Oxfordshire Primary Care Trust
Strategy 2007-2012

1 Executive Summary

1.1 Our vision

Oxfordshire PCT is ambitious about improving the health and wellbeing of local people**.** It intends to work with its partners over the next five years to deliver a transformation in local health services, so that by 2012 the people of Oxfordshire will:

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

1.2 Our aims

This strategy proposes that between 2008 and 2013 the PCT should strive to deliver this vision by:

1. Commissioning safe, high quality services that promote wellbeing, reduce health inequalities, deliver improved health outcomes and secure excellent levels of patient satisfaction.
2. Engaging the public effectively in the development of healthcare and wellbeing services in Oxfordshire.
3. Strengthening the role and influence of clinicians in improving services, through the development of Practice Based and other forms of commissioning.
4. Improving partnership working in order to deliver properly integrated services and to improve health outcomes for vulnerable communities.

5. Supporting the development of PCT, wider NHS and other providers of health and social care services, so that they and their staff can meet our commissioning requirements and there is greater choice available to patients.

6. Establishing itself as a highly effective and innovative organisation – one that has a workforce that is well placed to deliver on its strategy.

1.3 How we will deliver these aims

Until March 2010 the PCT will be working to deliver these aims by focussing on three strategic commissioning priorities and four development priorities.

These priorities have been selected on the basis that they will:

- Enable us to make significant progress on delivering our vision.

- Make a very real contribution to meeting the most urgent local health needs.

- Help improve the efficiency and effectiveness of everything we do – because we can learn lessons from each that can be used to improve how we conduct all the vitally important core business of the PCT.

1.4 Our strategic commissioning priorities

We will be prioritising:

a) ***Breaking the cycle of deprivation*** by developing partnership based activity to reduce physical and mental health inequalities and improve outcomes for deprived children and families in targeted geographical areas.

b) ***Providing a better deal for older people by focussing on older people's*** physical and mental health services, in particular:

   - Tackling avoidable admissions to hospital.
   - Preventing people from becoming unwell.
   - Providing more services in the community.
   - Improving our understanding of the economic impact of the growing population and of how we might get a better return for older people on the investment we make in services for them.

c) Ensuring that when we commission services we are increasingly assured that we are ***commissioning excellence.*** This work will begin with commissioning delivery of the recently agreed new ***diabetic care pathway***. As well as improving outcomes for diabetics, this will help us to develop skills and experience that we can then apply to:

- Commissioning whole pathways of care (i.e. commissioning from the perspective of the patient not the perspective of the service providers).
- Improving all long term condition (LTC) management.
- Redesigning other care pathways to improve services.
- Moving to a system whereby we contract and pay providers for the outcomes they deliver, and the quality of service provided, as well as the volume of activity they undertake.

1.5 Our development priorities

We will prioritise:

a) Development of plans for all care provided outside the acute hospital sector in Oxfordshire.

b) Undertaking a strategic review of services directly provided by Community Health Oxfordshire and agreeing a long term business model for delivery of community health provision in Oxfordshire.

c) Leading the work required across the local health economy to ensure that all patients receive treatment within 18 weeks of referral.

d) Ensuring that the PCT has the skills and capacity to deliver this ambitious agenda.

1.6 Our 5 year strategy

Our strategy describes how the PCT intends to deliver these priorities alongside its core business of:

- Commissioning health services on behalf of the local population from other organisations.

- Providing health services to the public through its 2,500 community health professionals.

- Managing the performance of hospitals, mental health services and primary care services.

- Delivering faster and better access to health care for everybody.

In addition to this Executive Summary, the full strategy therefore sets out:

a) An introduction to the PCT and it's strategy (chapter 1).

b) A description of the core purpose of the new PCT, its vision, strategic aims and immediate commissioning and development priorities (chapter 2).

c) An analysis of the financial and strategic context in which the strategy has been developed and will be delivered (chapter 3).

d) The conclusions we have drawn from our analysis of local health needs, and a summary of the factors that have led us to adopt our three strategic commissioning priorities for 2008/9 and 2009/10 (chapter 4).

e) The outcomes we intend to deliver in those three areas and the steps we will be taking to ensure we do this successfully (chapter 5).

f) The other programmes of work we are committed to delivering (chapter 6).

g) A programme of work we need to undertake "behind the scenes" to inform and support delivery of our strategic aims (chapter 7 and Appendix 1).

h) The detailed objectives against which we will measure our success in delivering this strategy (chapter 8).

i) The work we need to undertake to complete and adopt a robust five year strategic plan by the end of November 2007 (chapter 9).

1.7 Your role in developing this strategy

This is the first public draft of Oxfordshire PCT's five year strategy. We will be finalising and adopting it in November 2007, and hope that, with your help, we can improve and strengthen it over the coming months.

We hope you will take the time to read the full document and to give us your views on our proposals. You can tell us what you think either by e-mailing us at strategyfeedback@oxfordshirepct.nhs.uk, or by participating in the programme of meetings and events we will be holding in September and October. Details about these will be published on our website (www.oxfordshirepct.nhs.uk) over the summer.

Fred Hucker	Andrea Young	Dr Stephen Richards
Chair	Chief Executive	Chair, Clinical Executive
Oxfordshire PCT	Oxfordshire PCT	Oxfordshire PCT

1 Introduction

Oxfordshire Primary Care Trust (PCT) was formed on October 1st 2006. It is responsible for investing approximately £760m of public money each year in services that will improve the health and wellbeing of around 625,000 local people.

The PCT is a major provider of health services to the public, employing over 2,000 community health professionals across the county through our community services directorate – Community Health Oxfordshire. It is also responsible for managing the performance of hospitals, mental health services and GPs, for improving local health services and for delivering faster and better access to health care for everybody.

The new PCT faces unparalleled demands for those resources. It is establishing itself as a pro-active organisation – one that is responsible for ensuring high quality, safe and effective services that will deliver real health improvements for the local population. This shift from funding a reactive "sickness" service for Oxfordshire to growing a pro-active health and wellbeing service for the county requires a new, and strongly strategic, approach on behalf of the PCT and its commissioning and providing partners.

Oxfordshire PCT is committed to taking this newly strategic approach and we have warmly welcomed the opportunity to develop our first five year strategy with support from the World Class Commissioning programme which has been initiated by NHS South Central on behalf of the 9 constituent PCTs.

At this stage this strategy is a working draft. It has been developed during the period May – July 2007 with input from the PCT Board, our Clinical Executive (the clinical and service experts who help us develop and deliver our services), our staff and our main partners.

The PCT intends to use this draft as the basis for further dialogue with commissioning partners, health and social care providers, patients, the public and our own staff during the early autumn of 2007. This strategy will then be redrafted before being formally adopted by the PCT Board, at its public meeting, in November 2007.

The strategy will set out a shared vision for the future of health care in Oxfordshire. It will be used to guide all future decisions about the investment of the substantial resources that are available to purchase and improve health care services for people across the County.

We welcome your comments on this document and your suggestions as to how our draft strategy can be strengthened. If you would like to give us your views please e-mail them to strategyfeedback@oxfordshirepct.nhs.uk. If you have a media enquiry related to this document please contact the Communications team on 01865 336831.

2 What the PCT wants to achieve

2.1 Our mission

Oxfordshire PCT is ambitious about improving the health and wellbeing of local people**.**

2.2 Our Vision

The PCT will work with its partners over the next five years to deliver a transformation in local health services, so that by 2012 the people of Oxfordshire will:

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

2.3 Our strategic aims

For the next five years Oxfordshire PCT will strive to deliver this vision by focussing on six core aims. It will:

1. Commission safe, high quality services that promote wellbeing, reduce health inequalities, deliver improved health outcomes and secure excellent levels of patient satisfaction.
2. Engage the public effectively in the development of healthcare and wellbeing services in Oxfordshire.
3. Strengthen the role and influence of clinicians in improving services, through the development of Practice Based and other forms of commissioning.
4. Improve partnership working in order to deliver properly integrated services and to improve health outcomes for vulnerable communities.
5. Support the development of PCT, wider NHS and other providers of health and social care services, so that they and their staff can meet our commissioning requirements and there is greater choice available to patients.

6. Establish itself as a highly effective and innovative organisation – one that has a workforce that is well placed to deliver on its strategy.

The PCT will deliver these aims in ways which best secure the financial sustainability of local health services.

2.4 Our strategic commissioning priorities

For the next two and a half years (to March 2010), the PCT proposes to focus on three main strategic commissioning priorities. These are:

a) Breaking the cycle of deprivation by developing partnership based activity to reduce physical and mental health inequalities and improve outcomes for deprived children and families in targeted geographical areas.

b) Providing a better deal for older people by focussing on older people's physical and mental health services, in particular:

- Tackling avoidable admissions to hospital
- Preventing people from becoming unwell
- Providing more services in the community
- Improving our understanding of the economic impact of the growing population and of how we might get a better return for older people on the investment we make in services for them.

c) Ensuring that when we commission services we are increasingly assured that we are ***commissioning excellence.*** This work will begin with commissioning delivery of the recently agreed new ***diabetic care pathway***. As well as improving outcomes for diabetics, this will help us to develop skills and experience that we can then apply to:

- Commissioning whole pathways of care (i.e. commissioning from the perspective of the patient not the perspective of the service providers).
- Improving all long term condition (LTC) management.
- Redesigning other care pathways to improve services.
- Moving to a system whereby we contract and pay providers for the outcomes they deliver, and the quality of service provided, as well as the volume of activity they undertake.

2.5 Our strategic development priorities

In parallel with this work to strengthen commissioning skills the PCT will be leading four longer term development initiatives. These will be:

a) Developing plans for all care provided outside the acute hospital sector in Oxfordshire.

b) Undertaking a strategic review of services directly provided by Community Health Oxfordshire and agreeing a long term business model for community health provision in Oxfordshire.

c) Leading the work required across the local health economy to ensure that all patients receive treatment within 18 weeks of referral.

d) Ensuring that it has the skills and capacity to deliver this ambitious agenda.

2.6 Our core business

Oxfordshire PCT will continue to deliver:

a) Local community health services.

b) Locally agreed service improvement programmes (e.g. projects to improve Musculoskeletal care, heart failure services and care for those with Chronic Obstructive Pulmonary Disease).

c) Mental health priorities as set out in the agreed Oxfordshire mental health strategy.

d) Commitments made in partnership with the Oxfordshire Children and Young People's Partnership Board such as development of services for children with a complex range of needs and behaviours.

e) Public health programmes such as sexual health programmes, obesity, screening, infectious diseases and breastfeeding.

f) Programmes designed to ensure faster access to treatment and improved choice.

2.7 Ensuring we invest strategically

The PCT must ensure that it can invest its resources in line with its strategic aims and objectives in future. Work is therefore underway to develop a new range of financial modelling and activity planning tools that will allow the PCT to:

a) Plan for and analyse its investment in response to demographic factors, geography, programme budget (i.e. disease related) spend and investment by provider organisation.

b) Factor in cost drivers (e.g. demographic change, technological advances) and potential cost improvements.

c) Consider potential disinvestment where evidence of poor return on investment exists in terms of health gain in relation to health spend.

Until that work is further developed this working draft of Oxfordshire PCT's five year strategy cannot be properly costed. A first iteration of budgets for the next five years will be included in the operating plan which will support this strategy, and this is due to be completed by September 30th 2007.

Those budgets will then be refined and finalised during negotiations this autumn to agree the Oxfordshire health budget in the form of the Local Development Plan (LDP) for the next three years, and will be incorporated into the finalised strategy when it goes to the PCT Board for adoption in late November.

In order that this work can be progressed, the PCT Board has agreed a set of financial planning assumptions and these will form the basis of future budgets. Some preliminary work has also been undertaken to identify the sums potentially available as the balance for investment over the next five years, based on these assumptions.

The PCTs financial planning assumptions and the results of this preliminary analysis on potential balances for investment are set out in Appendix 1. These figures will form the financial envelope within which the detailed costing of this strategy will be completed.

2.8 The way we want to work – our core values

The new PCT is committed to ensuring that in everything it does, it adheres to a core set of organisational values. These are:

a) **Openness and Transparency** – this means that in all our activities we adhere to the highest standards of honesty and integrity which will stand the test of probity.

b) **Innovation** – this means that we actively seek creative excellence sometimes taking risks to achieve change for the better.

c) **Respect**– this means that we aim to treat patients, our staff and those we work with in other organisations with the compassion, dignity and understanding that we ourselves would want.

d) **Quality**– this means that we are always seeking to improve the way we conduct our business striving for the highest levels of safety, efficiency and professionalism.

e) **Positive Patient Experience** - this means we are accessible, accountable, courteous and efficient and that we understand and are driven by the needs of the people we serve.

2.9 The benefits of this approach

This strategic and values based approach will help to deliver significant improvements in the health and wellbeing of local people and will significantly improve our ability to:

a) Get a better return on all our investment in terms of the improvement that is made to local people's health as a result of the ways in which we spend tax payer's money.

b) Deliver the objectives we have agreed with our partners.

c) Increase public satisfaction with local health services.

d) Improve public awareness and understanding of the local NHS.

e) Plan ahead.

3 The context for this strategy

3.1 Local health economy

Oxfordshire PCT controls a budget of c. £760m on behalf of the Oxfordshire population. It uses these funds to:

a) Contract primary care from independent contractors, including 82 GP practices, 98 pharmacies, 100 dental practices and 75 optometry practices.

b) Commission services from a range of providers including local hospital trusts and independent sector organisations.

c) Provide a range of services itself – and these include running nine community hospitals (of which 3 have a Minor Injury Unit and 3 have first aid units), delivering adult and children's nursing, therapy services, health visiting, sexual health and out-of-hours urgent care.

The PCT's budget for 2007/8 is summarised in the tables below[1]. The largest area of spend is the £480m that the PCT invests in hospital and other healthcare services on behalf of the local population.

2007/08 Oxfordshire PCT Spend	£'000	As a % of spend
Primary Care Services	158,126	21%
Commissioned Services (inc DAAT, independent and voluntary organisations)	484,092	63%
Directly Provided Services	61,961	8%
Public Health	7,545	1%
Corporate / Management	19,564	3%
PCT Financing	32,907	4%
TOTAL	**764,206**	**100%**

Please note that Optometry is centrally funded and therefore does not appear in PCT budgets

[1] A more complete breakdown of PCT spend by Programme Budget (i.e. disease category) is available on request from strategyfeedback@oxfordshirepct.nhs.uk

2007/08 Oxfordshire PCT Spend	£'000	As a % of spend
Primary Care		
Dental	*2,050*	
Pharmacy / Prescribing	*80,749*	
Prison	*2,332*	
GP's	*72,941*	
Other	*54*	
Primary Care Services Total	158,126	21%
NHS Hospital and Other Healthcare		
Oxford Radcliffe Hospitals Trust	*209,472*	
Nuffield Orthopaedic Centre	*29,329*	
Oxfordshire and Berkshire Mental Health Trust	*54,992*	
Royal Berkshire Foundation Trust	*11,437*	
South Central Ambulance	*11,835*	
Ridgeway Partnership	*1,226*	
Specialist Commissioning	*48,978*	
Out of County/Non-contract	*10,752*	
Drugs & Alcohol Action Team (Oxfordshire)	*3,456*	
Other NHS Providers	*40,229*	
NHS Hospital and Other Healthcare Total	421,706	
Non-NHS Total	12,920	
Pooled Budgets		
Learning Disabilities	*27,422*	
Mental Health	*1,574*	
Older People	*20,470*	
Pooled Budgets Total	49,466	
Commissioned Services Total	484,092	63%
Adult	*35,956*	
Children's	*9,599*	
Estates	*2,917*	
Other Projects	*2,424*	
Management	*2,304*	
Specialist	*7,440*	
Workforce	*1,321*	
Directly Provided Services	61,961	8%
Public Health (Inc Smoking Cessation)	7,545	1%
Corporate / Management	19,564	3%
Other (Capital charges, depreciation, reserves, etc)	32,907	4%
TOTAL	**764,195**	100%

3.2 Partnership

Oxfordshire PCT is not developing its strategy in isolation. We are one of a network of 152 PCTs across England, and have a clear responsibility both to deliver national health policy locally and to ensure that locally available health services are designed to meet the needs of our particular population.

The NHS is a key player in ensuring that the priorities and objectives of those responsible for Oxfordshire's social, educational, economic and environmental development can be delivered. It is also – in its own right - a big local employer with responsibility for a large portfolio of land and buildings. The PCT is responsible for ensuring that the NHS is playing an appropriate part in shaping and delivering the Oxfordshire of tomorrow – and its strategy must also reflect that.

Much of the work of the PCT is – and will continue to be - determined by national policy and targets, regional strategic planning and the health needs of the local population.

Our strategy must therefore reflect local need and dovetail with the strategies of our partners – particularly the Department of Health, the South Central Strategic Health Authority and Oxfordshire County Council.[2]

This means that the PCT must ensure that it works to secure:

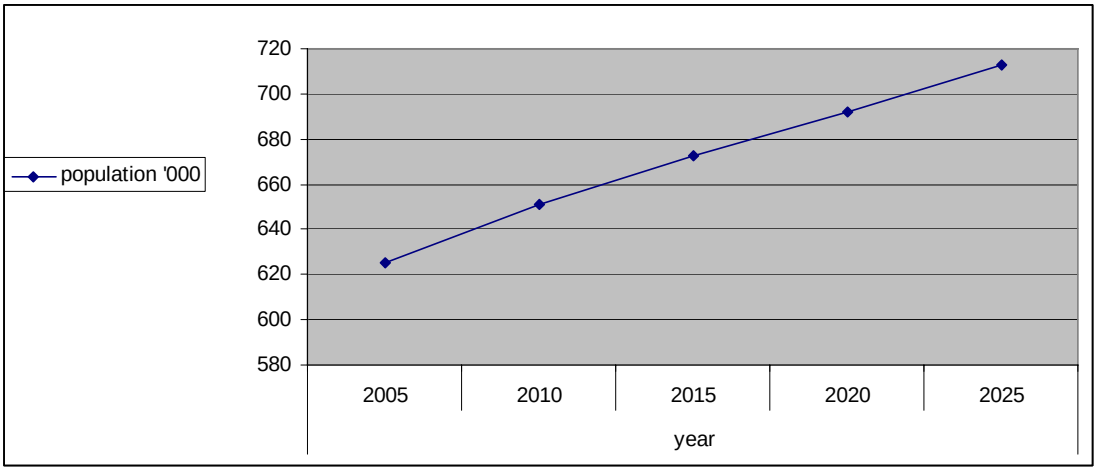
- Improved access to health services.
- Improvements to the quality of health services.
- Reduction in local health inequalities.
- Improvements in the health of the local population.
- Improved support for people with long term conditions.
- Targeted action to improve service provision for particular conditions – in response to local health needs and local health outcomes.
- Health services that will evolve to meet the change in demand resulting from expected demographic change.
- Successful delivery of national targets and quality standards for health.
- Long term financial stability in the local health economy.

[2] Further details relating to the National, Regional and Local Drivers are available on request from strategyfeedback@oxfordshirepct.nhs.uk

4 Local health needs

4.1 Population statistics

a) The population of Oxfordshire in 2005 was approximately 625,000 and by 2025 (20 years) it is expected to increase to 713,100 - an increase of 11.4%.[3]



b) The Office of National Statistics (ONS) projections shown above do not however reflect the expected impact of housing growth on the population served by the PCT, and the South East England Regional Assembly (SEERA) has agreed plans to develop substantial numbers of new dwellings in the region during the next twenty years.

c) The South East Plan proposes building 1,700 new dwellings per year in Central Oxfordshire, and 660 new dwellings per year for the rest of the County. This would mean a total annual development of 2,360 dwellings and a total of 47,200 new homes in Oxfordshire in the next twenty years.

d) This growth will not however be evenly spread across the County. The County Council has undertaken more detailed forecasting work for the period 2006-2011, which factors in housing growth and this suggests the following distribution of population growth[4]:

[3] ONS population projections for Oxfordshire (all ages), 2005-25

[4] Oxfordshire Forecast of Population and Households by District, Town and Ward from 2001 to 2011

	All persons				Households			
	2001	2006	2011	% change 2001-2011	2001	2006	2011	% change 2001-2011
Oxfordshire	**607,277**	**617,169**	**635,101**	**4.6%**	**241,218**	**251,853**	**267,245**	**10.8%**
Cherwell	**131,988**	**134,717**	**140,571**	**6.5%**	**53,225**	**55,444**	**59,697**	**12.2%**
Banbury	41,863	43,529	45,140	7.8%	17,492	18,454	19,889	13.7%
Bicester	28,705	30,238	31,291	9.0%	11,612	12,473	13,090	12.7%
Kidlington	13,744	13,496	13,157	-4.3%	5,518	5,566	5,632	2.1%
Oxford City	**135,509**	**137,848**	**139,894**	**3.2%**	**51,732**	**54,430**	**56,922**	**10.0%**
South Oxfordshire	**128,307**	**127,929**	**131,071**	**2.2%**	**52,105**	**53,204**	**56,152**	**7.8%**
Didcot	23,468	24,020	26,796	14.2%	9,771	9,989	11,691	19.6%
Henley	10,631	10,423	10,327	-2.9%	5,040	5,157	5,245	4.1%
Thame	11,075	11,017	10,935	-1.3%	4,455	4,539	4,636	4.1%
Vale of White Horse	**115,772**	**116,758**	**120,168**	**3.8%**	**45,759**	**47,702**	**50,673**	**10.7%**
Abingdon	31,329	32,075	32,438	3.5%	12,764	13,477	14,028	9.9%
Wantage	10,511	10,922	11,373	8.2%	4,064	4,363	4,685	15.3%
West Oxfordshire	**95,701**	**99,917**	**103,397**	**8.0%**	**38,397**	**41,073**	**43,801**	**14.1%**
Carterton	11,791	13,852	14,816	25.7%	4,438	5,240	5,758	29.7%
Witney	22,764	25,173	27,605	21.3%	9,103	10,359	11,689	28.4%

e) New housing – particularly in Banbury, Bicester, Didcot, Carterton and Witney, is expected to generate an increase in young families, and health services in these areas will need to develop and adapt accordingly.

f) Despite this housing growth and the projected increase in demand for maternity, children's and family services, the principal demographic change expected in Oxfordshire over the next 20 years is a large increase in the elderly population.

g) Whilst affecting all the UK, the demographics of the ageing population are disproportionately significant for Oxfordshire and this growth is not uniform across the county; ***growth is particularly seen in the rural areas of Oxfordshire***. An increase in the numbers of people who are in what is normally a less-healthy and more dependent period of their life will increase demand on the NHS.

Population Change in Oxfordshire 2004 – 2029

Geographical Area	AGE 65+			AGE 80+			AGE 85+		
	Pop in 2004 (1,000s)	Pop in 2029 (1,000s)	%age Increase 2004 to 2029	Pop in 2004 (1,000s)	Pop in 2029 (1,000s)	%age Increase 2004 to 2029	Pop in 2004 (1,000s)	Pop in 2029 (1,000s)	%age Increase 2004 to 2029
Cherwell	18.8	34.9	85.6%	5.1	11.1	117.6%	2.2	5.5	150.0%
Oxford City	17.2	23.0	33.7%	5.4	7.5	38.9%	2.3	3.9	69.6%
South Oxfordshire	20.5	32.5	58.5%	5.8	11.5	98.3%	2.6	5.8	123.1%
Vale of White Horse	18.8	29.4	56.4%	5.2	10.6	103.8%	2.2	5.4	145.5%
West Oxfordshire	16.2	28.0	72.8%	4.7	10.1	114.9%	2.1	5.2	147.6%
Oxfordshire	**91.5**	**147.8**	**61.5%**	**26.2**	**50.8**	**93.9%**	**11.4**	**25.8**	**126.3%**

Source: Office for National Statistics: Subnational population projections based on 2004 mid-year estimates
These show what the population will be in the future, given the current trends

i) Black and Minority Ethnic communities make up 4.5% of the county population with higher proportions in the city where the total is 12.5% (2001 Census data).

j) Average life expectancy for Oxfordshire is higher than the England average but there are inequalities by locality with the lowest 20% of wards having an average life expectancy of 77 years, in comparison with the highest 20% wards average of 83.4 years. Women have higher average life expectancies than men and the rural district councils have higher averages than the City of Oxford. Overall both men and women are living longer than in 1991 but the trend for improved life expectancy is showing better outcomes for the less deprived communities, with the ***inequalities gap in Oxfordshire getting wider.***

4.2 Local health needs

In March 2007 the Director of Public Health (DPH) for Oxfordshire published his annual report. This report was adopted by the Oxfordshire Community Partnership Board, and provides a comprehensive analysis of the health needs of this population.

That analysis has not been repeated here in full as copies of the report are widely available, but can be summarised as follows:

a) Health outcomes in Oxfordshire are generally good, except in deprived areas – and we have agreed locally that the best way to try and start breaking the cycle of deprivation is through partnership work on early intervention, prevention and mental health services with children and families – this is reflected in the first of our strategic commissioning priorities[5].

b) The number of over 85s living in Oxfordshire will increase by 126% (approximately 14,000 individuals) by 2029 - and we know that not only is per capita health spend highest in this age group, but some of that spend is avoidable or could deliver better health outcomes.[6]

c) The Oxfordshire Mental Health Strategy clearly identifies that partnership working between all those involved in commissioning and delivering services to older people with mental health problems needs to improve.[7]

d) The local redesign work already begun for diabetes gives us a model for a way of working that, if successful, we can apply to a range of other conditions.

[5] Director of Public Health for Oxfordshire Annual Report 2005-2007
[6] Director of Public Health for Oxfordshire Annual Report 2005-2007
[7] Oxfordshire Mental Health Strategy 2007-2012

e) Diabetes is a LTC where we are delivering below average outcomes for above average investment and growth in prevalence is expected.[8]

f) Breaking the cycle of deprivation, providing a better deal for older people and commissioning excellence – particularly for LTCs like diabetes – are priorities shared by our local partners.[9]

The report concludes that there are four main threats to the future health, wellbeing and prosperity of Oxfordshire, and that these are:

- The ongoing cycle of deprivation of children and families.
- The rapidly ageing population.
- The increasing prevalence of obesity which is a major cause of several chronic diseases, including diabetes.
- The spread of infectious diseases – and we are focusing particularly on how this relates to the sexual health of young people.

Oxfordshire PCT is therefore proposing to prioritise ***breaking the cycle of deprivation for children and families, providing a better deal for older people*** and ***commissioning excellence*** with an initial focus on ***diabetes*** care.

[8] Initial Analysis of Oxfordshire Programme Budget spend against mortality outcomes mapped to average UK PCT is available from the PCT Head of Decision Support by contacting Andrew.fenton@oxfordshirepct.nhs.uk

[9] Director of Public Health for Oxfordshire Annual Report 2005-2007 & draft work done for Health and Wellbeing section of Oxfordshire Sustainable Communities strategy.

4.3 What we know about the deprivation faced by children and families

Poverty, teenage pregnancy, smoking, diet and educational attainment will all impact on long term physical and mental health outcomes of children, and the DPH annual report highlights some key facts about deprivation in Oxfordshire, drawing attention to the following issues:

a) Geographical inequalities persist in small pockets in Oxfordshire. Measures of multiple deprivation show 13 Super Output Areas (SOAs) in Oxfordshire among the 20% most deprived in England and one of these areas in the 10% most deprived. All these most deprived SOAs are in Oxford or Banbury, within the wards of Northfield Brook, Rosehill & Iffley, Barton & Sandhills, Blackbird Leys, Carfax and Banbury Ruscote.

b) Measures of child poverty show a total of 19 SOAs in the worst 20% in England and most of these are in Oxford, with 2 in Banbury and one in the Abingdon area. Indices of Child Poverty also show that some areas in the county are in the 10% most deprived in England, in the wards of Northfield Brook, Barton & Sandhills, Blackbird Leys, and Banbury Ruscote.

c) Teenage pregnancy rates in the county are falling slightly, but remain comparatively high at 34.1 per 1000 females aged 15 – 17, and are not reducing at the rate required to achieve national targets. Teenagers in the most deprived wards are 2 to 3 times more likely to become pregnant than those in the least deprived wards.

d) The percentage of women initiating breast feeding varies by more than 10% between the most advantaged and disadvantaged wards - A baby born in Blackbird Leys in Oxford is 40% less likely to be breast fed than a baby born in parts of Henley.

e) Mothers in the most deprived wards are between 2 and 3 times more likely to smoke than those in the least deprived wards.

f) Evidence from the Millennium Cohort Study shows that children from deprived areas are more likely to have incomplete immunisation status (Bedford et al 2006).

g) The rate of emergency admissions to hospital in children 0-4 is 50% higher in the most deprived wards compared to the least deprived wards.

h) There is a 27% gap in attainment at foundation stage between students in the worst and least deprived areas of the county – compared to national average of 16%, and markedly different attainment at GCSE across the County according to 2005/6 figures:

all pupils

	District				
	South	Cherwell	City	Vale	West
No of pupils on roll	1,765	1,325	1,020	1,123	1,265
% achieving 5 + A-C grades incl maths and English	56.8	38.6	39.4	46.5	54.5
Number of Pupils	1,003	511	402	522	689

If some of these inequalities cannot be addressed, the cycle of deprivation experienced in parts of Oxfordshire will continue, with the result that the long term call on primary care, mental health, social care, hospital and specialist care resources from this population group will continue to grow and another generation of children and young people will not be given a fair chance to realise their full potential.

It is known, for example, that:

- Young people face an increased risk of suffering from poor mental health when exposed to poverty, family instability, parental mental health problems, parental substance misuse, neglectful or harsh parenting style and poor attachment in infancy.

- Risk factors associated with poor maternal mental health and post natal depression include previous history of mental illness, being an unsupported mother, a teenage mother, on a low income, and suffering from drug and/or alcohol misuse.

- There is a clear association between social inequality and poor oral health with children in deprived areas having higher rates of decayed, missing and filled teeth.

- Risk factors for poor sexual health and teenage pregnancy include lack of knowledge, drug and alcohol misuse, inability to access services, being the daughter of a teenage mother, poor educational attainment, non attendance at school, being a vulnerable young person e.g. homeless, in care or a young offender.

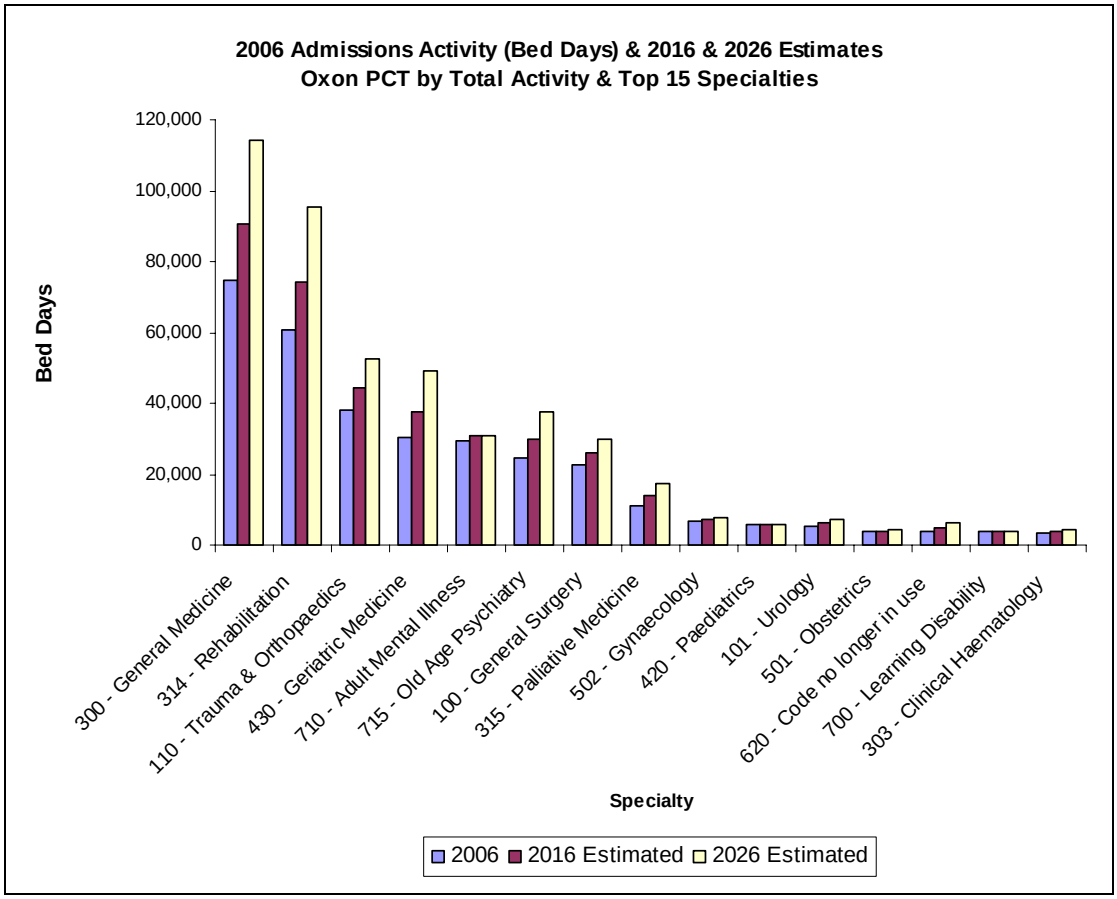
- There is a clear association between social inequality and obesity.

4.4 The importance of providing a better deal for older people

As already indicated, Oxfordshire's elderly population is expected to increase dramatically over the next 20-25 years – predominantly in rural areas. Some preliminary analysis of the impact this population growth might have on demand for healthcare has been undertaken by the PCT to inform this strategy.

At this stage that work has just looked at a straightforward predictive model that asks the question "if the population grows as predicted and current patterns of healthcare usage stay the same, what will the increased usage of services be?".

Initially this question has been asked of uptake of hospital beds by specialty, and results suggest there is likely to be a big increase in demand for general medical, rehabilitation and old age psychiatry services if preventative and early intervention action is not taken across the whole local health and social care system.



Far more detailed and rigorous analysis of the potential impact of the ageing population is now needed[10], in order to allow the PCT to undertake long term work with its partners to ensure that:

- More people in these age groups stay healthy for longer.
- The health needs of this population group are met through effective partnership working between primary care, secondary care, mental health services, the voluntary sector and social care.
- Meeting the health needs of this population group does not impact negatively on our ability to meet the needs of other population groups.
- The potential of this older population to be a positive economic, social and health resource is fully realised.

The plans in place to do this further work are outlined in Appendix 1.

4.5 The need to commission excellence – beginning with diabetes

Improving ways in which the health service manages and treats people with long term conditions is essential if we are to improve health outcomes, the quality of care given and value for money.

Long term conditions are increasing, and over a lifetime someone with such a condition may well receive services from a wide variety of different organisations that includes their GP practice, Community Health Oxfordshire, acute hospitals and social care.

At the moment these services are commissioned by the PCT through a series of contracts with each of the organisations involved – and in theory this buys a linked chain of care for the patient. However we suspect that the chain is often not actually well linked from the patient's perspective, and that this probably reduces the benefit of the care provided as well being inefficient in terms of use of resources.

The PCT therefore wants to prioritise making improvements in the way in which it commissions care for those with long term conditions. It proposes starting with diabetes because:

a) All the GP commissioning (PBC) consortia in Oxfordshire are already engaged in diabetes service redesign and implementation, and this work is already firmly established as a countywide priority.

b) Diabetes is a known issue of public and patient concern – as evidenced in response to service redesign work undertaken by predecessor PCTs last year.

[10] Further information is available from the PCT Head of Decision Support by contacting Andrew.fenton@oxfordshirepct.nhs.uk and is summarised in Appendix 1.

c) Tackling diabetes will help to address some of the longstanding health inequalities identified in the population.

d) The diabetes care pathway starts with prevention work and continues through to lifelong Long Term Condition management. Focusing on how we commission services for patients with diabetes therefore gives us a mechanism for testing new ways of working right along the care pathway.

e) Work already done on the diabetes service redesign means that a new way of working is close to being ready to implement and we should be able to make enough progress to evaluate some new approaches to commissioning within the first 18 months of this strategy.

f) The prevalence of diabetes is likely to increase if lifestyle issues connected particularly with increasing obesity are not addressed.

g) The PCT has undertaken some preliminary analysis of how much it spends on diabetes compared to other PCTs and of the health outcomes it achieves from that investment – again compared to other PCTs[11]. This initial analysis (although crude) suggests that outcomes for diabetics in Oxfordshire are worse than the average but that investment on diabetes services in the county is higher than average.

[11] Initial Analysis of Oxfordshire Programme Budget spend against mortality and other standardised outcomes is available from the PCT Head of Decision Support by contacting Andrew.fenton@oxfordshirepct.nhs.uk

5 Delivering our strategic commissioning priorities

This strategy will be supplemented by detailed and costed activity plans for each of the three strategic commissioning priorities – and the initial conclusions from those will be included in the one year operational plan that is being produced in conjunction with this five year strategy**.**

Outlined below is the approach the PCT intends to take in order to work up this detail for each of the three priorities it intends to adopt.

5.1 Breaking the cycle of deprivation for children and families

a) Where are we now?

Health need

- There is growing evidence that poverty, teenage pregnancy, breast feeding, smoking, diet and educational achievement will impact on health outcomes for children as they grow up – and as we have seen children in the most deprived parts of Oxfordshire face increased risks of having poor health outcomes a result of all these issues.

- In addition, having a child with the most complex needs (including conduct disorders, learning disabilities and life limiting illness), can limit parents' ability to work and has a significant impact on the whole family.

- There is evidence that outcomes for these children are poorer in Oxfordshire than in comparable counties[12].

Service provision

In drawing up its plans for 2007/8 the PCT made commitments to a range of development initiatives:

- Investing an additional £186K in services to ensure full funding of the Primary Child and Adolescent Mental Health service, case management for children with complex needs and provision of sustainable funding for the community based respite service.

- Continuing to improve the coordination, availability and accessibility of CAMHS services, particularly around the redesign of Tier 3 specialist services.

[12] Oxfordshire Best Value Review of Services for Vulnerable Children and Young People 2005

- Reducing the use of harmful drugs and alcohol through integrated prevention and early intervention services and to build on the accessibility and availability of the Young People's Treatment Service (Evolve).

- Reducing teenage conceptions and improving sexual health in young people (including reducing Sexually Transmitted Infections).

- Integrating support services for young people aged 13-19 years old to reduce the number of 16-18 year olds not in education, employment or training.

- Improving early practical support for vulnerable families, to prevent abuse, neglect and family breakdown (includes Children's Centres, Extended Schools and integrated locality teams).

- Redesigning the pathway of care for children and young people with complex disabilities to ensure effective and equitable access to both community and residential provision on the basis of assessed clinical need.

- Enhancing access to assertive outreach/therapeutic support services for children and young people with severe learning disabilities and challenging behaviour with the aim of reducing out of county placements and managing transition into adult services more effectively.

These programmes will all be delivered, but they will not be enough to deliver substantive change for those children and families with the greatest needs.

b) Where do we want to be?

The PCT has committed to reducing the health inequalities gap in Oxfordshire by 10% by 2011, with a specific focus on children and families in targeted priority areas.

Health inequalities gaps for children are measured by infant mortality, but because absolute numbers are very small, proxy measures used. These are rates of breast feeding initiation and smoking in pregnancy.

The detailed outcome measures set by the PCT are given below. Some require further work to establish measurable and time based targets:

- Increase breastfeeding initiation rates in the most deprived SOAs by 10% by March 2010 (Definition: SOAs in the highest 20% nationally for child poverty).

- Reduce the percentage of women who smoke during pregnancy in the most deprived SOAs by 2% by March 2010 (Definition: SOAs in the highest 20% nationally for child poverty).

- Reduce the rate of conceptions in women aged under 18 in line with national targets.

- Reduce the number of year 7 to year 11 pupils drinking alcohol two or more times per week from 2007 baseline of 14% measured through children and young people's survey.

- All young people eligible for free Chlamydia screening are tested and treated if necessary.

- Halve the increase in the percentage of children who are overweight or obese from the baseline in 2007 by March 2010.

- Increase provision of evidence based intensive parental support programmes to vulnerable families.

- Reduce the impact of parental substance misuse on child physical and metal health by improving access and support to treatment programmes.

- Reduce the impact of poor maternal mental health and postnatal depression on infant physical and mental health and wellbeing.

- Reduce the number of young people (years 7-11) who smoke regularly by 1% by March 2010 from 2007 baseline of 9%.

- Reduce drug and alcohol related A&E attendances amongst young people.

- Increase access to drug and alcohol misuse prevention and early intervention programmes for young people.

- Increase provision of universal services for children and families in areas of high need.

- Meet Chief Nursing officer's recommendation of 1 wte school nurse for each secondary school and its cluster primary schools by 2012.

c) How do we get there?

The high impact changes that would make a real difference in terms of delivering these measurable outcomes for the most vulnerable children and families include:

- Identifying the geographical areas of highest need, and the most vulnerable children, young people and families, and then shifting investment of early intervention and preventative resources to support them.

- Clearly specifying what needs to be commissioned through the PCT universal services, articulating a vision for the future and developing an outcomes based monitoring framework.

- Agreeing care pathways for children and young people with the most complex needs and shifting use of resources upstream to identify and intervene earlier.

d) Timetable and next steps

In order to deliver these high impact changes the PCT will need to:

- Ensure that the Oxfordshire Children and Young People's Partnership Board are signed up to these targets and action plans , and get agreement from all members by the end of September 2007 as to how we can work together to deliver this agenda.

- Work with the Children and Young People's Partnership Board to produce accurate baseline data for use by all agencies in relation to a basket of seven child health indicators. These are due to be agreed by September 2007.

- Establish a project board to develop a detailed commissioning plan related to delivery of the objectives listed above in September 2007.

- Develop a detailed commissioning plan by October 2007 to inform the PCTs financial planning process. This will set out what services need to be purchased.

- By December 2007 agree a framework with the Children and Young People's Partnership Board for the joint delivery of any activity required to deliver these objectives. This to likely to include commissioning delivery of services through some or all of the following:

    - Children and Young People's Partnership Board
    - Extended services and children's centres programme board
    - Service integration board
    - Joint commissioning team
    - CAMHS Steering group
    - Mental health taskforce
    - Health and Wellbeing Partnership
    - Teenage pregnancy partnership
    - Breast feeding Strategy group
    - Sexual health partnership

- Ensure that all parties are ready to start delivering newly commissioned services from April 2008.

5.2 Securing a better deal for older people

Old age is not an illness; today, older people are healthier than their parents were, and making a huge contribution to the community both through voluntary and paid work. However, the unique position of the older person is that when they become unwell and more dependent they often have multiple needs and require a higher level of support to maintain an acceptable quality of life within the community.

a) Where are we now?

Traditionally health services for adults and the older person in Oxfordshire have been based around centralised acute care, with high levels of admission, long stays within hospital and services based around in-patient care. Joint working between health and other public services has been strong; however there has not been a joint strategic vision for the services for the older person and the development needs related to this.

The PCT's plans for 2007/8 committed it to developing those aspects of the older people's NSF that support responsive and effective alternatives to admission and early discharge for all Older People. This year we will:

- Continue to invest in these services, with an additional £1.4m pledged for older people's services in 2007/08, to address demand management, intermediate and continuing care programmes.

- Work with our partners to implement a clearer pathway for older people with urgent care needs including proactive case management, rapid access to diagnostics and specialist assessment and alternatives to admission.

- Further develop the integration of intermediate care services under the locality managers to improve efficiency, capacity and quality of the services. This will include all domiciliary and bed based intermediate care services across the county.

- Implement the Enhanced Intermediate Care Service developed with Oxfordshire and Buckinghamshire Mental Health Trust and Social and Community Services which will provide a single pathway for older people with mental health problems. Funding of £1.2m will contribute to an overall increase in episodes of home based intermediate care in the county and is intended to help cap spending on long term residential care placements.

- Develop a comprehensive public health plan to contribute to prevention of ill-health in an aging population.

- Implement the proposals to streamline further access to equipment funded from the pooled budget through a contract with a single provider.

- Continue to develop the joint health and social services falls service.

- Focus on reducing delayed transfers of care.

b) Where do we want to be?

Over the next twenty years, as the proportion of the older population in the community expands, the key to meeting their needs in a sustainable way will be improving:

- Early intervention.

- Long term condition management.

- Early supportive discharge.

- Self care and supporting the ageing population to remain healthy.

- Acute care when needed.

- Partnership working across the whole health and social care community.

The outcomes that we would wish to see for the older person in ten years time are:

- An older population that is able to remain active and independent longer, living in their own homes and being proactive decision makers about their care.

- To make sure that the population can age well by putting in services, education and information to allow this, and by targeting those areas of underlying health problems e.g. High blood pressure and social isolation, therefore enabling patients to become ‘expert patients’ and managers of their own health.

- To have a reactive integrated community service 24/7 so that it is accessible when it is required, offering high quality integrated care, and avoiding unnecessary admissions to hospital.

- Joined up pathways of care across organisations, so that the older person can pass smoothly through different levels of health and social care without unnecessary delays.

- To have robust rehabilitation services, so that when illness does occur, the older person has every opportunity to regain their full potential in physical, mental and social interaction.

- To ensure older people with mental health illness have effective and personalised services which allow for individual circumstances.

Specifically the PCT and its partners - including the Practice Based Commissioning Consortia and County Council - will be seeking, over the next five years, to:

- Reduce the number of older people having unplanned admission to hospital.

- Reduce the length of time older people spend overall in hospital, especially the over 85's.

- Increase the number of older people being cared for in their own home.

- Improve the access to diagnostics and rapid access and assessment clinics in the community.

- Increase the number of 'expert patients' in the older population.

- Increase the application of assistive technology.

- Reduce the number of assessment systems and data information records for an individual user of health and social services.

- Reduce the levels of obese adults at the age of 65.

- Increase the number of over 65s taking regular exercise.

- Undertake annual medication reviews for 100% of older people taking four or more drugs, including those living inc are homes.

c) How will we get there?

Developing an older people's services strategy
The critical mechanism for ensuring delivery of these outcomes will be for all relevant partners to work together to develop a detailed, shared strategy for the development of older peoples services. The PCT envisages that this will be developed in response to (or even as part of) the wider Care Outside Hospital Commissioning framework which it plans to produce during the Autumn of 2007 (see Appendix 1).

This work will be ultimately overseen by the new Health and Well-Being Partnership Board, which will hold its inaugural meeting on September 13th 2007.

The Board will report to the Oxfordshire Partnership Board and will bring together the PCT, county and district level local authorities and service user representatives.

It will be responsible for setting direction for a range of joint Health & Social Care and Public Health initiatives across the county. It is expected that the Health and Well-Being Partnership Board will oversee the work of the relevant programme boards implementing the actions to meet these strategic aims.

It is expected that the Health and Wellbeing Partnership Board will establish a sub group to lead development of the Care Outside Hospital Commissioning Framework, and that this sub group will need to work closely with the existing PCT led Older Peoples Programme Board which has responsibility for overseeing the service design and commissioning of health services for older people.

The older people's strategy will:

- Inform the redesign of health services so that we can transform services, and therefore outcomes, over the next 5-10 years.

- Develop the outcome targets above so that they are described in ways that they are all time based and quantifiable –so progress on their delivery can be meaningfully measured.

- Be developed in conjunction with (or as an integral part of) a wider strategy for development of care outside hospital across Oxfordshire.

- Specify arrangements for joint commissioning of older people's services.

- Describe the activity that will be commissioned in order to deliver the change envisaged.

Specific commissioning proposals

It is expected that the strategy will recommend commissioning specific programmes of activity designed to deliver the broad outcomes listed above. These will be linked to specific and more detailed outcomes, and are likely to include:

- Action to prevent illness in the 45 – 65 age group including
    - Reduce the prevalence of obesity in people aged 45 - 65 by 2% by 2010, by commissioning weight management programmes in primary care, promoting increased activity, including exercise on

referral and promoting healthy eating, including nutritional support and advice.
    - Reduce smoking prevalence in people aged 45 - 65 by 1% by 2010 by commissioning appropriate cessation services and using social marketing techniques to target different groups appropriately.
    - Contribute to the reduction in cancer mortality through increasing the uptake of cancer screening programmes in the eligible adult population and through the introduction of the national bowel screening programme.
    - Reduce number of people drinking alcohol at above recommended levels by 2% by 2010 (establishing baselines by 2008) through commissioning brief advice interventions in primary and secondary care.
    - Increase the number of people that undertake at least 30 minutes if moderate intensity physical activity on at least 5 days a week.
    - Increase the proportion of adults taking part in moderate intensity sport and recreational physical activity for at least 30 minutes, on at least 3 days a week by 1%, measured through the active people survey.
    - Increasing prescription of anti-hypertensive or anti-cholesterol drugs to wider range of risk groups, including to 20% of those on GP practice registers with 20% risk of CHD by 2010.
    - Delay or prevent onset of osteoporosis through information campaigns and appropriate interventions, targeting the 10% at most risk aged 45-65 by 2010.
    - Commission comprehensive mental health promotion and target vulnerable groups, increasing the number of people aged 45 – 65 with mild to moderate mental health problems accessing services by 20% by 2010.

- Action to help increase and maintain independence such as:
    - Reduce the number of injuries sustained following falls by developing the falls prevention programme to include early prevention activity with 20 day centres / community groups across the county and increasing interventions with the highest risk clients by 10% by 2010. including falls prevention support to care homes in line with the LAA target.
    - Ensure high levels of uptake of winter flu and pneumococcal immunisation campaigns across all groups of the population, increasing uptake to 75% in all community groups for people aged over 65 by 2010.

  - Increasing availability of intensive home support available through joint commissioning with Social and Community Services by 1% per year until 2011.
  - Increase the numbers of people aged 65 and over accessing appropriate information on managing CHD and diabetes by 10% a year.
  - Increase numbers of people on diabetes and CHD registers having annual reviews in line with, or in excess of LDP targets.
  - Increase numbers of patients on disease registers meeting recommended levels of control. E.g.: Blood pressure, body mass index, cholesterol and HbA1C.
  - Commission health trainer services to work with older people on practice risk registers, ensuring access for the most vulnerable.

- Underpinning actions such as:
  - Commission improved medicines management across sectors (Primary, secondary and residential care sectors) thereby reducing the prescribing costs by 5% for certain medications.
  - Decrease risk of health care associated infection by commissioning appropriate interventions and information campaigns that reduce incidence by 5% per year.
  - Ensure support for unpaid carers including increasing the number of annual health checks carried out by GPs for carers by 10% per year until 2012.

d) Timetable and next steps

- Social services have already completed preparatory work on reviewing social care services for older people and on identifying areas for redesign.

- The PCT Older People's Programme Board (which includes older people's representatives) will complete a similar review of health services for older people by the end of September 2007.

- The Older People's Programme Board will be overseeing an agreed programme of work to improve services and lay the foundations for the wider strategy, and by the end of September 2007 this Board will have:

  - Identified the activity and spend on services for the older population at a high level of data collection, but not full detailed profile.

  - Identified gaps in service delivery which already have robust business cases developed for inclusion in the PCT's Operational Plan.

  - Put in place an agreed partnership arrangement for the strategic development and monitoring of older peoples services across the county.

- The Care Outside Hospital commissioning framework and principles will be considered by the PCT Board at its workshop on October 25th 2007. It will:

  - Specify that detailed planning and target setting for older peoples services will be the first demographic focus for work to deliver the Care Outside Hospital Framework.

  - Confirm the approach to joint planning, commissioning and delivery of older people's services previously proposed in the Older People's Programme Board brief.

- Work will be completed by the spring of 2008 on developing:

  - A joint health and social care older people's strategy.

  - An Older People's Health needs assessment and service design model.

  - An Older People's Mental Health needs assessment and action plan.

  - Implementation of the elderly mentally ill element of existing intermediate care plans.

  - A first report on plans for a further intermediate care services development project.

  - A finalised first report on falls service development.

  - Costed plans to deliver specific commissioning proposals.

5.3 Commissioning excellence – beginning with diabetes

a) Where are we now?

It is known that:

- Approximately 3% of the population suffer from diabetes.
- The number of people with diabetes (especially type 2) will increase by at least 10% over the next 5-10 years.
- People are likely to develop diabetes at a younger age than previously and will live longer with the disease.
- Obese women are 12 times more likely to develop the disease than women with a normal body mass index (BMI) – making obesity an important factor in the development of diabetes.
- As the population ages the incidence of diabetes will increase.

As it is anticipated that the number of people with diabetes is likely to increase significantly, and that those with the condition will be younger at onset and living with the condition longer, there is a need to focus on both prevention of the disease and different ways of delivering services for those people who do develop it.

People with diabetes access a wide range of health services including support for diet, vision and mobility due to foot health issues. In severe cases diabetes may mean people are unable to work, and so may also call on social care services.

Demand for services (and expenditure on them) is increasing and will continue to do so unless change occurs. A large amount of resource is currently used to buy services for diabetics from the acute sector, but it is evident that many of these services could be provided in a ‘one stop shop’ community setting, closer to patients’ homes and at times that are more convenient to them – and this should deliver cost savings as well as meeting the changing expectations of patients.

b) Where do we want to be?

A set of outcomes that we want to achieve for diabetes has been agreed, but further work is required to ensure that all these goals are time based and measurable, and this will be undertaken in the autumn of 2007.

In broad terms we want:

- To be providing an integrated tiered patient care pathway which includes prevention, self care, primary care services, enhanced primary care services and specialist (acute sector) care services.

- Enhanced primary care diabetes services to be provided in community 'one stop shop' settings for as many people as possible wherever it is safe and clinically appropriate. These will be rolled out from April 2008, and will offer a range of services including dietary advice, footcare, self care education and achieving better control of diabetes through blood sugar level control.

- Agreed county wide thresholds and service specifications (with clear outcomes) for primary, enhanced primary and specialist care agreed by late 2007.

- A reduction by at least 50% in number of type 2 diabetics being managed in the acute sector.

- Reduce prevalence of obesity in the 45 -6 5 age group by 2% by 2010,

- A halt to the increase of incidence rate for new type 2 diabetes sufferers.

- Reduce smoking prevalence by 2% of people with diabetes who are aged 45-65 by 2010

- Increased numbers of people undertaking self management of their diabetes.

- Improvements in the quality of diabetes care so that local services meet NICE guidelines and the Diabetes NSF.

- Improvement in the skills of professionals treating people with diabetes.

- Reduction in the long term complications of diabetes.

- Targeting prevention and early intervention services towards those populations known to have an increased risk of diabetes so as to identify people with diabetes earlier.

c) How will we get there?

A diabetes project implementation group has been established which will report to the PCT's Long Term Conditions Programme Board.

This group comprises commissioners, clinical specialists from primary, community and secondary care, clinical governance and standards managers and public health, finance and data specialists.

This group has already significantly progressed the work on the care pathway for diabetes in preparation for a procurement process for suitable providers.

This work will be closely integrated with work on an Obesity Strategy that is being led by the Public Health Directorate.

In addition it is expected that Public Health will commission the following:

- Primary prevention of diabetes
    - Weight management programmes in primary care, promoting increased activity, including exercise on referral and promoting healthy eating, including nutritional support and advice.
    - 5 health trainers to work with black and minority ethnic communities at higher risk of diabetes, providing an individual approach to healthy eating, increasing physical activity, reduced smoking and sensible drinking (as appropriate).
    - Nutritional support and advice to populations most at risk of diabetes to increase confidence and effectiveness in healthy eating, ensuring that 10% of those on risk registers who have BMI over 30 receive appropriate advice each year.

- Secondary prevention of complications for people with diabetes
    - Diabetes specific smoking cessation services.
    - Diabetic retinopathy and foot care services and target information to improve uptake to exceed targets.
    - Comprehensive education programmes for people with diabetes to include nutrition advice and self care, including 10% per year increase in uptake by BME and other vulnerable groups. Aim to increase client confidence and provide information that is culturally appropriate for different client groups.

d) Timetable and next steps

The remit of the diabetes project implementation group will need to be expanded to reflect the significant strategic importance of this work, and this will take place in September 2007.

In addition to its existing commitment to begin procurement of a new tier 2 (enhanced primary care) service specification, this group will:

- Complete the work on redesign of the three tier service model during the autumn of 2007, and will complete work to refine the thresholds for the tier 1 and 3 components by December 2007.

- Review the outcomes proposed above and develop them into time based and quantifiable targets during the autumn of 2007.

- Develop detailed activity plans to set out how these targets are going to be delivered.

- Detailed activity planning is unlikely to take place in time to inform the PCT's detailed five year financial planning in September and October 2007. These financial plans will therefore assume that redesigned diabetes services can be provided within the previously agreed funding allocations for 2007/8, rolled forward into 2008/9 and 2009/10.

6 The PCTs other work programmes

Work on the three strategic commissioning priorities will be delivered in tandem with work to progress agreed programmes of work for 2007/08- some of which will continue into 2008/9. This programme may change in light of further detailed planning about how the PCT is going to deliver its agreed strategic priorities.

The current programmes of work were determined as part of the LDP process, of which 2007/08 is the final year of a 3 year plan. The following summary highlights some of the key programme areas in terms of financial and resource investment.

These programme areas will benefit the whole population, ensuring that whilst time and resources are targeted either at population groups with the highest need, or at building the PCTs skills, the majority of the population continue to benefit from a wide range of steadily improving services.

6.1 Health and well-being of the population

For 2007/08, the PCT made an additional £1.6m investment in Choosing Health. This spend has been focused on access to sexual health/GUM (Genito-Urinary Medicine) services, smoking cessation and healthy lifestyle initiatives. In addition £800,000 has been invested in extending current, and implementing new, screening programmes.

Over the next three years various prevention programmes will continue to be introduced, developed or improved. These will include:

- 48 hour access to GUM.
- Availability of Chlamydia screening.
- Diabetic retinopathy.
- Development of screening programmes including cervical and breast cancer screening and antenatal and newborn screening programmes.

6.2 Long Term Conditions and Case Management

The PCT wants to develop and improve case management for all those with long term conditions – with a particular emphasis on increasing independent living, ensuring care is planned around the needs and choices of the individual, providing easier and more timely access to services and improving joint working across all agencies and disciplines involved in the care of an individual.

The diabetes work we have committed to will provide valuable learning that can then be applied to other conditions, and will also be applied in line with National Service Frameworks (NSF), to:

- Respiratory services.
- Case management (increased investment of £300,000).
- Heart failure – lifestyle health promotion programmes, implementation of new service model for diagnosis and management, working with partners to ensure appropriate capacity and access.
- Musculoskeletal services.

6.3 18 weeks

Delivering an 18 week pathway for all patients from referral to the start of treatment by the end of 2008 is a key objective for the NHS – and will ensure faster access to treatment fro everybody.

In order to take forward this agenda, the PCT has established an 18 Weeks Taskforce, which will be responsible for ensuring delivery of the national 18 week wait target requirement across the local health economy.

The Taskforce will set the vision and direction for defined project groups, determine programme budgets where applicable, approve project plans, performance manage project groups, resolve issues escalated to them, and hold providers to account for delivery of the 18 week targets and their contract performance.

In addition to providing assurance to key stakeholders that the PCT has a dedicated focus on 18 weeks, the Taskforce will report directly to the PCT Clinical Executive Committee who will hold them to account for the effective delivery of agreed priorities.

Key requirements for the 18 week programme are that Trusts will deliver (as a minimum) two milestones for admitted and non-admitted pathways by March 2008. These are that 85% of admitted patients (whose treatment required a stay in hospital) and 90% of non-admitted patients (whose treatment was completed without a hospital stay) will be treated within 18 weeks.

PCTs in South Central may also be required to deliver on the “Further Faster” Programme aims to secure early achievement of the 18 week target by March 2008 (90% admitted and 95% for non-admitted patients).

The first phase of this will be to “Buy out the Backlog”. Capacity and gap analysis has been undertaken in order to calculate the additional activity required to meet the accelerated targets as well as to establish the financial viability of this approach.

The second phase of the programme will relate to sustaining this level of achievement. PCTs will have a critical role in leading the redesign of services

needed to achieve the 18 week target so that by the end of 2008 all patients are seen within this timeframe. The Health Authority is currently reviewing options to deliver this, and the mechanisms that will be required to support accelerated delivery in each organisation. A decision is expected to be reached by the end of July 2007.

6.4 Specialist Commissioning

The PCT has made an additional investment of £2.3m in Specialist Commissioning, and the work during 2007/08 is focussing on:

- Strengthen commissioning across the 9 PCTs in the South Central Specialist Commissioning Group (SCG).
- Improving the financial management of specialised commissioning (SCG) budgets through better performance monitoring.
- Working collaboratively with other PCTs to review activity and develop agreed clinical criteria for specialist services. Work in progress includes a review of new types of Bone Marrow Transplants and some elective neurosurgery procedures.
- Continuing to work closely with newly reconfigured clinical networks, ensuring the development of a consistent approach to the delivery of clinical services. Examples include: critical care, cancer, cardiac and older peoples services.

6.5 Cancer Services

In 2007/8 the PCT will have:

- Invested an additional £530,000 in cancer network priorities including increased access to PET (Positron Emission Tomography)[13] scanning and increasing NHS funding towards inpatient specialist palliative care.
- Developed a comprehensive lifestyle health promotion programme in line with the Choosing Health White paper, targeting populations or localities experiencing inequalities in access or outcomes.
- Sustained delivery of reduced cancer waiting times (2 week wait, 31 and 62 day targets) and extending this to all cancer pathways.
- As part of the Thames Valley Cancer Network developed increased access to PET scanning and brachytherapy[14] treatments.
- Implemented the bowel cancer screening programme.
- Delivered electronic prescribing for chemotherapy.

[13] A positron emission tomography (PET) scan is a unique type of imaging test that helps to see how the organs and tissues inside the body are actually functioning. They are most commonly used to detect cancer, heart problems, brain disorders and other central nervous system disorders.
[14] A type of radiation therapy where radioactive materials are placed in direct contact with the tissue being treated.

6.6 Mental Health

The PCT, County Council, voluntary sector and mental health trust agreed a 5 year mental health strategy in late 2006.

The main theme in 2007/08 is the continued development and redesign of patient care pathways with a particular focus on the interface between primary and secondary care. In 2007/8 the PCT will have:

- Invested an additional £1.6m in mental health services across continuing care, psychological therapies and Mental Health act section 3 placements.
- Reviewed psychological services to inform 2008/09 contract.
- Worked with our voluntary sector partners in implementing the recommendations of the earlier Day Services Review for Adults of working age.
- Built on our successful work to date, and continued to work towards achieving the Mental Health targets within the National Service Framework.
- Explored further and reviewed the flexibility of Pooled Budget arrangements with the aim of further integration with our Social and Community Care Partners.

6.7 Urgent and Intermediate Care

The PCT has invested £1.6 million in ambulance services in 2007/08 to improve response times and further work is targeted towards:

- Accident and emergency services.
- Minor injuries units.
- First response/emergency care practitioners and ambulance services.

Additionally, £1.9 million has been committed into developing intermediate care provision to achieve a better sense of balance between care in hospitals and care at home. The PCT wants to secure services that can offer patients, and those looking after them, a viable alternative to an acute hospital in order to avoid unnecessary hospital admissions and enable people to be cared for in their homes wherever possible. The PCT will concentrate on:

- Increasing the medical and nursing cover in care homes.
- Improving the way we work with people who have LTCs through proactive case management.
- Ensuring that a patient's stay in an acute hospital bed is no longer than it needs to be.
- Improving access to assessment and specialist advice.
- Reducing the delays to patient discharge from hospital.
- Ensuring that appropriate care is available to people when they return home.

6.8 Practice Based Commissioning

The PCT has pledged Investment of £1.5million in 2007/08 to support the development of Practice Based Commissioning and to implement PBC consortia business plans. The focus over the next 18 months will be on:

- Encouraging engagement.
- Providing financial and managerial support.
- Ensuring robust governance processes in place.
- Encouraging local initiatives and ownership.
- Supporting development of practice plans/business cases which help to deliver/align to the strategic aims and commissioning priorities.

The PBC consortia have also identified a range of other priorities for further development in 2007/08:

- ENT – Audiology
- Children and Young people – protection and links to Social Care
- Utilisation of Independent Sector Treatment Centres
- Urology – peripheral services; local cystoscopies; one stop shops
- Mental Health – particularly psychological therapies
- 18 weeks
- Renal
- Neurology
- Cancer care
- Improved access to diagnostics
- Opthalmology
- Gynaecology
- Cardiology – Investigations, echo and arrhythmia
- Dermatology
- Gastroenterology – endoscopies
- DVT – Near patient testing/haematology
- Pulmonary rehabilitation
- Health promotion – obesity and sexual health
- Minor surgery.

7 Enabling work

The PCT has identified a set of planning and developmental workstreams that will need to be delivered over the next two years if it is going to deliver this strategy effectively. The detailed proposals for implementation of these workstreams are set out in Appendix One, and they are summarised below.

7.1 Financial planning

The PCT is undertaking work to strengthen its financial planning, and as described in section 3, has begun to develop a new range of financial modelling and activity planning tools that will allow the PCT to:

a) Plan for and analyse its investment in response to demographic factors, geography, programme budget (i.e. disease related) spend and investment by provider organisation.

b) A process will be developed that:

   - Factors in cost drivers (e.g. demographic change, technological advances) and potential cost improvements.
   - Links these to the 5-year financial plan
   - Develops prioritisation criteria that take into account the overall strategy and immediate priorities.
   - Will enable development of the Local Delivery plan

c) Consider potential disinvestment where evidence of poor return on investment exists in terms of health gain in relation to health spend.

In order to progress its financial planning the PCT will:

a) Establish a Project Board to oversee the creation of the operational plan.

b) Develop its financial model.

c) Begin to develop a range of activity/financial scenarios in relation to the three strategic priorities and the “must do” work programme.

d) Complete a first cut of its financial planning for the five years beginning in April 08 for incorporation in the Operational Plan by the end of September. This will be the first draft of the LDP for 2008/9.

The planning assumptions on which budgets will be based, and the indicative financial envelopes within which investment will therefore be planned are detailed in Appendix 1.

7.2 Complete and implement a Communications and Public Involvement Strategy

The PCT believes that it is vitally important for the public and patients to be involved in the development and delivery of this strategy.

A draft Communications and Public Involvement strategy is therefore being developed that will outline the PCT's approach to communications and public involvement for the next 5 years. It will eventually be supported by an action plan but this will be developed at the end of the process and will involve the PCT's Communication and Public Involvement Group (CPIG).

The overall aim of the strategy will be to ensure that communications and public involvement activities support the PCT's key aim of:

> *Engaging the public effectively in the development of healthcare and wellbeing services in Oxfordshire.*

Confidence that we are delivering this will be achieved by obtaining feedback on the services we provide and commission in order to continually improve them and ensure they are responsive to people's needs , and by fully engaging with patients, carers and the public when we develop services. The steps we will take to complete work on this strategy are set out in Appendix 1.

7.3 Developing care outside hospital

The PCT is committed to commissioning the best possible services for the population. The national policy direction of increased choice, independence and services provided on a pathway basis supports the PCT's direction of travel for care outside of hospital.

We are also aware that demographic changes identified elsewhere in this document will place increasing demands upon the service and changes will have to be made to ensure that the PCT can commission 21st century services for the population.

To take forward the development of care outside hospital the PCT will be working with key stakeholders to develop a framework for the delivery of care outside hospital. These principles will cover areas including:

- What is appropriate to deliver in a community setting.
- What do people want/expect from community services.
- How these can principles help in the delivery of 'Our Health, Our Care Our Say which discussed providing people with more choice for local services.

- How we can make the most of technical advances which mean that clinical activity that was previously provided in a hospital setting can now be safely provided in the community.

- How we can best use the estate we have and how does this need to change to deliver these services.

These principles will cover areas including older people's services, long term conditions, and Out of Hours urgent care services.

Detailed business cases will then be developed for the services needed to deliver this framework in a range of localities and demographic groups. Immediate priorities will include:

a) Bicester Community Hospital and Townlands Hospital in Henley – both of which will have new services specified by the end of March 2008.

b) Chipping Norton Community Hospital, where new services are provisionally scheduled to open in 2009.

c) Developing older people's services across the County.

7.4 Community Health Oxfordshire

The PCT is committed to:

a) Ensuring that Community Health Oxfordshire plays an active role in delivering the three strategic commissioning priorities, and expects shadow contracts for relevant services to be in place from April 2008.

b) Undertaking a strategic review of its directly provided community health services and agreeing a long term business model for community health provision in Oxfordshire by March 2009.

The timetable and milestones for delivering these two objectives are set out in Appendix 1.

7.5 Strengthen and improve contracting, planning and market development

The PCT has identified three internal processes that need to become much more robust if it is to realise its ambition to become a truly world class organisation.

In addition to improving its own internal planning processes – of which creating this strategy is a significant first step – the PCT has also committed to working with partner organisations across NHS South Central, through the World Class Commissioning build, share, procure programme, to:

- Develop new commissioning contracts which will be used as standard across the region.

- Support the development of the provider market.

The approach we will be taking to progressing this work is set out in Appendix 1.

7.6 Model the likely impact of demographic change on demand for health services

Understanding the likely impacts of demographic change is essential to the planning of future health care services and preventative interventions.

The PCT – in partnership with the County Council – is launching a demographic modelling project that will be designed to answer a number of strategic questions including:

- What is likely to happen to patterns of health need and demand over the coming 5 – 10+ years?

- What is the impact of those changes likely to be in terms of health service utilisation, localities, and finances?

- What alternative scenarios can be modelled which address the challenge of demographic change in relation to ageing and trends of disease prevalence – through partnership initiatives, service re-design and re-configuration, and preventative / early intervention activity?

This work will happen in three phases – and the detail of each is expanded in Appendix 1:

a) Initial analysis – already completed and used to inform the development of the strategic aims and objectives set out in this strategy (July 2007).

b) Further analysis to inform the development of the Operational Plan for 2008/09 (September 2007).

c) Medium and long-term developments of modelling capacity and capabilities, utilising both in-house and external expertise (informing re-iterations of the PCT strategy, and operational plans, for 2009 onwards).

7.7 Develop an Estates strategy

As the PCT strategy develops and work is undertaken to develop a future model for community health services, we will begin to be able to determine the amount and type of facilities needed to deliver safe, affordable, quality services in appropriate locations across the County. The PCT estate needs to provide facilities that are fit for this purpose now and which will meet our future needs.

There is also likely to be an increase in joint service provision between the PCT and its partners, and in the variety of services provided at the client's home. Both these factors this will affect the sole and shared estate requirements of the PCT.

The estate provided needs to enable and enhance how services are delivered by ensuring the environment:

a) Improves the patient experience and staff working conditions.

b) Is accessible and can be flexible for future development.

c) Supports effective risk management.

d) Supports multi-disciplinary and partnership working.

e) Complies with current legislation and statutory requirements.

f) Is well managed and has a positive impact on the wider local environment.

Our success in delivering effective estates planning and management will be influenced by how much co-operative working on estates strategies can be achieved between public sector, partner organisations and the local authorities within the implementation of the local development frameworks in the respective localities.

A detailed estates strategy is being developed (see Appendix 1), and this will set out how these objectives are going to be achieved.

7.8 Agree and implement a three year organisational development plan

In order for the vision of Oxfordshire PCT to become a reality, leaders at all levels of the PCT must:

- Understand and be driven by the needs of patients and the public of Oxfordshire.
- Work in effective partnerships with others.
- Operate within the resources available.

To deliver these goals the PCT senior leadership must nurture and protect an environment that expects and empowers staff to work in this way.

Specifically this means:

a) The vision, strategic aims, values and strategic commissioning priorities of the PCT must be clearly communicated and understood.

b) Key roles and responsibilities must be clearly understood and communicated.

c) There must be a clear decision- making framework that is consistent with the PCTs strategy and values.

d) Effective team working will be essential at all levels, but in particular amongst senior leadership teams.

e) The Board and staff must understand and be driven by the needs of the people who receive services from the PCT.

f) Staff at all levels of the organisation must have the right skills and resources to do their job effectively.

The PCT is producing an Organisation Development (OD) Plan, which will be designed to ensure that we have the capacity and capability to work in this way. The OD Plan is due for completion by 30th September 2007 and will set out the steps which the PCT will take in order to deliver this overarching organisational development goal. The detailed work programme is set out in Appendix 1.

8 Measuring and monitoring our progress

If Oxfordshire PCT is going to demonstrate that it can deliver this strategy, then it will be crucial for the organisation to commit to a set of measurable goals, and to demonstrate, year by year, how well it is doing to deliver those targets.

The measurable goals – or objectives – that we propose to set for ourselves so that we succeed in delivering our aims are set out below.

8.1Governance arrangements

It is essential that all these objectives are measurable, and further work will be required to develop an appropriate method for measuring and monitoring progress of each one. This is likely to include a combination of performance indicators, audit and customer satisfaction tools.

Once appropriate mechanisms been agreed, individual Directors will be delegated the responsibility to ensure specific objectives are met. Information gathered by Directors will be reported to Board using the PCT balanced scorecard. These reports will enable the Board to hold Directors to account as appropriate.

Directors will also identify any potential risks that may result in the PCT failing to meet their objectives and will ensure adequate controls and action plans are in place where required. This information will be reported to the Board using the PCT Assurance Framework.

The Board will use all this information to monitor progress and ensure successful delivery of this strategy.

8.2 SMART Objectives

Aim 1
Commission safe, high quality services that promote wellbeing, reduce health inequalities, deliver improved health outcomes and secure excellent levels of patient satisfaction.

Objectives

a) Agree outcome measures and smart objectives for 3 strategic commissioning priorities and implementation plans by October 2007.

b) Develop an approach for a significant proportion of services to be commissioned through quality driven contracts with measurable patient outcomes by April 2009.

c) Increase life expectancy of Oxfordshire population by 1 yr by 2012.

d) Reduce inequalities gap by 10% by 2011 with a specific focus on children and young people.

e) Achieve patient experience/approval rating of good or excellent of at least 80% and increase levels of public satisfaction to at least 75% by 2011.

f) Ensure measurement and reporting of patient satisfaction is a contractual requirement with all providers by April 2009 and this is used to inform provider service improvement and commissioning decisions.

g) By the end of 2007 develop a framework to guide the future commissioning of all care provided outside acute hospitals across Oxfordshire.

h) Develop detailed proposals – based on this framework - for the commissioning of care provided outside acute hospitals in Bicester and Henley by March 2008.

Aim2
Engage the public effectively in the development of healthcare and wellbeing services in Oxfordshire.

Objectives

a) Complete work to develop and adopt Communication and Public Engagement strategy by December 2007 and work in partnership with PBC consortia to deliver the key performance indicators (KPI's) set out in that document from March 2008 onwards.

b) Ensure that the KPIs in the Communication and Public Engagement strategy relate to strengthening patient and public involvement in :
   - Development of PCT commissioning strategies
   - Development of policies relating to Choice
   - Action to promote health and wellbeing
   - Sharing the knowledge and skills required to enable people to support their own health and wellbeing more effectively.

c) Conduct a baseline survey (in collaboration with other South Central PCTs if appropriate) of public satisfaction with health services by March 2008 and set targets for improvement in the light of findings.

Aim 3
Strengthen the role and influence of clinicians in improving services, through the development of Practice Based (PBC) and other forms of commissioning

Objectives

a) By March 2009, understanding and ownership of PBC has become embedded across the wider primary care community.

b) By March 2010 PBC consortia leads are effectively engaged in developing and contributing to the delivery of the 3 top strategic commissioning priorities.

c) By March 2010 PBC commissioners are routinely and actively engaged in the development of service specifications, and awarding of contracts, in support of agreed service redesign initiatives.

d) PBC and other clinical commissioning capability, understanding and skills will have developed sufficiently by March 2010 to be driving future strategic change and priority setting in partnership with the PCT.

e) By March 2010, PBC consortia are taking an active role in defining, and holding providers to account for delivering, performance outcomes and quality measures.

f) The PCT will be able to demonstrate effective clinical influence on decisions affecting 75% of all commissioning spend by March 2009.

g) PBC consortia across Oxfordshire will – between them - be able to demonstrate that they have actively participated in ensuring that at least 20 service redesign proposals have been successfully implemented by March 2010.

Aim 4
Improve partnership working in order to deliver properly integrated services and to improve health outcomes for vulnerable communities

Objectives

a) Establish Health and Wellbeing Partnership Board by end 2007.

b) Work to ensure that all partnership bodies or groups of which the PCT is a member have strategic objectives and plans that contribute measurably to the strategic aims of the PCT by March 2010.

c) Ensure that the PCT strategy and Oxfordshire Sustainable Communities Strategy are aligned in time to inform 08/09 detailed PCT and County Council service planning.

d) Ensure that the geographical areas identified for delivery of the PCT strategic commissioning priority for children and families are aligned with the priority areas due to be selected by the County Children and Young People's Board in Autumn 2007.

e) Ensure that the priorities of the PCT strategy are included as explicit targets in the second Oxfordshire Local Area Agreement by March 2008.

f) Develop an explicit mechanism for ensuring that the PCT's strategic commissioning priorities for 2009/10 10/11, 11/12, and 12/13, complement those of its key commissioning partners.

Aim 5
Support the development of PCT, wider NHS and other providers of health and social care services, so that they and their staff can meet our commissioning requirements and there is greater choice available to patients

Objectives

a) By March 2009 agree the most appropriate framework for the long term governance and delivery of Oxfordshire Community Health Services.

b) By April 2009 put in place specific outcome based contracts with those provider organisations responsible for delivering agreed care pathways.

c) Agree a collaborative approach to market development with other South Central PCTs by March 2008.

d) By March 2009 achieve a demonstrable reduction (measured through change in patterns of investment) in reliance on hospital based monopoly providers for diabetes services.

e) By April 2009, develop and implement a strategy to enable smaller provider organisations (e.g. primary care providers, PCT provider services and voluntary sector organisations) to compete equally for contracts, either as solitary providers or in partnership. This should increase the number of providers over and above 07/08 baseline by 2010 – so improving patient choice.

Aim 6
Establish the PCT as a highly effective and innovative organisation – one that has a workforce that is well placed to deliver on its strategy.

Objectives

a) The PCT will adopt a 3 year Organisational Development plan by November 2007 and will deliver the annual KPIs that this specifies.

b) The PCT will achieve full compliance with the core Healthcare Commission standards annually from April 2008 onwards, and will work towards compliance with developmental standards.

c) The PCT will achieve all other relevant national targets and standards from April 2008 onwards.

d) The PCT will be rated green on all World Class Commissioning Quality Assurance standards by March 2010.

e) The PCT will demonstrate year on year improvement in public approval rating for effective leadership in Oxfordshire on health and health services.

f) The PCT will achieve its statutory financial duties each year.

g) PCT will be recognised by the public as providing effective leadership on health issues for Oxfordshire by 2010.

9 Conclusion and next steps

This is the first public draft of Oxfordshire PCT's five year strategy. It is the first five year health strategy that the County has ever had, and marks an important turning point in the way we plan for the development and delivery of local NHS services.

This strategy will not be finalised or formally adopted until November 2007, and over the coming months we will be:

a) Seeking the views of our staff, our partners, patients and the public on the plans set out here.

b) Developing a five year financial plan that demonstrates the affordability and deliverability of this strategy, and that establishes some longer term investment and disinvestment principles.

c) Putting together a detailed Operational Plan that :

- Sets out how we are going to implement the delivery of this plan in 2008/9.
- Will form the basis of detailed negotiation with our partners about how NHS resources are allocated across Oxfordshire in the next financial year.

d) Finalising an organisational development plan which will set out how we ensure the new PCT has the capacity and capability to deliver its vision of an Oxfordshire where local people will:

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

Appendix 1 – Delivering the enabling work

A. Financial planning

1. Financial planning assumptions

The PCT is assuming that:

a) There will be growth of 3% in NHS funding from government from 2008/09 onwards.

b) Gross inflation will be 4% from 2008/09 onwards.

c) The Department of Health will expect all NHS bodies to meet an efficiency target of 3% from 2008/09 onwards.

d) It may pursue additional whole system financial improvement strategies in Oxfordshire order to increase available balance for investment on ongoing basis.

e) There may continue to be system-wide pooling of resources (possibly through the use of a reform fund) but overall this will be neutral with expenditure on the PCT population matching our contribution.

f) 50% of the 2007/8 top slice will be returned in 2008/9. This represents the assumption that the other half will be spent during 2007/8 on agreed projects.

g) It will budget to maintain a contingency of 0.5% of the recurrent baseline.

h) It will budget to maintain a recurrent surplus of 1% of the recurrent baseline.

i) The recurrent surplus will only be used on a non recurrent basis e.g. to pump prime progress on strategic priorities.

j) It will budget to break even each year.

k) The balance available for investment will be the balance remaining after all the above assumptions have been taken into account.

l) The balance for investment has to meet identified pre-commitments and fund the costs of the PCT's strategic priorities.

m) The PCT will plan for standard NHS efficiency either through contracts with providers or on directly provided services. Additional efficiencies / cost improvement plans may be developed as part of emerging commissioning business cases.

n) Capital – The financial plan does not assume additional capital funding over and above the PCTs normal block capital allocation (c£1.5m). It is expected that any significant investment in Primary Care / Community based facilities will be funded by non-NHS sources of funds such as LIFT and as such will be accounted for within revenue planning.

2. Indicative balance for investment

ASSUMPTIONS	**2007/08**			**2008/09**			**2009/10**			**2010/11**			**2011/12**			**2012/13**		
	R	NR	Total	R	NR	Total	R	NR	Total	R	NR	Total	R	NR	Total	R	NR	Total
Growth (%)	9.8%			3.0%			3.0%			3.0%			3.0%			3.0%		
Top Slice (%)		0.5%			0.0%			0.0%			0.0%			0.0%			0.0%	
Inflation (%)	5.0%			4.0%			4.0%			4.0%			4.0%			4.0%		
Efficiency (%)	-2.5%			-3.0%			-3.0%			-3.0%			-3.0%			-3.0%		
Technical Changes (%)																		
Pre Commitments (%)	0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%	
Investments (%)	0.0%	0.0%		1.2%	1.6%		2.0%	0.9%		2.0%	1.0%		2.0%	1.0%		2.0%	1.0%	
Contingency (%)	0.5%			0.5%			0.5%			0.5%			0.5%			0.5%		

LDP ANALYSIS OF GROWTH DISTRIBUTION	**2007/08**			**2008/09**			**2009/10**			**2010/11**			**2011/12**			**2012/13**		
	£'000 R	**£'000** NR	**£'000** Total	**£'000** R	**£'000** NR	**£'000** Total	**£'000** R	**£'000** NR	**£'000** Total	**£'000** R	**£'000** NR	**£'000** Total	**£'000** R	**£'000** NR	**£'000** Total	**£'000** R	**£'000** NR	**£'000** Total
Recurrent Allocation	745,371		745,371	767,732		767,732	790,764		790,764	814,487		814,487	838,922		838,922	864,089		864,089
Growth	(64,093)		(64,093)	(22,361)		(22,361)	(23,032)		(23,032)	(23,723)		(23,723)	(24,435)		(24,435)	(25,168)		(25,168)
SHA Top Slice (Net)		(4,951)	(4,951)		(5,456)	(5,456)		0	0		0	0		0	0		0	0
Repayments & underlying position		22,758	22,758	(18,557)		(18,557)	(7,677)		(7,677)	(7,908)		(7,908)	(8,145)		(8,145)	(8,389)		(8,389)
Inflation	17,620		17,620	6,192		6,192	6,637		6,637	6,903		6,903	7,179		7,179	7,466		7,466
Pre Commitments	24,279	750	25,029	17,740	500	18,240	0	400	400	0	300	300	0	200	200	0	100	100
Investments																		
Balance for Investment			0	9,107	12,633	21,741	16,049	7,508	23,557	16,464	7,845	24,309	16,889	8,189	25,078	17,324	8,541	25,865
Sub-Total (Surplus) / Deficit before Contingency	**(22,194)**	**18,557**	(3,637)	**(7,879)**	**7,677**	(202)	**(8,023)**	**7,908**	(115)	**(8,263)**	**8,145**	(119)	**(8,511)**	**8,389**	(122)	**(8,767)**	**8,641**	(126)
Contingency (maintenance of defined % of baseline)	3,637		3,637	202		202	115		115	119		119	122		122	126		126
(Surplus) / Deficit	**(18,557)**	**18,557**	**(0)**	**(7,677)**	**7,677**	**0**	**(7,908)**	**7,908**	**0**	**(8,145)**	**8,145**	**0**	**(8,389)**	**8,389**	**0**	**(8,641)**	**8,641**	**0**

Inflation Sensitivity																		
Movement (£'000) per 0.5% change in gross inflation rate				3,096			3,319			3,451			3,590			3,733		

B. Communications and public involvement strategy

1) The strategy will set out how we will:

a) Improve the quality of information provided by the PCT with clear and consistent messages written in plain language.

b) Enable patients, carers and the public to have a greater say in decisions about their own care, the development of local health services and about how health services are commissioned for the local population.

c) Develop the expertise necessary to ensure the involvement of patients, carers and the public by all PCT staff and that all staff can meet their responsibilities for communications as set out in this document.

d) Develop a culture that promotes open communication throughout the organisation, which in turn encourages excellence in communicating with all stakeholders.

e) Ensure the PCT adopts current best practice and strives to create best practice to meet the requirements of Section 11 of the Health and Social Care Act 2001, working closely with partner organisations including:
   - Oxfordshire PCT Patient and Public Involvement Forum (PPIF)
   - Oxfordshire Health Overview and Scrutiny Committee (HOSC)
   - Local Strategic Partnerships (LSP)
   - Local Compact/Voluntary sector organisations
   - Local authorities
   - Other healthcare provider organisations.

f) Develop methods for systematic feedback for patients and dissemination of feedback throughout the PCT.

g) Promote good public relations and to increase public and staff confidence in the PCT and local health services.

h) Provide timely and accurate information about the PCT to its intended audiences.

2) Timetable for developing the Communications and Public Involvement strategy.

This work is already underway and the major milestones agreed are:

a) Draft strategy shared with directors for comment 14 July.

b) Draft strategy onto the PCT website with feedback option 21 July 2007

c) Staff invited to comment via staff bulletin linked to strategy.

d) Draft strategy shared with key stakeholders, comments invited.

e) Workshop in September to consider feedback and agree changes.

f) Establish CPIG to oversee the implementation of the strategy and action plan. Chaired by a NED.

g) Establish a wider 'Reference Group' from staff and patients/public who would be interested in working with the PCT on specific projects from the action plan.

C. Care Outside Hospital

Outcome/process step	Completion date	Process
PCT strategy	September 2007	Internal and external stakeholder engagement including HOSC and PPI involvement
Framework and Commissioning Principles for Out of Hospital Care debated at PCT Board Workshop	October 2007	Stakeholder engagement to include HOSC and PPI Sept 2007
Application of approved Principles to localities of Oxfordshire in agreed sequence	Bicester: Oct 2007-Feb 2008	Process to include: ▪ Understanding what the health (and linked social care) needs are ▪ Exploring options for delivering these ▪ Determining what this may mean for current services ▪ Exploring options for sites for services NB: much of this work has been done for Bicester and so we will not need to start again but simply build on this and enhance it.
Strategy and Business Case for health services for Bicester presented to PCT Board	March/April 2008	
Strategy and Business Case for health services for Henley presented to PCT Board	May/June 2008	

D. Community Health Oxfordshire

Community Health Oxfordshire will be fully involved in developing and delivering the strategic commissioning priorities set out in this strategy. It will also be involved in a detailed project to determine a viable future business model that will ensure the stable long term development and delivery of community health services for Oxfordshire. The major milestones in this work are likely to be:

September 2007

- Review of current services completed and reported to Board, with recommendations to move to shadow contracting arrangements for specified services.

October 2007

- Care outside hospital framework will give clear signal of commissioning intent for community health services.

November 2007

- Complete and implement Performance Management Reporting framework for Community Health Oxfordshire and submit first completed report to Board.

January-March 2008

- Initial response to care outside hospital framework and its probable impact on Community Health Oxfordshire reviewed on a locality by locality basis.

April 2008

- Community Health services operating within shadow contracting relationship and governance arrangements with commissioning arm of PCT.

April- June 08

- Possible options for future business models agreed in outline, in consultation with all relevant parties.

June-August 08

- Detailed options appraisal carried out – measuring each option against criteria established in care outside hospital framework.

September-December 08

- Detailed business case developed for preferred option – which may include a variety of solutions for different aspects of the service.

December 08-February 09

- 3 month formal consultation on preferred option (if required).

March 2009

- PCT Board agrees preferred option and action plan for delivering it.

E. Strengthen and improve contracting, planning and market development

1) Contracting

Oxfordshire PCT's ambitions for this work are that it should enable it to adopt contracts, from April 2009, that allow it to:

- Purchase whole pathways of care.
- Purchase defined outcomes based on defined activity.
- Specify and measure the quality of services it wishes to purchase.
- Measure patient satisfaction.
- Collect and use data that will allow it to measure progress on delivery of this strategy and inform future financial planning by age, geography, disease and organisational spend.

Once the Build, Share, Procure work is a little more developed, the PCT will review its internal arrangements for negotiating, managing and using contracts – as it recognises the pivotal importance of contracts as a tool for driving up the quality, accessibility, safety and appropriateness of the services it commissions.

2) Market development

Driving up the quality and accessibility of healthcare services will depend in no small measure on helping to strengthen the organisations that provide them. This will entail:

- Performance management.
- Provision of organisational development support.
- Encouragement of competition.
- Identification of gaps in the market and proactive work to fill them.
- Support for the development of regional specialty service providers.

The Build, Share, Procure programme is developing a business case that will set out how this function can be provided regionally , and once the services that are going to be provided at a South Central level are defined, the PCT will agree it's local market management role and objectives, and will put in place the resources to deliver these.

3) Planning

Agreeing and adopting this strategy will mark a significant improvement in the PCTs planning. However, the process of creating this strategy has highlighted a number of ways in which planning needs to be improved further. Over the next twelve months the organisation will therefore put in place:

- A robust decision making matrix based on agreed and weighted criteria.
- An annual planning cycle that sets out a process for future prioritisation.
- Clear mechanisms for involving staff, patients, the public and partners in the development of future plans.
- An audit of strategic and other planning work being undertaken across the organisation.
- A clear framework for ensuring that this work is effectively joined up.
- Clear lines of accountability and mechanisms for ensuring effective joint and complementary planning with commissioning and provider partners.

F. Demographic and health needs modelling

The PCT is planning a programme of demographic modelling to:

- Explore what might happen if current patterns and trends of health need / demand are replicated in the future, but with a larger / older population (projecting forward).

- Inform scenario planning about strategic options for health spending and return on investment – this would focus on simulating the impact of alternative service strategies, public health interventions, and the effect of (for e.g.) medical technology advances and lifestyle changes (both positive and negative).

The work on demographic modelling in relation to the PCT's strategy falls into three stages and stages 1 and 2 will involve further partnership work on demographic modelling, as outlined below.

1) Initial analysis

This analysis is now complete and informed the Director of Public Health Annual Report and the PCT Board's choice of Strategic Aims and Commissioning Priorities as set out in this strategy. It focused on the older people's population growth and its impact on 'straight-line' projections of current utilisation rates. This work is based on population projections and rates of secondary care utilisation by specialty and programme budgeting category.

2) Operational Plan 2008/09

The demographic modelling input to the Operational Plan will be undertaken in conjunction with the preparation of the 5-Year Financial model. It will build on the initial analysis, and take account of the following inputs:

- Current activity and spend analysis by age group and service-sector (GMS, Community, Prescribing, Secondary, Mental Health & LD).

- Population projections for agreed boundary definitions and factors, ensuring a consistent approach with partner organisations.

- Top-level trend analysis of disease prevalence and lifestyle issues, by age group, drawing on existing health profile analysis.

These inputs will provide a more comprehensive base-line of activity and cost by age-group, and will support further modelling, with Commissioning and Public Health input, of alternative service strategies and interventions to provide activity and cost projections.

3) Building capacity and capability to model demographic change with partners

The initial analysis inputs to the Strategy and Operational Plan represent an advancement on earlier modelling but do not apply methods that allow for complex and multiple variables to be to taken into account, with degree of probability identified. The new PCT, working in partnership with the County Council and accessing expertise from external resources (e.g. SEPHO, PWC, academic research programmes etc) will develop modelling capabilities that support:

- Cost-benefit analysis of alternative service strategies and interventions.
- Scenario building of different rates of change in disease prevalence, lifestyle factors, and the impact of technology advances.
- Modelling across the health and social care system.

More advanced methods of modelling will explore and develop the use of key tools, for example:

- Factor analysis and Principal components analysis – statistical methods that enable multiple variables and their relationships to be factored into a model.
- Years of Life lost, QALYs (Quality Adjusted Life Years) – analysis supporting cost-benefit evaluations.
- Programme budgeting, a categorisation of health service activity that enables linkage and correlation of health spend with outcomes, also supporting cost-benefit analysis.
- Computational simulation models, e.g. MoSeS (Modelling and Simulation for e-Social Science, Leeds University), based on a synthetic model of a population which is then the basis for dynamic modeling of complex variables and factors, and building of alternative scenarios.

Two connected processes are being established to progress this work;

a) **PCT demographic modelling task-group** – membership including Public Health, Commissioning, Finance and Decision Support. The short-term priority for this group will be to lead the demographic modelling input for the Operational Plan, with close connections to the development of the 5-Year Financial model.

b) **Partnership group** (being convened by Nick Welch, Social & Community Services) involving the PCT (Commissioning, Planning & System Reform, Public Health, Decision Support), County Council, SEPHO, Oxfordshire Data Observatory: will address issues of joint interest in the development of consistent, modelling approaches that enable a system-wide perspective.

G. Estates strategy

1) Current position

The PCT commissions primary and community services from a varied number of providers on different sites. Some of these sites are owned by the PCT, some are leased by the PCT, and others are owned or leased by other parties.

The current estate portfolio across Oxfordshire is summarised in the Table below.

	PCT Freehold	PCT Leased
Health Centres*	15	20
Community Hospitals	9	2
Administrative buildings**	2	7

*Includes priority dental clinics
**Will include admin bases occupied by clinical staff with no patient or clinical activity in the building

2) Work committed to over the next 2-3 years includes:

a) Rationalisation of the PCT head quarter portfolio to a smaller and more efficient configuration.

b) The provision of a new community hospital service in Chipping Norton.

c) The provision of a new Health Centre in the centre of Oxford city through a long term lease contract with the University.

d) The development of a new hospital and community health facility in Bicester.

e) Doing feasibility work and assessing potential space for diagnostic procedures and Practice Based Commissioning activities in the identified localities.

f) Reviewing service needs and estate provision in Henley, including reconfiguration of Townlands Hospital.

3) Next steps

Key issues for the capital development team to address over the next 12 months are to:

a) Complete audit of primary care estates provision by September 2007 to inform development of the care outside hospital framework.

b) Develop an up to date Planned Preventative Maintenance (PPM) plan to ensure adequate resources are allocated to address the back log of maintenance on PCT freehold properties.

c) Put in place effective performance management of Estates and IM&T Services contracts.

d) Gather baseline information on all PCT facilities which can inform the development of the estate strategy aligned with the service and commissioning strategy.

e) Establish an Environmental Management Strategy group which will focus on energy targets and Green Transport plans in the first instance.

f) Implement a programme to assess the optimal utilisation of space for both services provided and commissioned by the PCT, the condition of this space, the utilisation rate and associated cost of this space and the subsequent development of a business model that reflects related revenue consequences and impact.

g) Create an enabling environment and infrastructure for flexible working for all staff with specific reference to remote access for multiple site and home working options for individuals.

h) Implement the year on year maintenance and capital investment programmes effectively.

3) We will do this by:

a) Commissioning surveys on statutory items of all facilities with specific focus on Fire Risk Assessment and Health & Safety aspects.

b) The development of a prioritisation tool which will apply to all capital bids to ensure an auditable and proper decision making process is in place to authorise implementation of the capital plan on an annual basis (short term) and ensure continuity of investment in following years (medium term) which take cognisance of previous spending.

c) Procuring appropriate software to record and manage the information, including early warning module on statutory and 6 facet survey items as part of the estate information system.

d) Modelling efficiency targets around utilisation and associated revenue impact and investment demand Vs potential output.

e) Maintaining close links with commissioning and community services leads, to ensure all work undertaken meets their requirements.

f) Developing and maintaining formal and informal partnerships with supplier and stakeholder organisations, in order to co-ordinate and combine expertise, manpower and resources and to deliver an integrated approach to health and social care. This will include maintaining an ongoing relationship with LIFTco (Oxford Infracare LIFT limited) through a Strategic Partnering Agreement and Lease Plus Agreements.

H. Organisational development

1) Establishing an OD priority

The PCT has agreed a single overarching OD goal, which is that:

Leaders at all levels of the PCT must:

- **Understand and be driven by the needs of patients and the public of Oxfordshire**
- **Work in effective partnerships with others**
- **Operate within the resources available.**

To deliver these goals the PCT senior leadership must nurture and protect an environment that expects and empowers staff to work in this way.

The table below sets out the process by which this goal was developed:

Process	When	Who was involved	Outcomes
An email survey was sent out to staff asking for their feedback on the PCT's draft mission, vision, strategic aims and values. The survey also asked staff to specify what they thought the characteristics of a "leading-edge" organisation were (the PCT's proposed 6th Strategic Aim) and how they thought the PCT was currently performing in relation to these characteristics.	21st May 2007	The PCT Board, the Clinical Executive, the Strategy Project Team and the PCT "Heads of" group	Data from the email survey was analysed and cross-referenced against the Fitness For Purpose report and the WCC Baseline report. 7 themes were identified and shared with the Executive Team.
The 7 themes were shared at a staff briefing and staff were asked whether the themes accurately summarized the OD needs of the PCT (if not, what needed to be added or taken away) and to rank the themes in order of priority. For those staff that were unable to attend the briefing (e.g. staff from provider services), the themes and task were sent out via email to senior managers with a request that they cascade the information to their colleagues and/or discuss it in team meetings.	15th June 2007	100 staff from across the PCT attended the briefing plus 7 staff respondin g directly to the email	The number one Organisation Development priority that emerged from this exercise was "LEADERSHIP" (prioritised in 7 out of the 10 groups)
Senior leaders were asked to reflect upon the PCT's 3 proposed strategic commissioning priorities, together with	28th June 2007	The PCT Board, the Clinical	The senior leaders identified "LEADERSHIP" as

Process	When	Who was involved	Outcomes
their mission, vision, strategic aims and values, and asked to consider what the organisation needed to be really good at in order to achieve these. Then they were asked in groups to rank their top 4 priorities and rate where they thought the PCT was currently in relation to achieving these.		Executive and the Strategy Project Team.	their top priority (prioritised by 2 out of 3 groups). This outcome was consistent with the data from the staff email survey and briefing (see above).

2) Getting from "Leadership" to an agreed OD priority

The term "Leadership" means different things to different people and is a vast area to address. To refine and define the work required to develop leadership the PCT reviewed the raw data from the email surveys, the staff briefing and the Board workshop to clarify exactly how staff wanted their leaders to behave in order to successfully deliver the PCT's vision, strategy and strategic commissioning priorities. A leadership model developed by Hawkins and Smith (2006) was used to help structure our thinking (see below).

Although every one of the areas identified in the diagram was rated as important by staff, several areas emerged consistently as being critical to achieving the PCT's goals. These were the need for:

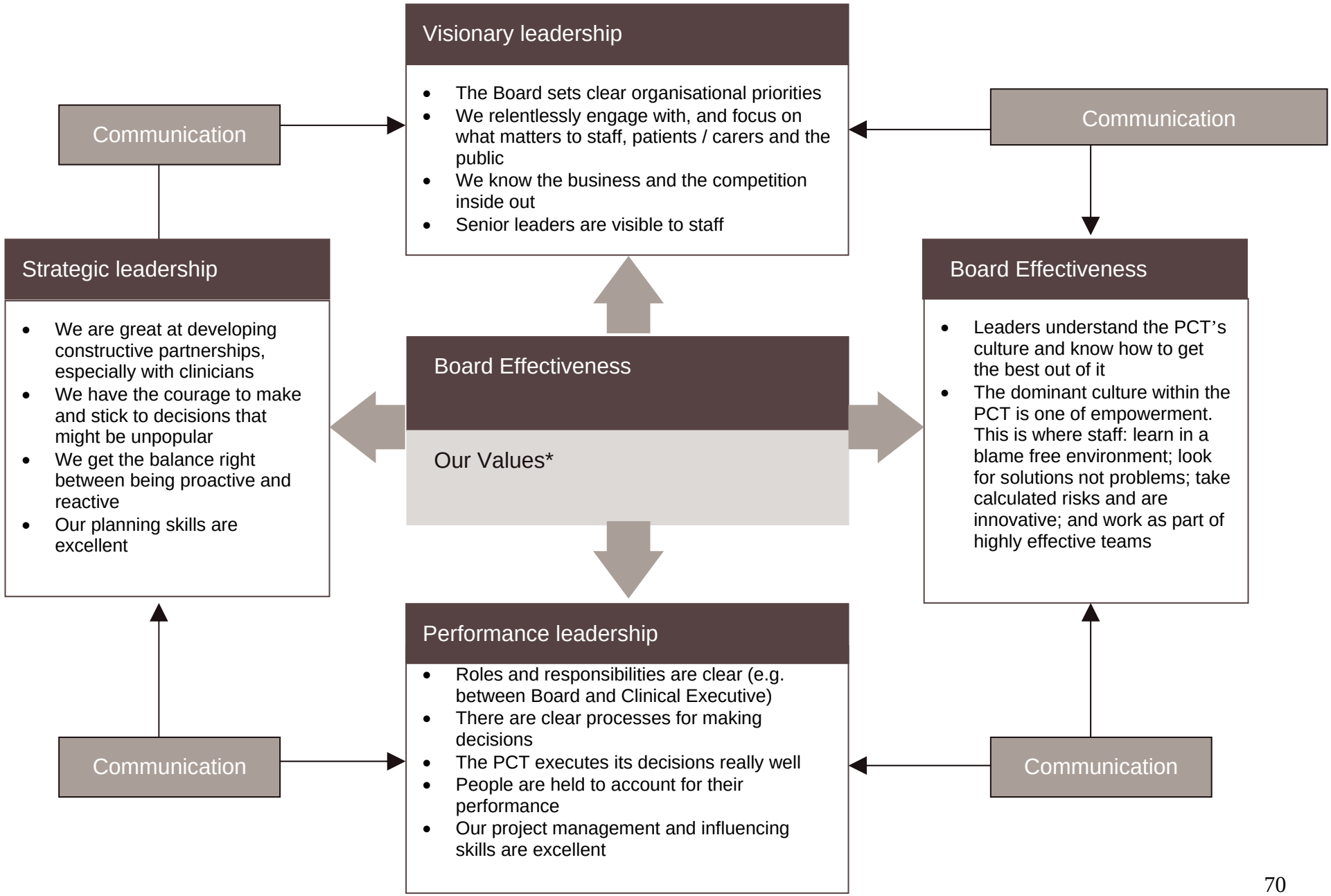
1. Effective leadership at all levels of the organisation.
2. Leaders to understand and act on the needs of patients and the local population.
3. Leaders to work in partnership with others, including other staff within the PCT and clinicians.
4. Senior leaders (i.e. the Board, Executive, Clinical Executive and Heads group) to create and sustain an environment within the PCT where 1, 2 & 3 can thrive. Staff repeatedly mentioned effective communications as a key feature of this environment.

Staff believed that focusing on areas 1 to 4 above would have a positive impact on all the other areas identified in the leadership framework below.

3) Work programme to deliver completed OD plan by September 30th 2007

Task	Date achieved by
1. Identify the specific objectives required to achieve each of the PCTs 6 broad aims	20th July
2. For each step identify the time period for delivery	20th July
3. Establish frequency and mechanism for reporting on progress to Strategy group / Directors / Board and build dates in to project plan	20th July
4. Manage the interface with the NHS Institute regarding	20th July

Task	Date achieved by
the ' Building a Learning Organisation' development programme scheduled to commence within the PCT in September 2007	
5. Establish project steering group with membership from across the PCT.	27th July
6. Establish focus group to look at what needs to change to ensure that the PCT's leaders are more patient centred	3rd August
7. Establish focus group to look at what needs to change to ensure that the PCT 's leaders work in constructive partnership with all others	3rd August
8. Identify the steps that require further detailed work, and draft the actions that will be taken to successfully drive the priorities forward. (Activity Plan)	3rd August
9. Identify any information gaps and how they will be filled	3rd August
10. Start to draft OD template which will include the following sections: Section 1 Organisational and strategic context Section 2 Key OD priorities – to include data sources that PCT has used Section 3 Testing the priorities Section 4 Guidelines for creating successful implementation Section 5 Activity Plan Section 6 Measurement	3rd August 3rd August 3rd August 10th August 17th August 17th August 17th August
11. Test out the priorities and detailed activity plan through engagement with the senior team and key stakeholders, to ensure it continues to match the change requirements considered critical to achieving the PCT's goals.	10th August
12. Define the steps that will be required to ensure successful implementation of the OD Plan e.g. engagement strategy, governance structure	10th August
13. Review the activity plan to ensure all actions have the requisite detailed information to demonstrate that the activity has been fully scoped, resourced and monitoring mechanisms are in place.	17th August
14. Identify and agree input measures i.e. those measures / processes that enable the PCT to track progress during the changes and output measures i.e. those measures / processes that define the successful outcome of the change	17th August
15. Submit first full OD plan	24th August
16. Further sharing, engagement	7th September
17. Refine	21st September
18. Agree and sign off at Board	27th September
19. Submitted to SHA	30th September


Visionary leadership
The Board sets clear organisational priorities
We relentlessly engage with, and focus on what matters to staff, patients / carers and the public
We know the business and the competition inside out
Senior leaders are visible to staff
Communication
Communication
Strategic leadership
We are great at developing constructive partnerships, especially with clinicians
We have the courage to make and stick to decisions that might be unpopular
We get the balance right between being proactive and reactive
Our planning skills are excellent
Board Effectiveness
Our Values*
Board Effectiveness
Leaders understand the PCT's culture and know how to get the best out of it
The dominant culture within the PCT is one of empowerment. This is where staff: learn in a blame free environment; look for solutions not problems; take calculated risks and are innovative; and work as part of highly effective teams
Performance leadership
Roles and responsibilities are clear (e.g. between Board and Clinical Executive)
There are clear processes for making decisions
The PCT executes its decisions really well
People are held to account for their performance
Our project management and influencing skills are excellent
Communication
Communication

Appendix 2 – Glossary

A&E	Accident and Emergency
BME	Black and Minority Ethnic
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Services
CHD	Chronic Heart Disease
CPIG	Communications and Public Involvement Groups
DPH	Director of Public Health
DVT	Deep Vein Thrombosis
ENT	Ear Nose Throat
GMS	General Medical Services
GP	General Practitioner
GUM	Genito-Urinary Medicine
HOSC	Health Overview and Scrutiny Committee
IM&T	Information Management and Technology
KPI	Key Performance Indicators
LAA	Local Area Agreement
LD	Learning Disability
LDP	Local Delivery Framework
LIFT	Local Improvement Finance Trust
LSP	Local Strategic Partnerships
LTC	Long Term Condition Management
MoSeS	Modelling and Simulation for e-Social Sciences
NED	Non Executive Director
NHS	National Health Service
NSF	National Service Framework
OD	Operational Development
ONS	Office of National Statistics
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PPIF	Patient and Public Involvement
PPM	Planned Preventative Maintenance
PWC	Price Waterhouse Coopers
QALY	Quality Adjusted Life Years
SCG	Specialist Commissioning Group
SEERA	South East England Regional Assembly
SEPHO	South East Public Health Observatory
SHA	Strategic Health Authority
SOA	Super Output Area
WCC	World Class Commissioning