Chapter 5

Service Development Plans

5. Service Development Plans

Introduction

5.1 OUH's ambition to deliver high quality care, its market assessment and the economic climate all require it to continue to adapt its services, to reduce cost wherever possible and to improve its use of estate and facilities while continuing to innovate in the delivery of clinical services.

5.2 Chapter 3 outlined a clinical services strategy which will, in continuing liaison with its commissioners, inform the Trust's development of services on each of its sites and in some cases further afield.

5.3 Significant investment in recent years has enabled many of OUH's services to operate from state-of-the-art facilities at the new Churchill Hospital, including the Oxford Cancer Centre; the West Wing, Children's Hospital and Oxford Heart Centre at the John Radcliffe Hospital; and the Nuffield Orthopaedic Centre. All provide scope for service development within the building fabric available.

5.4 OUH's Estates Strategy recognises that investment is required in the Trust's non-PFI estate, notably at the John Radcliffe and Horton General sites. The Trust's capital programme includes developments to improve facilities for care delivery on each site.

5.5 OUH plans to transform its service delivery through actions including realising benefits from the Electronic Patient Record, developing increasingly integrated local care with local providers and commissioners, providing specialised care through networks and, last but not least, a strong partnership with the University of Oxford and others to promote healthcare research and innovation and their rapid adoption into routine clinical practice.

Strengths, Weaknesses, Opportunities and Threats analysis

5.6 The Trust has considered strengths, weaknesses, opportunities and threats at Board seminars and in Divisional and Directorate Business Plans developed through its annual business planning process. The resulting analysis is shown below.

Strengths		
Factor	**Supporting evidence**	**Implications**
Clinically-led organisation	Clinically-led management structure is embedded. Clinical leaders supported in role through a leadership programme. Engagement between the Board and Divisions.	Autonomy and accountability for decision-making is vested in those best placed to balance the drive for improvement in quality, outcome and patient experience with the need to improve efficiency.
Comprehensive portfolio of services with high levels of subspecialisation	Few local referrals are directed outside Oxfordshire. Good clinical links between paediatric and adult services. MDTs in all cancer tumour groups. Range of nationally-commissioned subspecialties in Neurosciences and a high range of specialisation in Paediatric Services.	Comprehensive offer to local commissioners, GPs and patients. Infrastructure in place to support specialised services and continued designation.

Strengths		
Factor	**Supporting evidence**	**Implications**
Established tertiary centre with strong clinical network arrangements with surrounding hospitals	Provision of in-reach and out-reach services. Jointly funded consultant appointments e.g. in Neurology and Plastic Surgery. Oxford Academic Health Science Network hosted by OUH.	Support to referral base for specialised services. Extension of partnership working arrangements with a network including health and social care providers, commissioners, universities and other academic groups, third sector, life science industries, business, the public and patients.
Strong reputation for quality of care and treatment, including the use of innovative techniques	Patient comments through PALS contacts, patient panel feedback and "Let us know your views" leaflets. Inpatient survey. Friends and Family Test information. Good clinical outcomes in e.g. cancer, stroke, transplantation. Innovative use of radio-chemotherapy, robotic surgery, cardiac imaging and transplantation.	Encourages patients and GPs to consider OUH as provider of choice. Supports the Foundation Trust membership drive. Requirement to publish comparative data and feedback will influence choices of patients, carers and GPs. Strong basis on which to market services to commissioners and patients and to attract research funding and partners.
Reputation for excellence in teaching, training and research activity	Biomedical Research Centre and Biomedical Research Unit status. HEFCE Research Assessment Exercise (RAE) ratings. Top ratings for student experience in Oxford Medical School. Trust linked with Oxford brand.	Able to attract students and high calibre staff, including recognised clinical leaders, from global market. Increasing medical and non-medical research activity to support innovation, evidence-based practice and research in care. Translational research enabling innovation in clinical practice. Opportunities for patients to participate in clinical trials.
State-of-the-art facilities including high percentage of single rooms and latest technology	New Churchill Hospital, Nuffield Orthopaedic Centre and (at JR) West Wing, Children's Hospital, Oxford Heart Centre, Trauma Centre and part of Acute General Medicine. Approximately 50% of patient care estate is under eight years old. Beam matched linear accelerators; da Vinci surgical robot; core automated laboratory.	Investment made in key service areas. Quality of facilities offers opportunity to attract referrals.

Strengths		
Factor	**Supporting evidence**	**Implications**
Involvement in key academic health institutions	Joint Working Agreements with University of Oxford and Oxford Brookes University identify work streams for collaboration. Oxford Academic Health Science Centre partnership. Oxford Academic Health Science Network hosted by OUH.	Strong local focus to promote integrated working and adoption of innovation in healthcare delivery. Improved reputation, improved translation of basic research to applied research and patient benefit. Platform for collaborative working across health and social care, academic institutions, biomedical and biotechnology organisations, business and the third sector.

Weaknesses		
Factor	**Supporting evidence**	**Implications**
Access standards not consistently achieved in some areas	Breaches of standards for A&E four hour waits, 18 week referral to treatment time and some cancer standards.	Adverse patient experience. Additional costs, compounded by rising penalties for performance standards not met and the national tariff for non-elective care. Adverse impact on Trust's ability to vacate unsuitable facilities. Adverse impact on GPs and commissioners. Action to tackle delayed transfers (see below). Redesign of care for older people.
Areas for improvement in systems and processes identified from patient feedback	Comments, complaints and PALS contacts in relation to outpatient booking processes and discharge information and delays. Picker Inpatient survey.	Adverse patient experience. Adverse impact on choice by patients, GPs and commissioners. Action on outpatient service redesign. Implementation of Trust-wide patient feedback system to identify and prompt timely action on emerging issues.
Delayed transfers of care	Delayed Transfers of Care. Evidence that waits in the Trust's Emergency Departments closely match limitations on flow to inpatient beds. Cancelled operations.	Adverse patient experience. Adverse impact on GPs and commissioners. Targeted work to improve flow, strengthen clinical leadership and release downstream beds. Collaboration across primary, secondary and social care to provide integrated care pathways.

Weaknesses		
Factor	**Supporting evidence**	**Implications**
Outdated elements of Trust estate	Some services on the Churchill and Horton General sites are housed in sub-optimal accommodation.	Increase utilisation of PFI facilities. Investment in retained estate through capital programme. Reduction of overall cost of estate through Estates Strategy.
Relatively small local catchment population for specialised teaching centre	Market assessment. Poor cost-effectiveness for some specialties such as Neurology and Gastrointestinal Surgery.	Development of mutually beneficial partnerships to support the inflow of specialised work.
Split-site working	Multiple medical rotas.	Rationalisation and simplification of on-call rotas to optimise efficiency and improve value for money whilst ensuring patient safety. Pursuit of clinical services strategy to move medical subspecialties from the Churchill to the John Radcliffe.

Opportunities		
Factor	**Supporting evidence**	**Implications**
Electronic Patient Record	Opportunities to deliver improved patient care and service improvements e.g. developing order-communications in the next year, patient prescribing in the next two years, remote monitoring. The Big Data Institute will create an unrivalled capacity to store and analyse data from large population studies alongside data contained in, for example, the electronic patient record to support a fundamental change in the nature of research and the patient care pathway.	Improved and better integrated processes, reduced variation in outcomes and improved availability of clinical information. Wider contribution across academic and research partnerships with associated patient benefit.
Extended day and 6-7 day working	Optimising use of assets such as theatres, endoscopy and radiology.	Improved patient experience through timely admission and discharge and improved access. Greater flexibility and responsiveness support OUH being provider of choice. Improves value for money.

Opportunities		
Factor	**Supporting evidence**	**Implications**
Innovation in patient pathways developed in partnership with Oxford Health	Two thirds of annual NHS expenditure relates to patients with long term conditions. Oxfordshire CCG intent to commission integrated care. Need for reduction in delayed transfers of care.	Delivery of integrated care across health and social care providers. Strengthening of primary and community-based provision provides opportunity for integration with secondary care expertise and resilience.
National and regional strategies to centralise specialised services	Designation of OUH as Major Trauma Centre, a centre for complex elective and emergency vascular surgery and for newborn intensive care. Further designation processes in train for e.g. severe intestinal failure, specialised burns services.	Activity transferred to OUH with associated transfer of resource. Critical mass of work established to optimise outcomes and maintain expertise and modern technology. Defined standards of service delivery. Scope to strengthen mutually-beneficial partnerships with network hospitals.
Leverage of academic health institutions to deliver translation of basic research	Current focus on improvements to care and treatment of patients with dementia and diabetes.	Rapid adoption of innovation can be achieved where it adds value in terms of patient benefit or cost-effectiveness. Research is able to support wealth generation through stimulus to local economy.
Development of clinical strategy to make best use of Trust estate	Clinical Services Strategy and Integrated Business Plan.	Optimised configuration of services to provide improved local access to specialist services. Operation of services on a scale that ensures that they can be both safe and sustainable.

Threats		
Factor	**Supporting evidence**	**Implications**
Centralisation of specialised services threatens the viability of some services	"Safe and Sustainable" review of paediatric cardiac and neurosurgical services. Designation of specialised services by NHS England with associated service specifications.	Network arrangements to avoid adverse impact on linked services and patient care. Action to respond to service specifications and address specific derogations from them.

Threats		
Factor	**Supporting evidence**	**Implications**
Competitive tendering by commissioners removes activity and income	Failure to secure Oxfordshire contract for Banbury Independent Sector Treatment Centre.	Optimise service quality so that OUH remains the provider of choice for patients and GPs. Develop capability to integrate care across service boundaries. Enhance capability to develop successful tenders. Improve ability to remove costs in response to loss of income.
Costs of caring for an ageing population with increasingly complex treatment needs	Marginal tariffs apply for non-elective and elective referrals above baseline. Activity rising above this baseline is not directly within acute trusts' control. Patients living longer with increasingly complex co-morbidities.	Integrated care pathways to reduce duplication across primary, secondary and social care. Risk-sharing arrangements. Collaborative working with primary care and community care to agree a joint approach to demand. Integrated care pathways, including redesign to support greater self-management. Greater care delivery and resilience within community settings.
Increased complexity and rigour of regulation and scrutiny regime	Revised CQC inspection regime. Updated Monitor Risk Assessment Framework. Changes to national tariffs and contracts led by NHS England and Monitor.	Internal peer review to maintain focus on quality and evidence of meeting CQC standards. Requirement to maintain compliance with Monitor licence conditions.
National financial position and potential for continuing austerity measures	Shift in healthcare resources through Better Care Fund. Change in balance of funding between local and specialised commissioners.	Continuation of austerity measures with heavily constrained funding to NHS for the foreseeable future. Uncertainty regarding impact of shift in resources for healthcare at national level.
Oxfordshire CCG financial position	Oxfordshire CCG in deficit in 2014/15 and potentially in 2015/16.	Repayment of debt further restricts funding for service change.

Threats		
Factor	**Supporting evidence**	**Implications**
Recruitment and retention of specific groups of clinical staff is difficult	Demonstrable difficulties in recruiting certain staff groups e.g. pharmacists, cardiac staff, diagnostic and therapeutic radiographers, operating department practitioners, emergency department middle grade doctors. Reliance on bank and agency staff, with significant levels of associated expenditure.	Provision of subsidised housing. Dedicated recruitment campaigns. Rolling recruitment programme. Strengthening of appraisal, enhanced training and personal development to support retention. Development of in-house training capability. AHSN and AHSC links attract staff.

Implications of the SWOT analysis

Comprehensive care, subspecialisation and quality

5.7 The Trust's key strengths derive from its comprehensive portfolio of services with high levels of subspecialisation and a strong reputation for the quality of the care and treatment provided. Service delivery is underpinned by strong clinical support services and multi-disciplinary working.

5.8 Services are typically delivered from high quality facilities using the latest technology. These strengths are valued by the patient population served by the Trust. The clinical services strategy described in Chapter 3 aims to address remaining issues, including moving medical subspecialties from outdated facilities at the Churchill Hospital to the John Radcliffe and developing facilities and services at the Horton General Hospital. This chapter describes work in progress to find ways of improving care infrastructure at the John Radcliffe.

5.9 Partnership with the University of Oxford complements and enhances the reputation of clinical services, supporting the delivery of education, training and research. The range and quality of teaching is linked to the comprehensive portfolio of services provided.

Transforming care for local people

5.10 OUH and its local commissioners recognise a need to radically transform how care is delivered for local patients and the wider community.

5.11 With Oxfordshire's population ageing and those who are 'very old' increasing rapidly in number, the need to reconfigure services for older people is particularly urgent. Oxfordshire's high level of delayed transfers of care lends added urgency to this challenge.

5.12 OUH is working closely with Oxford Health NHS FT (OH) on how services for Oxfordshire patients can be reconstructed to provide better patient care and outcomes; to secure genuine and effective integration of care designed around the needs of individual patients; to reduce duplication, waste and unnecessary handoffs; and to provide a platform for responding to increasing demand.

5.13 A proposal has been made to local commissioners, including:

- An outline vision of a service model for consideration by the wider health and social care community.
- A definition of the scope of services to be included in terms of care pathways, populations served and finance.
- An indication of proposed benefits and outcomes and of implications for primary care and social care.

5.14 This development takes place in the context of Oxfordshire CCG's intention to move to outcomes-based commissioning, particularly for the care of frail older people, and commitment from OUH and OH to work towards this and use it as a catalyst for system-wide transformation.

5.15 Oxfordshire CCG is to make a decision in November 2014 on whether the proposal made meets criteria for the recognition of OUH with Oxford Health as Most Capable Provider for these services.

Developing and sustaining specialised services

5.16 OUH is in the relatively unusual position as a large, specialised teaching centre that it is not associated with a large local population. The Trust therefore aims to consolidate and extend its catchment population. There are several opportunities it plans to use to achieve this.

5.17 The Trust is well-placed to respond positively to the national drive to rationalise and consolidate specialised services into designated centres. It has already responded to commissioner-led initiatives to reconfigure specialised services, such as in centralising vascular surgery and repatriating cardiac surgery referrals from London providers. Taking advantage of such opportunities is necessary to support future clinical and financial viability by optimising clinical outcomes, using latest technology and techniques and achieving economies of scale.

5.18 The centralisation of specialised services can be expected to pose a risk to services with smaller critical mass. It is important for the Trust to develop network arrangements for the latter to prevent an adverse impact on related services. OUH is able and willing to work collaboratively as a 'spoke' as well as a 'hub.' This is demonstrated through its alliance with University Hospital Southampton NHS FT to have paediatric cardiac surgery provided in Southampton, with the arrangement supporting the continued provision of paediatric intensive care in Oxford. Collaborative network arrangements are also in place with Southampton for paediatric neurosurgery and paediatric critical care retrieval, and with Buckinghamshire Healthcare NHS Trust for burns care.

5.19 OUH recognises that network strategies to centralise or repatriate services to Oxford rely on changes to referral patterns and care pathways. The Trust has adopted a mutually beneficial network approach with surrounding healthcare providers and is agreeing partnership arrangements with neighbouring Trusts to support the operation of these networks.

5.20 OUH has built where possible on existing clinical network arrangements and relationships with neighbouring hospitals. It is developing clinical partnerships with trusts including Royal Berkshire NHS FT, Bedford Hospital NHS Trust, Buckinghamshire Healthcare NHS Trust, Frimley Park NHS FT, Gloucestershire Hospitals NHS FT, Great Western Hospitals NHS FT, Milton Keynes Hospital NHS FT, Northampton General Hospital NHS Trust and South Warwickshire Hospitals NHS FT.

5.21 Plans to develop radiotherapy services, described below, stem from a strong clinical network.

Innovation via collaboration

5.22 The **Oxford Academic Health Science Centre** (OxAHSC) is a partnership between Oxford Brookes University, Oxford Health NHS Foundation Trust, OUH and the University of Oxford.

5.23 Designated by the Department of Health in November 2013 with effect from 1 April 2014, OxAHSC combines the institutions' individual strengths in world-class basic medical research and science, translational research, training and clinical expertise to address 21st century healthcare challenges. It will allow scientific discoveries to move rapidly from the laboratory to the ward, operating theatre and general practice so that patients benefit from innovative new treatments. It will also drive economic growth through partnerships with industry, including life sciences companies.

5.24 Its focus is on six themes:

- 'Big Data': delivering the digital medicine revolution.
- Building novel NHS, university and industry relationships.
- Cognitive health: maintaining cognitive function in health and disease.
- Emerging infections and antimicrobial resistance.
- Managing the epidemic of chronic disease.
- Modulating immune response for patient benefit.

5.25 OUH is represented on OxAHSC's Board, which is chaired by the University of Oxford's Regius Professor of Medicine, and participates in the AHSC's Operational Group, Stakeholder Forum and Theme Groups.

5.26 The **Oxford Academic Health Science Network** is one of 15 AHSNs licensed in 2013 for five years by NHS England. It extends the platform of collaborative working to the wider geography in which OUH operates and includes life sciences and other industry partners as well as health and academic partners.

5.27 Oxford AHSN's vision is of "Best health for our population and prosperity for our region." Its objectives are to focus on the needs of patients and local populations, speed up the adoption of innovation into practice, build a culture of partnership and collaboration, and to create wealth.

5.28 The AHSN has three major work programmes:

Best care	Clinical networks in Diabetes, Dementia, Depression and anxiety, Mental and physical comorbidity, Early intervention in mental health, Imaging, Medicines optimisation, Maternity, Children and Out of hospital care.
	Continuous learning, in partnership with Health Education Thames Valley, including the Patient Safety Academy, dementia awareness training for 5,000 people, a careers fair to attract young people into healthcare and life sciences and the establishment of secondment opportunities between the NHS and industry.
	Innovation adoption, identifying ten innovations for delivery at scale over five years.
	Sustainability, using innovation to transform models of care for the future and minimise environmental impact, focusing initially on Diabetes, Dementia and Medicines optimisation.
Research and development	Working with the Thames Valley and South Midlands Clinical Research Network to support research, increase recruitment to trials, facilitate adoption of innovation, create coherent research platforms for partners and deliver cost-efficiencies.
Wealth creation	Working with Local Enterprise Partnerships and UK Trade and Investment to develop more and stronger life science businesses and clusters and to support the co-development, evaluation and spread of new products and services.

5.29 These work programmes are supported by two themes:

Informatics and Information Governance	Linking core business goals through technology innovation, within the Oxford AHSN and with partner organisations.
Patient and Public Involvement, Engagement and Experience	Involving patients and the public in the work though mechanisms such as governance, priority setting, teaching and education, identifying the need for innovation and assessing technologies. Supporting patients and their carers to be active participants in their own care through approaches such as personalised care planning and shared decision-making.

5.30 OUH is represented on Oxford AHSN's Board and its wider Partnership Board and acts as the host organisation for the AHSN. Further information is available at www.oxfordahsn.org

Current and future initiatives

5.31 Informed by its SWOT analysis, market assessment and continuing work with its commissioners, OUH has identified developments which underpin the delivery of its strategic objectives.

5.32 Three major initiatives are described in the context of the Trust's strategic objectives. Each is progressing towards the approval of final business cases. The development of radiotherapy services in Swindon is modelled as a service development in OUH's Long Term Financial Model.

Radiotherapy expansion

Swindon

5.33 The Trust's Board has approved an outline business case with a view to investing £14.4m in the development of a satellite radiotherapy service at the Great Western Hospital (GWH) in Swindon to provide care from 2017. This initiative is in line with the Trust's strategic objectives, particularly that of providing *"excellent secondary and specialist care through sustainable clinical networks."*

5.34 Patients residing in Swindon and parts of Wiltshire currently travel to Oxford for radiotherapy treatment. Many have travel times in excess of one and a half hours each way, significantly more than the 45 minutes recommended by the National Radiotherapy Advisory Group (NRAG).

5.35 The nature of radiotherapy treatment means that local access is particularly important since patients receive a course of treatment which may involve some 37 trips to their radiotherapy provider and long journeys pose an extra burden for those feeling very ill.

5.36 Developing a local radiotherapy service for the populations of Swindon and Wiltshire would mean significant reductions in time for over 13,000 patient journeys to radiotherapy treatment each year.

5.37 The development has specific goals to:

- Provide sufficient radiotherapy capacity for OUH to match the future needs of its current catchment population.
- Improve the patient experience for cancer patients living in Swindon and Wiltshire, the majority of whom would no longer need to travel to Oxford for their care.
- Provide the radiotherapy capacity required by commissioners in the most cost-effective way.

5.38 OUH's radiotherapy service has a catchment area of Oxfordshire, Swindon, approximately 20% of Wiltshire and 65% of Buckinghamshire, serving a population of some 1.14 million.

5.39 Long-standing relationships exist between OUH and GWH in the provision of cancer services. OUH provides radiotherapy solely at the Churchill Hospital with six linear accelerators (LinAcs), five of which are core treatment machines with one retained by the PFI partner to support maintenance.

5.40 The plan for a satellite unit has the strong support of Swindon CCG and is fully aligned with the national commissioning specification for radiotherapy and the Thames Valley Cancer Network's document *Response to NRAG* (May 2010), which highlighted the excess travel time for patients in Swindon and Wiltshire and called for extra linear accelerators by 2016.

5.41 Demand for radiotherapy has grown steadily and is expected to continue to do so, due to:

- Growth in the number of people diagnosed with cancer (incidence).
- Changes in treatment regimens which result in increased numbers of radiotherapy treatments for some cancer types (leading to improved outcomes and reduced side effects).
- Increased complexity of treatments delivered, increasing treatment delivery time such that each radiotherapy machine provides capacity for fewer patients.

5.42 The nationally recommended model for assessing radiotherapy needs has been used to assess the future demand for radiotherapy from the Trust's catchment population. The model is consistent with recent activity delivered by the Trust and the capacity forecast suggests that there will be a shortfall in the delivery of fractions which would require one extra LinAc by 2016 and a second by 2018 to meet the needs of the existing catchment population.

5.43 If the additional capacity was sited at Swindon, there could also be an increase in demand as the service would be closer to the populations of Wiltshire and Gloucestershire. It has been assumed that an additional 5% of each county's demand would switch to the new unit.

5.44 Following a benefits appraisal, financial assessment and risk analysis, the plan developed was to provide two LinAcs as a standalone satellite unit at the Great Western Hospital. Radiotherapy treatment planning would initially be carried out at the Churchill Hospital but capacity for the future development of a Computed Tomography (CT) scanner would be incorporated so that some planning could be done at GWH in the future.

5.45 The outline business case is based on a commitment by GWH and OUH to work together to deliver a charitable funding appeal to provide £2.5m of support for the investment. The remainder of the development is shown in Chapter 6 – Finance as funded from OUH's capital programme.

5.46 In terms of cumulative contribution, no option examined would have offered significant financial benefit to OUH. However, it is also clear that there is no other option which is financially attractive to maintain the Trust's service to its catchment population. The option chosen performed better than providing additional LinAcs at the Churchill or providing the LinAcs at GWH with a CT scanner.

5.47 This development makes a positive contribution in 2016/17 due to the inclusion of £1.3m in charitable monies before moving into deficit for the period 2017/18 to 2020/21. The contribution then increases from 2021/22 through to 2026/27 by which time it will have reached 11%. It should be noted that an additional £1.3m in charitable monies will be received pre-2016/17.

5.48 The proposed development would have the following impact on the Trust's balance sheet.

- Increasing OUH's fixed asset base, subject to valuations, by £8.1m for buildings and £5.3m for equipment. The equipment will be split between £3m worth of donated assets and £2.3m NHS funded assets. Depreciation will be charged to both forms of equipment asset, but the 3.5% interest charge will only apply to NHS funded assets.
- The building will be depreciated over 40 years based on the length of the lease with GWH. Equipment will be depreciated over 10 years.
- Cash generated through operations would become available for OUH's capital programme. The model assumes cash is used to replace equipment as it reaches the end of its 10 year life, but is otherwise available to be invested elsewhere in the Trust. By 31 March 2027 a cash balance of £26.8m is forecast.

5.49 The preferred option provides OUH with the flexibility to implement CT within the scheme subject to success in charitable fundraising and the effective management of risk, but does not commit it at an early stage to an option which adds to the cost.

5.50 A full business case will be presented to the Trust Board with selection of a Principal Supply Chain Partner and infrastructure design to proceed in parallel with the development of this case.

Milton Keynes

5.51 OUH began providing radiotherapy for the population of Milton Keynes in late 2013 in response to a request by commissioners related to the withdrawal of Northampton General Hospital NHS Trust from the provision of this service. Radiotherapy capacity was

commissioned from Cancer Partners UK in Milton Keynes in 2014/15 to supplement capacity available at OUH's Oxford Cancer Centre.

5.52 Plans are being developed by the Trust for a satellite radiotherapy unit in Milton Keynes to enable this population to be served locally and sustainably.

5.53 A Strategic Outline Case for the development of radiotherapy services in Milton Keynes has been developed and approved by the Trust's Board and by the NHS Trust Development Authority.

5.54 Work is under way to develop and evaluate options to enable a full business case to be considered by the Board.

5.55 A capital loan for this development is shown in Chapter 6 – Finance.

Electronic Patient Record

5.56 The Trust's IM&T strategy notes the critical importance of information in managing care and transforming the way that it is provided. In particular a coherent strategy and robust systems are essential to the delivery of clinical safety, performance improvements and clinical research. This strategy therefore forms a core element of the Trust's delivery of its strategic objectives, particularly *"delivering compassionate excellence"* and *"delivering better value healthcare".*

5.57 At the heart of the IM&T strategy is the continued implementation of the Electronic Patient Record (EPR) as an integrated system with use for the bulk of routine administrative and clinical activity. This provides the opportunity to derive value by building on the significant investment to date and further developing the established technology and skills.

5.58 EPR and the associated Patient Administration System (PAS) are central to OUH's operational services and are embedded into processes for admissions, outpatient attendances, diagnostic requests and results and clinical services in the Emergency Departments and Maternity. The Trust has made substantial investment to successfully establish EPR in these areas, developing procedures, testing software and training thousands of staff.

5.59 EPR is also fundamental to the delivery of national policies for IM&T, including those for a patient-centred NHS[1], quality initiatives including the Safer Hospitals and Safer Wards Technology Fund and the development of paperless and 'paper-light' working.

5.60 As part of the Safer Hospitals and Safer Wards Technology Fund, OUH has received national funding which it must match to progress three innovative projects linked to EPR:

System for Electronic Notes Documentation (SEND) An iPad app developed with the Oxford BRC is running in OUH's haematology wards as an electronic version of the observation chart which automatically calculates an acuity score for patients and records critical observations. Once roll-out across OUH wards is completed the aim will be to see if it can also be used in community hospitals. The scheme includes making the software 'open source' and helping others to implement it, expected to begin with hospitals in the Oxford AHSN.
Automating the dispensing of To Take Out (TTO) drugs TTO medication for patients currently requires drugs to be prescribed by medical staff, to be screened and approved by ward pharmacists and then to be sent to the pharmacy where the details are transcribed and dispensed either manually or through the Trust's pharmacy robot. This scheme is to interface the EPR discharge summary pharmacy system and the robot dispensing drugs. This will generate online prescribing and screening and automated dispensing without any transcription. This should reduce delays in discharge and medication errors.

[1] *The power of information* (Department of Health, 2012)

Oxfordshire Care Summary

The first Oxfordshire Care Summary enables the Trust's CaseNotes system to access GP data. It is now used routinely by pharmacists to screen patient prescriptions and understand what drugs and allergies are recorded in local GP systems. This has proved immensely popular and is being rolled out to out-of-hours GP services and the Emergency Department.

In partnership with Oxfordshire CCG, the technology fund will allow the system to be enhanced to provide views on data for patients with long term conditions, starting with diabetes. It will also be enhanced to give patients a view of their own data.

5.61 PAS/EPR services are provided via contracts managed by the Department of Health which expire in October 2015. NHS organisations must procure their own solutions beyond this date. OUH must make alternative arrangements for provision and address the funding gap that will arise on exit from the national service.

5.62 A full business case for the re-provision of the Trust's electronic patient record services was approved during 2014 by the Trust Board and by the NHS Trust Development Authority. The Trust has chosen to retain the Cerner Millennium product and is also contracting with Cerner for hosting services. An initial contract has been signed, thereby helping to secure a planned and safe exit from the existing contracting arrangements within the nationally-specified timetable. The full business case identified total capital investment from 2014/15 of £7.3 million and a revenue cost of £38.3m to 2025/26. Funding for this scheme is shown in Chapter 6 – Finance.

5.63 This investment is seen as supporting service quality and high quality clinical data, with checks and alerts supported by EPR in the care process being an essential ingredient of high quality patient care along increasingly complex care pathways.

5.64 Strategic objectives for the procurement of the new EPR are to:

- Enable safe and efficient care.
- Improve the quality and efficiency of care through access to the right information at the right time.
- Meet current needs and enable extension or adjustment to meet future needs.
- Minimise risk and disruption to operational services at transition.
- Deliver the service as cost-effectively as possible.
- Provide increased autonomy in system configuration to meet new service or commissioning requirements. This is a notable restriction of the current service.

5.65 The underlying economic case for the new EPR is based on specific areas where measurable efficiency and quality gains have been identified and the provision of a flexible system that will allow the Trust to adapt to new requirements in national policy, new treatment regimes, collaborative working with partners and research initiatives.

5.66 Measurable efficiency and quality gains include building relevant checks into processes such as dementia screening and venous thromboembolism testing to ensure that quality standards are met.

5.67 Overall, the integrated patient-centred view provided by fully-functional EPR is expected to improve the visibility of care along the pathway, improving overall patient experience and enabling easier communication with other providers of care.

5.68 Flexibility will be offered by a sophisticated system widely used by a trained workforce with developments supported by a skilled technical team.

5.69 The procurement approach agreed by OUH is to use London Procurement Partnership (LPP) framework contracts which provide the necessary scope to ensure service continuity and future-proofing. They enable a rapid, lower cost procurement, which can be tailored to the

Trust's needs and provide template service definitions and contracts that further reduce risk. The process by which the frameworks were established has set guaranteed maximum prices, which ensures that competitive pressure is retained for individual procurements by the Trust.

5.70 The transition phase of the project will run into 2015, with a period of time allowed between transition to the new service and the end of the existing contract.

Operating theatre and adult critical care infrastructure at the John Radcliffe Hospital

5.71 Development of operating theatres and adult critical care facilities at OUH's John Radcliffe site is needed to maintain safe and high quality services in line with the Trust's strategic objective of *"delivering compassionate excellence".* Development should also make best use of infrastructure consistent with the Trust's objective of *"delivering better value healthcare".*

5.72 The Trust has 44 operating theatres across its four sites. 24 are at the John Radcliffe, with eight within the main hospital building, opened in 1979, which require redesign and upgrading to improve the space available for modern surgical care and upgrade their infrastructure and building fabric.

5.73 The Trust also requires at least one hybrid theatre (allowing operating and interventional radiology) to support agreed expansion of its vascular surgery.

5.74 OUH has a range of critical care facilities for adults including cardiac, neuroscience and general adult intensive care at the John Radcliffe, an adult intensive care unit at the Churchill and a combined intensive care/high dependency care unit at the Horton General.

5.75 The adult general intensive care unit (ICU) at the John Radcliffe requires redesign and upgrading to meet modern expectations of space, facilities and layout. The John Radcliffe also does not have a high dependency unit (HDU) offering Level 2 critical care and it is unusual for a specialised centre not to provide this facility for patients who do not require intensive care but need more support than can routinely be provided on general wards.[2]

5.76 OUH has conducted a feasibility study to assess options for JR theatres and has considered options for ICU and HDU facilities. With a high anticipated capital cost for a combined development representing a level of investment that could not be sustained without impairing the Trust's financial risk rating, but with a compelling clinical case for change, work is underway to review all potential options for improving these services which might deliver a solution at a lower cost. These include:

- A rigorous review of existing options to identify where costs could be reduced.
- Identification of potential models that might enable staffing efficiencies and savings that could mitigate the capital costs proposed.
- Identification of physical/estates solutions that might be more cost-effective.

5.77 Revised proposals will be considered by the Trust Board in the context of the financial framework provided by the Trust's Long Term Financial Model.

5.78 Capital loans for these schemes are shown in Chapter 6 – Finance.

Conclusions

5.79 Changes to local health services are a priority and OUH is fully committed to the partnership working required to transform local health services and resolve the historical causes of high rates of delayed transfers of care in Oxfordshire.

[2] *Comprehensive Critical Care* (Department of Health, 2000) describes four levels of critical care, with Level 3 (the highest) being in an Intensive Care Unit. Level 2 refers to patients requiring more detailed observation or intervention including support for a single failing organ system or postoperative care and those 'stepping down' from higher levels of care. This is the level described here as needing HDU care.

5.80 The Trust will continue to focus on improving its infrastructure to support its delivery of safe services from a high quality environment, while making best use of new technologies to deliver patient benefit and improved cost-effectiveness.

5.81 The Trust is engaged in developments which enhance its position as a specialised provider working as a key partner within a clinical network. These developments are well aligned with the direction of national strategy for specialised services.

5.82 OUH will continue to develop its networks, strengthening regional partnerships to consolidate activity flows, supporting the reconfiguration of specialised services to repatriate care into the region and extending its network of relationships to sustain and develop its catchment population.

5.83 The Oxford Academic Health Science Network unifies these themes, establishing a coherent structure within which a broad range of clinical and academic partnerships can flourish and which can drive the innovation needed to strengthen the quality and sustainability of services at local and regional level.