The estate has an important role in supporting the delivery of the Trust's vision and business plans. Our estate strategy aims to develop our estate to support the delivery of our clinical services. We have established that in order to deliver these key objectives, and ensure that our service delivery models are able to operate efficiently and effectively within our estate, our future estate should be developed in order to provide the following:

- **Creation of single campus site for Medium Secure Forensic Inpatient Services** – This will support the delivery of service wide care pathways and approaches; allow for greater peer support and a more integrated approach to learning from best practice/adverse events. It will also enable the efficient use of clinical, managerial and administration resources.
- **Creation of single campus sites for Adult Mental Health Inpatient Services –** The Trust has recently completed the Whiteleaf development, which is to serve as the single mental health inpatient site for Buckinghamshire. The development of a single site to serve Oxfordshire has been proposed. In addition to the benefits that we have already identified this will reinforce and further develop our reputation as a provider of 21st century care.
- **Provision of high quality and functionally suitable accommodation –** We want the best possible environments for our patients, their families as well as staff. To enhance the patient experience and recovery, by incorporating best practice guidelines in relation to dementia environments; art in hospitals; access to external green spaces and access to therapeutic space.
- **Locally based integrated services –** Our proposals are designed to support the Trust's plans to provide care closer to people's homes and our new methods of information technology supported working, which will allow greater time to be spent with patients. We have therefore identified that we will be able to rationalise our estate, which will release the funding that will enable us to develop more innovative and patient-focused services.

In Oxfordshire it is proposed to deliver services using locality and area hubs, enabling the integration of physical and mental health care services. This is critical to the Trust's long term service delivery plans and the successful integration of community services. The provision of community hubs will allow service users to receive care for both physical and mental health concerns at a single location, and clinicians can better work together ensuring that service user care plans are integrated and well-managed. In Buckinghamshire we aim to continue to develop strong partnership links with other healthcare providers, ensuring that service users requiring both physical and mental health care receive a high quality integrated care package. In Wiltshire we aim to ensure that our services are located in locations that support the delivery of care. An environmental strategy is also under development that will ensure our estate carbon emissions are as low as possible and our waste management and recycling processes are improved.

5.0 Service-Level Strategic Options

5.1 Capacity Analysis

OHFT'S current capacity is 416 inpatient beds and 203 community hospital beds. As of May 2014, OHFT employs a headcount of 6,250 staff and a contracted whole time equivalent of 4,770. The numbers of directly employed staff is likely to reduce over the next five years as we deliver better value care through our re-modelled services and in line with outcomes-based contracts.

The **Adults** Directorate will review their inpatient services and benchmark them against other mental health organisations. This information will help us improve our discharges and reduce our readmission rate and maintain bed occupancy levels at 96%, and may lead to a reduction of the number of beds available in 2015. For some services, capacity is difficult to estimate as this is based on the number of referrals from A&E or GPs. An example is the Psychiatric In-reach Liaison (PIRLS) service. NHS England are reducing their funding for complex needs services nationally, and the risk is that replacement local funding for these services may not be available. Contractual agreements with the local CCGs are still to be agreed for FY15 and FY16 and these may determine changes in capacity.

The current Forensic services capacity is 142 beds, spread over nine wards. This is not expected to increase significantly in FY15 and FY16. We would like to reconfigure medium secure services so that the Marlborough House services are centralised at the Oxford Littlemore site and a single Forensic campus is formed, however a suitable ward is not yet available and work has not commenced. Therefore any capacity changes are likely to come in to force in FY17-FY18.

The workforce figures for Adults services are expected to remain constant over the next five years and the services aim to work to the optimal levels indicated. Small changes in staffing levels are anticipated as new services become operational (Personality Disorder gatekeeping service within the probation service and a community pathfinder service).

There are no current plans to change the bed capacity for **Children and Young People's** services during the first two years of this strategy. This may change depending on the outcome of upcoming tenders and with the work that is underway to deliver value along care pathways. Workforce changes in the Children and Young People's services will therefore also be dependent on the outcome of new tenders.

The capacity for the **Older People's** Directorate is likely to change over the next few years. There are currently two types of inpatient beds for Older People: in community hospitals and mental health beds. A critical issue for resolution in FY15 is the reduction in older adult mental health inpatient beds by a third in line with service remodelling and consultation. This remodelling work will enable community teams to deliver older adult mental health services seven-days-per-week, including extended hours, increased rapid response, and an increased staff-to-patient ratio on the wards. This will allow us to increase patient throughput and deliver the same number of patient episodes through a reduced bed number, and fund service enhancement.

Over the duration of the strategic plan, key considerations for capacity for Older Adult Mental Health will be skills and competencies (physical and reablement) in both community and inpatient settings to manage a more acute and complex case mix.

Community hospital beds are currently unevenly distributed across the county, and the variety of unit sizes (ranging from 11-60 beds on each site) does not support high value, sustainable care long term. The shift in patient need and demand (due to the ageing demographic) and limited long term viability of the current estate within the available financial envelope means that this is a critical strategic issue for Oxfordshire. A key objective is to undertake the necessary re-modelling of care, public consultations and capital investment to ensure that the right configuration of sub-acute and rehabilitation beds for 21st Century healthcare in Oxfordshire.

Based on turnover and retirement, we will focus on the recruitment and development of 10-12% of our WTE year-on-year to maintain current service provision. Significant areas for staff development are a shift from contracted to employed medical cover for community hospitals, which has been under development during 2013-14 and will be embedded during 2014-16. Multi-disciplinary team (MDT) working will ensure the appropriate utilisation of multi-

professional skills in managing patients with complex co-morbidities, including generalist and sub-specialism skills. We will also focus on sub-acute clinical skills (injuries and illness) including extended use of near patient diagnostics and advanced assessment skills, and clinical and operational leadership.

Productivity (effective use of staffing resources within the funded envelope) will be improved through the implementation of a new patient electronic record and mobile IT, a care pathway 'lean' review (including ceasing/repatriating interventions where we do not offer the best value and a reduction of duplication of effort across teams/providers), use of patient-level costing to evaluate and monitor planned versus actual costs of delivery of care and delivering value-based care as we shift to outcomes-based contracting with commissioners.

5.2 Key Challenges

The specialist service line plans for each of the three clinical directorates have been developed in response to the demographic challenges, healthcare trends, and financial and commissioning challenges outlined previously. They build on the plans contained within our two year operational plan. The following section outlines the key service lines within each directorate and their plans to review and develop their services, key milestones and the impact of their plans on the Trust and LHE partners.

5.2.1 Adults Services

The key service lines within the Adults Directorate are:

- Adult Community Services
- Adult Inpatient Services
- Specialised Forensic Services
- Prisons, Harm Minimisation
- Psychological Therapies

These services operate across Oxfordshire, Buckinghamshire and Berkshire, delivering care for individuals aged 18-65 years old. The challenges facing these services will be addressed through system transformation and growth, and increased collaboration with partners from across the LHE.

Through the proposed changes to the services, patients will receive the care they require in a suitable environment from the right person at the right time. The quality of care they receive will be suitable to their needs and evidence-based practices will ensure this. There will be a reduction in the estates required as teams come together in the community. Benchmarking capacity against other mental health services will ensure we manage the capacity on the wards. There is a risk that community demand will increase, however through the use of care clustering to manage the patient pathway, service users should only remain with services until suitable for discharge. The workforce may require further training to ensure they have the skills required to meet the patient need.

Over the next five years, the Directorate as a whole plans to:

- Develop a unique 'brand' within OHFT as one of the leading adult mental health providers in the country, which will distinguish us within the market place as the preferred provider for mental health. This will include promoting the AMHT model, the integrated work undertaken into the acute hospitals with EDPS and PIRLS and work with NHS England to become the preferred provider for prison mental health.
- To work alongside the Older People's Directorate to create an ageless mental health pathway for any individual, no matter their age, access to a single mental health service.
- To develop services within Wiltshire alongside the implementation of children and young people's services
- To continue to work with neighbouring providers to improve provision of acute and community mental health care across Thames Valley.

Specialised Forensic Services

We must understand the efficiency and effectiveness of the specialised Forensic services (community and inpatients) to ensure that an efficient service is delivered. A full review and remodelling of the services over the next two years will identify the full benefits of a quality review. There will also be improved links between services (where applicable) thus

reducing the number of 'hand-offs and referrals' where required. Once the services have been remodelled, it may be possible to join these with the other community services and acute services if patient needs can be met.

Prison Services

The development of the prison services to a wider geographical area is central. As a specialised area of care, the work currently undertaken by OHFT in the prisons is relatively small, however as the model of care provided is suitable for other services the quality of service and reputation of OHFT could be expanded into other areas. Maintaining existing contracts with each prison is also essential if OHFT is going to expand with other providers. Ensuring the efficiency of services and quality provided will ensure that we are able to deliver this strategy. We need to build excellent relationships with commissioners to fully understand the needs of the service areas and requirements of the market as this is a specialist area. Winning tendering opportunities in line with this strategy would see OHFT establish a strong brand in a wider geographical area and thus create more opportunities for expansion.

	Year One	Year Two	Year Three	Year Four - Five
Forensic and Prison Services	• Review of services including inpatients, community and prisons leading to remodelling of services as identified Implementation of the Recovery model of care (from AMHT to Forensic services), introduction of the Recovery Star and scoping of care clustering packages throughout services. • Integration of Forensic community mental health teams (CMHTs) with AMHTs for single point of access services for all mental health and to grow expertise of risk management for the AMHTs. • Outline plan for centralisation of medium secure units for approval and sign off. • Proposal for assertive discharge unit – exploring links of developing localised discharge units across the country with NHS England. • Completion of sustainability plan of services focussed on the outcomes of the remodelling exercises and taking into account national opportunities and constrictions. • Implementation of new Forensic Personality Disorder services	• Implementation of centralisation of medium secure units. • Implementation of assertive discharge units; initially within Oxfordshire and Buckinghamshire (local provision) whilst outlining plans for further expansion. • Expansion of provisions into Prisons (close supervision centres) through the promotion of the Adult Directorate brand and working with NHS England to become the preferred provider. • Implementation of sustainability plan to ensure the continuation of services • Review of the implementation of the new Forensic Personality Disorder services	• Continued implementation of centralisation of medium secure units. • Review of assertive discharge unit ahead of expansion to other areas of the country. • Outline review of specialisms within the services. • Review of estates for the services to ensure appropriate use of facilities and identify any cost savings through reallocation of units & teams. • Renewal contract of services with NHS England for years four to six • Implementation of Close Supervision Centres in at least two further prisons across the country	• Implementation following review of specialisms within the services and review of implementation at six and twelve months • Implementation of estates changes following review and agreement from facilities to the changes • Review of progress of centralisation of medium secure units. • Review of the Close Supervision Centres implemented in the new Prisons • Review of sustainability plan to identify next steps required to continue with the development and expansion of Forensic services

Adult Community Services

To mitigate the risks due to funding cuts, the existing adult community services were remodelled in 2013/14 moving to a seven day a week/twenty-four hour service with access improved for patients, carers and referrers. Through these changes the services now offer an assessment and treatment function to ensure that all patients are assessed and receive the appropriate treatment based upon their needs. The use of care clustering to identify the appropriate package of care provides the outcomes-based evidence needed to support the commissioning of services.

Adult community teams have begun to work with the third sector to meet the needs of service users from an employment, accommodation and wellbeing approach. The integration with these services in both counties is important in the development of services over the next five years, especially with the changes in demands from the population. Service users and families should be able to access all services through one route whether this is physical health, mental health or social care. In Oxfordshire there are already strong links with OUHT, and furthering these will see access to healthcare improve and open the patient pathway from general health to mental health.

Psychological services

The two streams of the psychological services face commissioning challenges. Within IAPT, it is the retention of existing contracts, and for the other areas it is the integration of services with the established community and inpatient services within their existing contractual requirements.

IAPT is a good service, shown to have good outcomes for patients, providing care closer to the patients' homes and therefore leading to fewer interventions. It is important that funding of this service continues and it becomes an

integral part of the adult mental health pathway as demand is increasing. Working with commissioners to integrate the other areas of psychology into the main AMHTs and inpatients services will ensure that patients can access all the services they require easily, without the need for additional referrals and waiting times.

Increasing the IAPT services and changing the AMHTs operating hours means that aligning both of these services will ensure patients are seen by the right person at the right time, without the requirement for internal referrals and hand-offs. Access to services will become easier with all referrers (self/GPs/others) accessing the teams through one central point. It is this kind of re-modelling and team working that will deliver the greatest value across the full cycle of a patient's care.

	Year One	Year Two	Year Three	Year Four - Five
Psychological services	• Review of the psychological services streams • Completion of IAPT tender in Oxfordshire and successful awarding of the service • Development of academic programme with psychology and furthering the links with research and development • Scoping and working with CCGs to confirm the care clustering packages for the services	• Implementation of new model of service • Implementation of care clustering packages • Continuation of developing links with universities and research and development	• Integration of services with the AMHTs and existing Forensic psychological services • Review of the care clustering packages	• Review of integration of services at 6/12 month to identify any concerns/issues and what has worked well • Preparation for re-tendering of services

Harm minimisation services

OHFT is the only provider of this service in Oxfordshire and is now commissioned by the local authority following a transfer from the CCG. The model of the commissioned service is fragmented as it is an outcomes-based approach model which is leading to clinical and financial risks. Due to these risks and the Trust's belief that this service model is not the correct one for our patients, before the decision to tender for this service again is made, we will be undertaking an evaluation of the proposed model to decide whether we wish to bid.

Adult inpatient services

Capacity is one of the primary risks within the inpatient services. With the need to reduce bed occupancy to 96% to allow for variance in admissions and discharges, managing this occupancy rate will affect the sustainability of services. If the wards cannot accept admissions, there is a risk of an increase in the number of ECRs (extra contractual referrals) and out of area placements. ECRs or out-of-area transfers (OATs) not only increase the costs of care but can have a very negative impact on the experience and sometimes outcomes for patients and their families.

Funding issues for placements and residential care also impact on the capacity of the ward. Without funding agreements, patients cannot be discharged from the wards and therefore occupy beds which they no longer need for acute treatment resulting in a higher than average length of stay when compared to national figures. If commissioners use this information when selecting providers then OHFT inpatient services may have funding withdrawn, which would in turn result in the need to make savings and thus lead to a ward closure to ensure services can still be maintained. It is important that we clearly explain our data. Reducing overall capacity will mitigate these risks and ensure that those service users requiring treatment can access this.

Through working with County Councils and third sector organisations to improve the transitions from acute services into residential placements, capacity issues experienced will reduce as the demand on inpatient services will decrease and reduce the number of people whose discharge is delayed. With the inpatient services working closely with the AMHTs to ensure timely discharge of patients, this would ensure that there are a number of beds available across the units when required. Inpatient services cannot currently be increased without further investment into estates for units.

The following milestones outline the strategic milestones for work to be completed within the community (AMHTs, Harm Minimisation, and Community Psychiatric Medicine Service) pathway, for the inpatient units (based in Aylesbury and Oxford including the redevelopment of Mandalay Unit Aylesbury) as well as the services run from acute hospital bases (the Emergency Department Psychiatric Service, at OUHT in Oxford and Psychiatric In-reach Liaison Service, at Stoke Mandeville, Aylesbury).

	Year One	Year Two	Year Three	Year Four - Five
Adult inpatient services	• Review of AMHT remodelling (September '14) to understand the impact of the changes on the services for patients, carers, staff and partners. This will include reviewing the implementation of the Recovery Star and other Patient Reported Outcome Measures (PROMs) including the Care Review Questionnaire. • In conjunction with the AMHT review, there will also be a review of the care package process for all partners and implementation of shared care packages building on clustering (for health focused partners) and mental health disability model (for recovery/social care focused partners. • Work with service user groups to develop single involvement and engagement strategy and processes. This will sit alongside separate partner engagement strategies that form part of ongoing governance for each organisation • Work with carers reference group to develop joint working and single involvement and engagement strategy and processes This will sit alongside separate partner engagement strategies that form part of on-going governance for each organisation • Formalising an options appraisal for a crisis response house provision and work with Comfort Care to redevelop Mandalay House (Aylesbury) into a new high-support accommodation unit; this will include working with the 3rd sector to create an effective pathway from acute inpatient wards into the units to support efficient discharges. • Review of Leading the Way and Planning for the Future programmes to aid in the creation of a staff development programme; working with our academic links to identify joint training initiatives to equip our staff with the skills they require. • Review of the Harm Minimisation service ahead of the Boards decision to tender for the service when the contract is available for renewal. Outcome of review and board decision will affect the 2-5 year plan of these services – until this is known it is not possible to confirm the specific milestones for this service.	• Review of the AMHT remodelling (April '14 – 1 year review) to understand whether any changes/issues identified at the 6 month review have been addressed and realise the benefits of the new model. This will include reviewing the patient clusters to understand patient recovery. • Review of dual diagnosis pathway to understand how this can be integrated into the AMHTs – this will include the Autism service, learning disabilities and patients with addictions. • Review of joint working between the AMHTs and inpatient units to understand the effectiveness of the new AMHT model on admissions ahead of the inpatient review (service review) to understand whether it is possible to close a ward • Inpatient service review • Implementation of the SIL pathway strategy and review within 6 months to understand effectiveness on inpatient services • Development of the 'Recovery College' through joint working with our University partners and implementation of the staff development programme. • To build upon research and development opportunities with our University partners to ensure all patients have access to research studies and • Review of the Community Psychiatric Medicine Service (CPMS) following the completion of the pilot in year one to understand the impact of the service and whether this can be further developed and implemented across the Directorate. • Review of the PIRLS/EDPS services following the first year's implementation to understand impact on reduction in admissions to inpatient services from emergency departments • Review of the Street Triage pilot scheme to identify the impact on reducing the number of S136 admissions and inappropriate admissions to the inpatient units. To work with TVP to discuss further implementation across the Directorate. • Review of mobile working initiatives in conjunction with the IT department to understand the impact of mobile devices on the staff/patient – productivity and access to information. ➢ Develop shared estates, IT and staff training strategies, where appropriate. ➢ Review outcomes achieved ➢ Inclusion of other services into OBC contract as agreed with CCG ➢ Development of common IT strategy	• Integration of a dual diagnosis pathway into the AMHTs • Implementation of actions identified from inpatient review • Integration of psychological Services pathway into AMHTs/IP services (see psychological services for further information) • Implementation of Year 2 of the SIL strategy including a review at 6 months • Review of the staff development programme to understand impact on staff and identify any further areas for inclusion; continual working with academic links to ensure that staff have access to the most up-to-date training/knowledge • Review of working between the AMHTs, Inpatient Units and the SIL pathway • Review of care clusters and recovery star to ensure the pathways are remaining effective and suitable compared to patient reported measures. • Review of the EDPS and PIRLS services to ensure effective working continues within the emergency departments and understand the reduction in admissions through interventions used. ➢ Inclusion of other services into OBC contract as agreed with CCG ➢ Implementation of estates and training strategy ➢ Review of outcomes achieved	• Review of implementation of staff development programme and research opportunities undertaken within the directorate • Review of the integration of dual diagnosis services into AMHTs • Review of inpatient implementation changes (6/12 months) ➢ Completion of SIL implementation ➢ Review of models of care ➢ Inclusions of other services into OBC contract as agreed with CCG

5.2.2 Children and Young People's Services

The key service lines have been identified as follows:

- Children's Community Mental Health services
- Children's Community Services (physical health)
- Specialist Eating Disorder Community Services (adult)
- Specialist adult Eating Disorder inpatient services
- Integrated Children's Therapies
- School Based Health Services

- Specialist community Dentistry
- Adolescent inpatient services
- Health Visiting and Family Nurse Partnership

We are re-modelling our services with the focus on the quality of patient care, delivering health outcomes and efficiency that the Trust in order to remain financially sustainable. The difficulty in achieving the cost saving and the current rate of increasing demand for services makes delivering sustainable care the number one challenge we face.

Partnership Working

- Partnerships with other health and social care and third sector providers across all key service lines have the potential to grow further. Mergers will be dependent on the growth opportunities but we will look to work in partnership to strengthen our offer across pathways to ensure on-going sustainability. For example, by developing acute care pathway-joint working approaches with OUHT, to reduce admissions to acute hospitals as well as developing shared competencies for inpatient nurses, and creating shared liaison child psychiatry posts. Commercial prospects can grow, such as outcome measures apps with the help of the business directorate, and our commercial and university partners.
- Collaborative partnership working and stakeholder engagement is needed to ensure good patient experience in our pathways of care, for example with acute providers to develop pathways for autism spectrum disorders and attention deficit hyperactivity disorder.
- Collaboration is required with Wiltshire Community Services, third sector agencies, and the acute sector to extend service provision and increase care pathways, and with local authorities to ensure that we are working effectively and efficiently across children's services – particularly Looked After Children and Early Intervention.
- The Early Intervention in Psychosis pathway is being linked to services that are being developed to offer care to patients up to 25 years old in line with social care and higher education. This is being done in collaboration with adult mental health services, the CLAHRC, the AHSN, which brings access to research and development funding, the third sector, Local Authority and CAMHS. These developments impact on the growth of the CAMHS pathway and commissioned services.
- Community CAMHS services can link with other sectors to increase the pathway potential, and to expand the Early Intervention in Psychosis services in to other preventative interventions for other conditions. This could possibly be aimed at patients up to 25 years of age to address the transitions problems into adult care. Partnerships with other health providers, health sectors and the third sector across all key service lines have the potential to grow further.
- Changes to the adult specialist Eating Disorders pathway are planned in recognition of a need to provide intensive support for patients working towards recovery, and also to meet the differing therapeutic needs of those patients who are not working actively towards recovery but who need support to manage their Eating Disorder and to maintain a safer weight. There is potential to collaborate with Oxford University's Department of Psychiatry colleagues in developing and evaluating the pathway as well as work with colleagues internationally, e.g. in Italy.

Transformational Change and Growth

- Several service lines will be transformed. These include the Eating Disorder pathway for children, young people and adults to reduce inpatient admissions. Community CAMHS have already been transformed but further skill mix adjustments and the use of outcome measures to improve quality is needed. Community children's nursing will be reviewed in line with the development of best practice third sector partnerships.
- We are viewed positively as a good CAMHS provider. We are regularly approached regarding supporting service development or improvement reviews for other providers. There is an opportunity to make strategic alliances as well as to increase our reputation as a transformational service provider. The potential consequences of this positive reputation are possible future collaborations, partnerships or increased business.
- There are several potential areas of growth within Children and Young People's services. There is the potential to win new business in Wiltshire and to increase the number of adolescent inpatient beds in the South West, to include high dependency beds, in collaboration with our commissioners. Community CAMHS services will link with other sectors to increase the pathway potential, and expand the early intervention in psychosis services in to other preventative interventions for other conditions. This could possibly be aimed at patients up to 25 years of age to address the transitions problems into adult care.

Adding Value

- We need to work with commissioners to ensure that key performance indicators (KPI's) and service specifications reflect the service user needs, demand and requirements of service delivery, which will bring the most value to our services.
- School-based early interventions in mental health are shown to have a positive impact on health gains for children and young people. We will develop evidence based interventions to be delivered.
- Value-based review of care pathways across children's services to ensure that we are maximising the use of resources and developing high levels of expertise across clinical pathways. We will review pathways in autism spectrum disorder, Psychosis, Eating Disorders, and mood disorders. We will also review physical health pathways across acute, continuing care and palliative care pathways seeking to provide sustainable children's services in terms of health outcomes and value.
- Community CAMHS are being benchmarked against Royal College of Psychiatrists' standards for our community teams and skill mix to provide a five star service and utilise our skill mix effectively whilst delivering the same or improved levels of outcomes for patients. The purpose of this is to ensure we maximise our skill mix to meet the demand for the services and we market the best efficient CAMHS service.

Future Developments

By 2015:

- We will ensure that patients who use our services are aware of research trials and encouraged to take part in research, which will enable innovation and opportunities for the services to be at the forefront of providing innovative care.
- Proactively seek opportunities to develop research collaborations with other providers, for example, Great Ormond Street Hospital and Bath University. Our organisational reputation and potential opportunities will grow as a result, and the impact of this would be beneficial to the whole Trust.

By 2016:

- The School Health Nursing contract was re-awarded for 2014/2015 after the tender process in Oxon. Use increased access in school to develop more school based interventions to promote emotional wellbeing of children and young people. Develop evidence based model that can be rolled out and provided in other areas.
- Remodel primary care MH services to ensure they are sustainable in face of increasing demand: Work with partners in academia, public health, children's social care, education and GP colleagues to do this.

5.2.3 Older Adults

The Older People's Directorate is currently made up of around fifty services spanning physical and mental health (inpatient and community) for older people's care, long term conditions and urgent care. These services vary in size from over 100,000 patient contacts per annum (district nursing, GP out of hours) to very specialist small services such as chronic fatigue service, which has three WTE staff.

As outlined in the two year operational plan, fundamental redesign of the patient models of care is required to achieve integrated care for older people that delivers:

- Patient outcomes regarding independence, recovery and well-being
- A positive and "joined-up" experience of care for patients and carers
- Lowest possible levels of avoidable harm
- Management of increasing demand
- Effective utilisation of resources
- Financial sustainability

There are many strategic options available to tackle these challenges for older people's services. None of the options considered can be rejected completely. However, not all of them have sufficient likelihood of delivery, or scope and timeliness of impact required to meet the scale of the challenge faced by the Older People's Directorate.

For example, the Trust could grow by acquiring community and/or older adult mental health services in neighbouring counties, by providing domiciliary care or by undertaking private-funded work. Whilst the Trust is actively seeking opportunities to expand its older people's provision (integrated physical and mental health) in bordering counties, this

cannot be relied upon as a definite future source of income / profit to address fiscal and capacity challenges within existing provision. Similarly it is unlikely that private income alone will address the fiscal challenge, although it will have a small but significant contribution to make.

Given the demand and acuity pressure across health and social care, it is unlikely that commissioners will raise the thresholds for treatment to the extent where it is displaced elsewhere in the health economy. It is also unlikely that commissioners will sanction changes in service scope that prompts such displacement. However, collaborations along pathways (including with the third sector) will be based on our ability to deliver the most value in terms of interventions that achieve the outcomes patients want at the best possible cost. This will allow pathways of care to:

- Eliminate low value interventions (limited clinical impact to the patient, or impact which can be achieved via alternative and cheaper methods)
- Ensure the best placed provider delivers each intervention type (quality and cost)
- Support systematic uptake of self-care, self-management and co-production with the third sector
- Ensure care pathways are delivered within acceptable variation parameters, based on the evidence

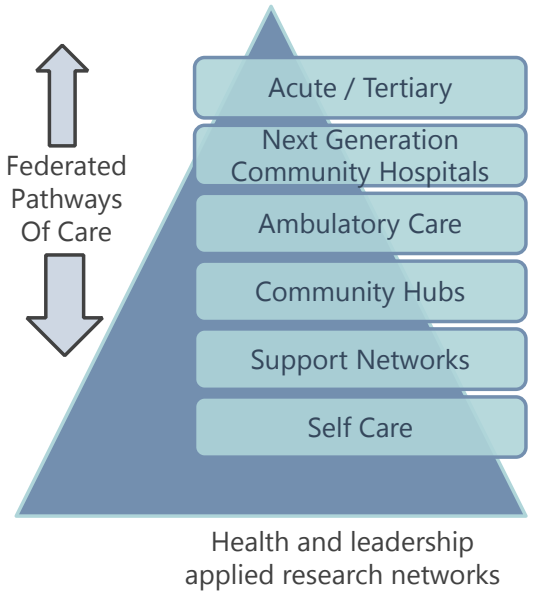
Some shrinkage prompted by active reallocation of some services to align effectively within the wider pathways of care will produce some reduction of income, activity and cost. For the Older People's Directorate this is addressing historic allocation of service provision between acute and community providers which does not reflect the current functioning of the care pathway, and which places cost pressures on OHFT. Examples of this include acute-end podiatry, speech and language therapy and nutrition and dietetics, which are being repatriated (together with their cost pressures) back to acute as they sit within the acute pathway. Much of this has already been undertaken, and will be fully completed within the two year operational plan.

Older adults' services could be merged with a number of partners, including the acute sector, social care, and the third sector or with primary care. However, formal organisational mergers may be a long term outcome (five to ten years) of transformational change and collaboration in Oxfordshire. However, this will be the result of such collaboration and transformational change, not a strategic aim or objective in itself. This is for a number of reasons. Time spent working up formal mergers is time not spent on driving transformational change along federated pathways. The clinical, operational and fiscal benefits of merging above and beyond federated care pathways are unclear. Alliance contracting and section 75 agreements will provide the necessary legal and contractual infrastructure for federated pathways of care without the need for additional organisational mergers.

<u>New Model of Care</u>

The transformational change in Older People's services broadly can be considered in three groups:

- **Locality integration** (physical health, mental health, social care, primary care and third sector) **–** focused on long term conditions management, proactive intervention to maintain independence and well-being, recovery, reablement and end of life care
- **Ambulatory Urgent Care** (physical health, mental health, social care, acute, ambulance, primary care and third sector) **-** focused on rapid (within 0-2 hours) response to adults with complex co-morbidities and escalating needs likely to result in imminent acute admission without intervention. Includes MDT assessment and intensive care intervention in the person's usual place of residence.
- **Inpatient Care** (acute older adult mental health and sub-acute or rehabilitation within community hospitals with acute emergency admission assessment functions and non-elective medical beds) **–** this includes both "step-up" and "step-down" inpatient care where the diagnosis is either urgent with primarily mental health or



physical health needs. Given the co-morbidities present in the majority of the 75+ population, all inpatient care needs to provide holistic care and address all the person's needs (physical health, mental health and social care) in its recovery and reablement model of care and discharge planning. This includes multidisciplinary team supported discharge care.

This model of care focuses on meeting the needs of the patient (physical health, mental health and social care) in the most appropriate setting for their needs, based on whole system care pathways. This shifts the focus from referral between services / organisations based on organisational structures to a model where multi-disciplinary teams work together along the patient pathway focused on meeting the patients' needs, regardless of staff employer.

This model of care:

- Reflects the holistic and inter-dependent physical, mental health and social care needs of frail elderly patients
- Puts clinical decision-making at the heart of the patient pathway
- Supports local commissioners (Oxfordshire) in their preferred move to outcomes-based alliance contracting
- Acknowledges, supports and enhances patients' own self-care and informal care networks
- Shifts the model of care from a paternalistic intervention to one of co-production: enabling patients to be as independent as possible, and thus focusing statutory health and social care resources where they can have the greatest clinical impact
- Reduces service bureaucracy through multi-disciplinary team working replacing patient hand-offs: better for patient experience and improved productivity for clinical teams

There are two strategic options that are the preferred ones for the Older People's Directorate:

Transformation - We will transform services by integrating them services along pathways and through multi-disciplinary care provision, by maximising personalisation, self-care and self-management, and by reducing the cost of our infrastructure (estates, IT, staff time to provide care or administration). These plans contributes to the Trust's strategic goals for quality of care, delivery of integrated services for older people, supporting independence and recovery and making effective use of resources. They are also aligned to the Oxfordshire Older People's Strategy and national policy regarding health care for older people.

Collaborating on our Services - We will develop federated pathways of care with partners along key service lines:

- Locality integration (physical health, mental health, social care, primary care and third sector)
- Ambulatory Urgent Care (physical and mental health, social care, acute, ambulance, primary care, third sector)
- Inpatient Care (acute, ambulance, social care, mental health and physical health)

This aligns to national policy on integrated care to improve patient outcomes and experience within reducing fiscal envelope and increased demand and acuity. These plans also align to local commissioning focus on integrated and outcomes based contracting, and the Trust strategic aim to be a world leader in providing integrated care that maximises patient outcomes and positive experience of care and delivers evidence-based value.

Impact and Benefits of our Plans

Benefits will be aligned to outcomes and outcomes measures, and reflect the six priorities in the Older People's Strategy for Oxfordshire (2013-16) and the developing system-wide vision for Older People's Care in Buckinghamshire. They will also draw on the emergent national and international evidence base (for example King's Fund evaluations on integrated teams, learning from mental health in moving care closer to home and Philp's principles for multidisciplinary team geratology care). Evaluation of the innovative programme will be commissioned by the venture via the AHSN and the CLAHRC. Benefits sought can be summarised as:

For patients and carers:

- Timely and responsive MDT assessment and treatment plan, with a default to assess and treat within four hours, and support home care wherever clinically appropriate and operationally feasible;

- Focus on patient-determined recovery and reablement, with the aim of supporting return to optimum independence wherever possible;
- High quality inpatient care with integrated discharge planning initiated at or prior to admission;
- Consistent care pathway delivery over seven days per week.
- Carers actively involved in care planning, including use of informal and third sector support networks;
- Joined up care provided by integrated teams, reducing the burden of care co-ordination on the carer.

Estates:

- Requirement to address disparate and not-fit-for-purpose current estate as part of Trust's estates strategy – replace with buildings that support delivery of 21st century healthcare
- Reduction in number of staff bases and fixed desks (mobile IT and new ways of MDT working)

Workforce:

- Expansion of clinical skills (generalist and specialist) to deliver integrated care to an population in increasing acuity, dependency and fragility of need
- Development of "co-productive" care pathways to increase self-care and self-management and maximise dignity and independence of patients
- Extended competencies in leadership, management, IT skills and team-working
- Change of ways of working, including a move to seven days a week extended hours of service provision
- Refinement of clinical supervision (professional and MDT) to reflect shared caseload and new models of care
- Reduction in staffing costs achieved through productivity and LEAN working, including reduction of low value interventions aligned to reducing income from commissioners

The Trust has developed the above plans for collaboration and integration in partnership with local statutory health and social care (commissioner and provider) and third sector organisations. Assessment of the likely impact across the whole system and the impact on individual commissioners and providers has therefore been a prime consideration in the development of the Trust-specific plans. In summary the expected impacts on the LHE are:

- Reduction in unacceptable variation in care (impact on patient outcomes, experience and LHE costs)
- Reduction in avoidable / duplicate urgent care contacts (ED, acute admission, ambulance call-outs, GP out of hours)
- Improved and sustainable delivery on whole system standards (A&E four hour standard, delayed transfers of care)
- Improved productivity through reduction in duplication of assessment, care plans and hand-offs between organisations along the patient pathway
- Reduced cost of assessment (social care) through increased self-assessment
- Reduction in length of urgent care episodes (inpatient and community) through increased MDT co-ordinated input to improve clinical outcomes

It is expected that the move towards GP federation will factor significantly in the development of all three integrated pathways for older people (integrated localities, ambulatory urgent care and inpatient care): however, greater clarity on the scope and delivery of this is expected by FY17 and is not fully defined in plans to date.

Support and Resources Required

Statutory Partners (health and social care, including primary care):

- Shared values and commitment to deliver integrated care that achieves the best outcomes for the patient (individual and population) within the available resources
- Shared clinical governance and LEAN operational management processes, including provider-provider agreements where appropriate
- Implementation of MDT-based team working that are based on patients' needs / pathways of care and focussed on delivering outcomes rather than traditional organisational boundaries, or contracts
- Shared infrastructure arrangements as appropriate (workforce policies, budgets, performance and quality reporting, learning and development)
- Shared clinical and operational leadership

- Practical interface of IT, including use of mobile working, telehealth/telecare and virtual team conferencing

Commissioners:

- Practical and timely transition to new contractual arrangements that are outcomes focused, and enable delivery of new integrated models of care
- Realistic (scope and timing) cost reduction against a backdrop of increasing demand and need
- Agreed and defined risk-sharing arrangements across providers and commissioners
- Willingness to embrace transformational change, and provide clinical commissioners to work with providers in public and patient engagement and consultation
- Effective contractual management of key dependencies not directly within the control of providers

Third sector:

- Partnership and shared model of care that optimises the benefits both statutory and voluntary providers can offer to patients / carers within available resources
- Implementation of MDT-based team working that are based on patients' needs / pathways of care rather than traditional organisational boundaries, or contracts
- Shared clinical and information governance processes to support the pathways of care
- Implementation of MDT-based team working that are based on patients' needs / pathways of care rather than traditional organisational boundaries, or contracts

Key Milestones

Integrated Locality Teams (Oxfordshire) - As per the two year operational plan:

- Phase one locality integration (July-14)
- Wallingford hub (September-14)
- Phase two: Older adult mental health into integrated localities (September-14)
- Phase three: community Nursing and Adult social Care into integrated localities (March-15)

Vertical Integration with Acute and Social Care (Oxfordshire)

	Year One	Year Two	Year Three	Year Four - Five
Vertical Integration with Acute and Social Care (Oxfordshire)	• The envisaged order of developments is as follows: • Integration of the Supported Hospital Discharge Service and the Oxford Reablement Service into a single team managing patients with rehabilitation and/or personal social care needs; • Transfer of hospital social workers; • Take over management of crisis response contract; • Transfer management of third party contracts from CCG During year one there will be an ongoing development programme for staff promoting the aims of the venture, the key behaviours and outcomes we expect to achieve and preparing staff to enable a full rotation system to be implemented in year three. Proposals will also be developed to align terms and conditions and to develop an innovative group ward proposal which recognises staff's contribution to the success of the venture. Detailed infrastructure options and proposals will be developed.	• Fully integrate and redesign bed-based care encompassing intermediate, rehabilitation, sub-acute and acute care with a seamless transition pathway for patients geared to their clinical need; • Consultation on the future role of, and vision for, the Horton General Hospital and Community Hospitals, with a proposal to be built around development of comprehensive bed-based hospitals supported by diagnostic and assessment services, a range of ambulatory services and EMU functions; • Towards the end of year two it is anticipated that implementation of the strategy, post consultation, will commence on an incremental basis • Continue staff development programme focussing on clinical skills to enable staff rotation; • Consult staff on proposals for a reward and incentive programme together with the approach to aligning terms and conditions.	• Continue strategy implementation; • Introduce revised employment package based on outcome of consultation; • Begin full staff rotation; • Introduce diagnostic and assessment services at designated community hospitals	• Complete strategy implementation, including seven days per week diagnostic and assessment units embedded within the four local bed-based hubs; • Integrate Emergency Assessment Unit/ Surgical Emergency Unit (EAU/SEU) services at the John Radcliffe; • Integrate with enhanced primary care, with options including employment or associated model but with accountability within urgent care services.