Oxford University Hospitals NHS
NHS Trust

Trust Board : Wednesday 10 July 2013

TB2013.85

Title	Draft Trust Business Plan 2013/14

Status	For approval
History	This is the third draft of the 2013/14 Trust Business Plan. The first draft was discussed by the Trust Management Executive on 11th April 2013. The second draft incorporated comments received following the TME meeting and was considered by the Board in its session on 8th May 2013.

Board Lead(s)	Mr Andrew Stevens, Director of Planning and Information			
Key purpose	**Strategy**	Assurance	Policy	Performance

Summary

This is the third draft of the 2013/14 Trust Business Plan. A first draft was discussed by the Trust Management Executive on 11th April 2013 and a second draft by the Trust Board in its session on 8th May 2013.

The changes incorporated in this third draft are:

- Updated financial information, reflecting agreements with commissioners and internal budget setting and a revised version of the Capital Plan.
- Finalised 2013/14 corporate objectives. A draft set of priority objectives is also included, but these will be subject to further discussion.
- A reviewed Risk Management section, updated to reflect the finalised 2013/14 objectives.

Recommendation

The Trust Board is asked to approve this Trust Business Plan for 2013/14.

Oxford University Hospitals NHS

NHS Trust

Business Plan 2013/14

Delivering Compassionate Excellence

learning respect delivery excellence compassion improvement

ABBREVIATIONS

AHSC/N	Academic Health Science Centre/Network
BRC/U	Biomedical Research Centre/Unit
CCG	Clinical Commissioning Group
CH	Churchill
CIP	Cost Improvement Programme
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DTOC	Delayed Transfer of Care
EBITDA	Earnings before interest, tax, depreciation and amortisation
ED	Emergency Department
EDD	Estimated Date of Discharge
EMU	Emergency Medicine Department
EPR	Electronic Patient Record
FT	Foundation Trust
FYE	Full Year Effect
GI	Gastrointestinal
GUM	Genitourinary Medicine
HDU	High Dependency Unit
HGH	Horton General Hospital
I&E	Income and Expenditure
IM&T	Information Management and Technology
IMRT	Intensity Modulated Radiotherapy
IPR	Integrated Performance Report
JR	John Radcliffe
KPI	Key Performance Indicator
LiA	Listening into Action
LTFM	Long Term Financial Model
MRI	Magnetic Resonance Imaging
NHSCB	The NHS Commissioning Board
NHSLA	National Health Service Litigation Authority
NHSTDA	NHS Trust Development Authority
NOC	Nuffield Orthopaedic Centre
NTSS	Neurosciences, Trauma and Specialist Surgery
OT	Occupational Therapy
PCT	Primary Care Trust
PET/CT	Positron emission tomography - computed tomography
PFI	Private Finance Initiative
PP	Private Patient
QIPP	Quality, Innovation, Productivity and Prevention
R&D	Research and Development
RPI	Retail Price Index

RTA	Road Traffic Act
RTT	Referral to Treatment
SHDS	Supported Hospital Discharge Service
SHA	Strategic Health Authority
SHDS	Supported Home Discharge Service
SLA	Service Level Agreement
S&O	Surgery and Oncology
TDA	Trust Development Authority
TME	Trust Management Executive
VTE	Venous thromboembolism

Introduction

1. This Business Plan sets out the Oxford University Hospitals (OUH) Trust's objectives for 2013/14, the financial plan for their delivery and how the Trust will monitor success.

   1.1. Part One describes the Strategic Context in which the Trust has developed its plans.

   1.2. Part Two describes the Trust's strategy, including its strategic objectives and priorities to deliver these over the next three years.

   1.3. Part Three sets out the detailed corporate objectives for 2013/14 that the Trust has developed to contribute to the delivery of its longer term strategic objectives.

   1.4. Part Four establishes the financial framework in which the objectives must be delivered.

   1.5. Part Five describes the structure and processes that have been put in place to establish accountability for the delivery of the plan and monitor and manage progress.

   1.6. Part Six considers the risks to delivery of the objectives.

2. The Plan has been developed in the context of both the publication of Robert Francis' report of the Mid Staffordshire NHS Foundation Trust Public Inquiry[1], and the OUH's existing programme of work on Delivering Compassionate Excellence, embedding its agreed values into everyday practice and bringing about improvement through Listening into Action.

Part One - Strategic Context

National Strategic Context

3. The overall strategic context in which the OUH has developed its plan for 2013/14 is one of growing demand for health services, driven in particular by the needs of the ageing population and increased patient expectations. This growth in demand coincides with an economic situation which means that resources are going to be limited for some time. 2013/14 is the third year of the period which has seen a requirement for the NHS as a whole to make efficiency savings of £15-20 billion by 2014/15.

4. The OUH, in common with the NHS as a whole, must ensure that it learns the lessons from the failures at Mid Staffordshire NHS Foundation Trust and Winterbourne View and maintains a relentless focus on maintaining and improving the quality of the care delivered to our patients.

[1] http://www.midstaffspublicinquiry.com/report

Implementation of the Health and Social Care Act 2012

5. The implementation of the Health and Social Care Act 2012 is resulting in a restructuring of the way in which Health and Social Care is organised and the creation of new organisations. In developing its plan for 2013/14 and beyond the OUH has taken into account the emerging strategic thinking and planning guidance issued by new bodies which will have a key role in either commissioning the Trust's services or in its performance management:

Commissioning Bodies

6. Many of the Trust's services will now be commissioned by **Clinical Commissioning Groups** (CCGs), made up of GPs and other local clinicians. The CCG for Oxfordshire is Oxfordshire CCG (OCCG) which took on its responsibilities in full following the abolition of Oxfordshire Primary Care Trust in April 2013.

7. Clinical Commissioning Groups will be supported by **NHS England** (the NHS Commissioning Board). NHS England will also directly commission the more specialised services provided by the OUH, becoming the Trust's biggest commissioner. These services were previously commissioned on a regional or more local basis which resulted in variation across the country. NHS England aims to bring more consistency to the commissioning of specialised services. One of the ways in which it plans to do this is by issuing detailed service specifications, which will provide the OUH with opportunities to strengthen and expand its specialist portfolio.

8. The Health and Social Care Act also emphasised the role of local authorities in shaping local health services. They will be commissioning some services, including public health and some screening. New **Health and Wellbeing Boards** have been created to bring together local commissioners for health and social care, elected representatives and representatives of Healthwatch to agree an integrated way to improve local health and wellbeing.

Performance Management

9. Under the new legislation NHS bodies will no longer be performance managed by Strategic Health Authorities. Non Foundation Trusts, including the OUH, will work to achieve NHS Foundation Trust status, supported by the new **NHS Trust Development Authority** (NHSTDA).

10. The following sections set out the planning and strategic documents published by the new organisations described above.

NHS Commissioning Board/NHS England – "Everyone Counts: Planning for Patients 2013/14"

11. The NHS Commissioning Board (now known as NHS England) issued its planning guidance for 2013/14 in December 2012[2]. (This guidance replaces the annual NHS Operating Framework which was previously published by the Department of Health.)

NHS Outcomes Framework and NHS Constitution

12. The document references the **NHS Outcomes Framework** and **NHS Constitution** as setting out the key goals and responsibilities for the NHS. The key measures from the NHS Outcomes Framework which NHS England and CCGs will use to track progress are set out at Appendix A. NHS England has introduced a zero tolerance approach to MRSA infections.

13. The table below sets out the expected rights and pledges from the NHS Constitution 2013/14 which are relevant to the OUH's services, including the thresholds which NHS England will apply when assessing organisational delivery.

Referral to Treatment waiting times for non-urgent consultant-led treatment	**Operational Standard**
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%
Diagnostic test waiting times	
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%
A&E waits	
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%
Cancer waits – 2 week wait	
Maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%
Maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms where cancer was not initially suspected	93%
Cancer waits – 31 days	
Maximum 1 month (31 day) wait from diagnosis to first definitive treatment for all cancers	96%
Maximum 31 day wait for subsequent treatment where that	94%

[2] NHS Commissioning Board, December 2012, Everyone Counts: Planning for Patients 2013 http://www.commissioningboard.nhs.uk/everyonecounts/

	Operational Standard
treatment is surgery	
Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%
Maximum 31 day wait for subsequent treatment where that treatment is a course of radiotherapy	94%
Cancer waits – 62 days	
Maximum 2 month (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%
Maximum 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	None set
Mixed Sex Accommodation	
Minimise breaches	
Cancelled Operations	
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	

14. In addition to the rights under the NHS Constitution NHS England has introduced:

    14.1. Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, including contractual fines when this occurs.

    14.2. An expectation that all handovers between an ambulance and A&E Department must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. There will be a contractual fine for all delays over 30 minutes, in both situations and a further fine for delays over an hour.

    14.3. Reinforcement that it is not acceptable for patients to be waiting on trolleys in A&E Departments with no patients to wait longer than 12 hours.

    14.4. An expectation that no patient has to tolerate an urgent operation being cancelled for the second time.

15. The requirements in *Everyone Counts: Planning for Patients 2013/14* are reflected in the standard contract for 2013/14 which the OUH has signed with its commissioners. This contract includes penalties for failing to deliver against key quality and performance standards. There are a total of 26 penalties, 19 of which will be charged directly to clinical Divisions with the remaining 7 being reported corporately.

Innovation, Health and Wealth and "Comply or Explain"

16. NHS England also reinforces the requirement to implement **Innovation, Health and Wealth**[3], stating that "all NHS organisations should demonstrate how they are driving innovation and developing delivery mechanisms for long-term success and sustainability of innovation in their health economy". NHS organisations should also "demonstrate their commitment to implementing each element of the "Comply or Explain regime". The creation of **Academic Health Science Networks** (AHSNs) is an important part of the implementation of Innovation, Health and Wealth and the OUH's participation in the **Oxford Academic Health Science Network** is a central part of its strategy and planning.

Commissioning for Quality and Innovation (CQUIN)

17. NHS England will extend the use of CQUIN payments to encourage and reward improvements in quality and innovation. The available amount payable is set at 2.5% of the value of all services commissioned through the NHS Standard Contract. However, payment will only be paid if the Trust delivers a level of quality that is over and above the NHS Standard Contract. Trusts must also meet the minimum requirements of the **High Impact Innovations** as set out in *Innovation, Health and Wealth*:

    17.1. **3 million lives -** improving the service delivered to patients with long term conditions through the use of telehealth and telecare.

    17.2. **Child in a Chair in a Day -** having in place processes for timely referral and assessment of the child for the right equipment solution, so that equipment is delivered within a reasonable time-frame with the appropriate level of funding.

    17.3. **International and Commercial –** examination of the economic and industrial role of NHS organisations, both with respect to health and care related industries and the wider economy.

    17.4. **Digital first -** Reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions

    17.5. **Intra-operative fluid management -** Development/extension of the use of intra-operative fluid management technologies for patients during and after surgery

    17.6. **Support for Carers of People with Dementia**

18. One-fifth of the available CQUIN payment amount will be linked to the national CQUIN goals:

    18.1. **Friends and Family Test**

    18.2. Improvement against the **NHS Safety Thermometer** (excluding Venous thromboembolism – VTE), particularly pressure sores

[3] Department of Health, December 2011, Innovation, Health and Wealth: Accelerating Adoption and Diffusion in the NHS

18.3. Improving **Dementia Care**, including sustained improvement in **F**inding people with dementia, **A**ssessing and **I**nvestigating their symptoms and **R**eferring for support (**FAIR**)

18.4. **Venous Thromboembolism (VTE) –** 95% of patients being risk assessed and achievement of a locally agreed goal for the number of VTE admissions that are reviewed through root cause analysis

19. The remaining four-fifths of the CQUIN payment will be linked to locally agreed goals. A set of local CQUINs topics has been agreed with both the OUH's local and specialised commissioners. These are set out in Appendix B.

Integrated Care

20. NHS England emphasises that the integration of the provision of services should be an explicit consideration in local planning.

Five "offers"

21. NHS England has set out five "offers" which it will provide to NHS commissioners to give them the insights and evidence they need to produce better local health outcomes. These are set out in the table below:

1.	NHS Services Seven Days a Week
2.	More Transparency, More Choice
	This offer seeks to extend the level of data available to the public and to promote the strengthening of patient choice. It includes a national pledge that data on individual consultant outcomes in a range of surgical specialties will be published during 2013/14.
3.	Listening to Patients and increasing their Participation
	This offer includes the introduction of the "Friends and Family" patient feedback initiative for all emergency department patients and inpatients from April 2013 and for all maternity patients from October 2013.
4.	Better Data, Informed Commissioning, Driving Improved Outcomes
	This offer seeks to ensure that the data available both internally within the NHS and externally to the public is of a high quality.
5.	Higher Standards, Safer Care
	This offer includes the introduction of the "6 Cs"[4] in nursing, the roll out of medical revalidation and a number of related quality initiatives.

"Putting Patients First": NHS England Business Plan for 2013/14 – 2015/16[5]

22. NHS England followed up the guidance in "Everyone Counts" with its Business Plan for the next three years. This document emphasises the overarching theme of the

[4] Care, Compassion, Competence, Communication, Courage and Commitment
[5] Putting Patients First: NHS England Business Plan for 2013/14-2015/16, NHS England, April 2013

Francis report - that a fundamental cultural change is needed in order to put people at the centre of the NHS. It sets out NHS England's operating model which will put patient care at the centre of everything, through an emphasis on patient satisfaction and outcomes, focussing on:

- Listening;
- Publishing and sharing information; and
- Enabling staff to operate in an environment of trust and transparency

23. NHS England's Business Plan sets out an **11 point scorecard**, reflecting its core priorities against which it will measure its performance. This is summarised in the table below:

Measuring patient and staff satisfaction	
1.	Satisfied patients – Establishing the Friends & Family test for patients
2.	Motivated, positive NHS staff - Establishing the Friends & Family test for NHS staff
Improving health outcomes	
3.	Preventing people from dying prematurely
4.	Enhancing quality of life for people with long term conditions
5.	Helping people to recover from episodes of ill health or following injury – including a reduction in emergency admissions for acute physical conditions that should not usually require hospital admissions and readmissions within 30 days of discharge from hospital
6.	Ensuring that people have a positive experience of care
7.	Treating and caring for people in a safe environment and protecting them from avoidable harm
Promoting equality and reducing health inequalities	
8.	Promoting equality and inclusion through NHS services. Highlighting and reducing inequalities in health outcomes. This includes parity of esteem for people with mental health issues
The NHS Constitution	
9.	Continued delivery of rights and privileges, including delivery of key service standards (as set out above)
Becoming an Excellent Organisation	
10.	Ensuring NHS England's staff understand their roles, are properly supported and well-motivated
High Quality Financial Management	
11.	"Living within our means, whilst delivering our priorities" – continuing to improve efficiency and transform services

Oxfordshire Clinical Commissioning Group (OCCG)

24. As the OUH's local CCG, Oxfordshire Clinical Commissioning Group will commission a significant proportion of the Trust's services. The OUH has been

working with the emerging CCGs, including Oxfordshire to understand how commissioning intentions will change when budgets are devolved fully to them. OCCG is comprised of six localities. The table below describes the areas covered by these localities and the particular health issues that have been identified within them.[6]

Localities	Population	Practices	Approximate Share of Oxon PCT funding	Particular Issues for Locality
North (Covers area including Banbury and Chipping Norton)	104,359	13 practices (74 GPs)	15%	• Teenage pregnancy • Road traffic accidents • Skin cancer (Malignant melanoma) • Combination of rurality and large market town deprivation
North East (Bicester, Kidlington and Yarnton, Woodstock and Islip)	Almost 78,000	10 practices	11%	• Higher proportion of teenage pregnancy in Bicester (second only to Banbury) • High recorded rates of obesity • Prolonged hospital stays with delayed transfers of care • Population changes
Oxford City (Oxford City, Blackbird Leys, Iffley, Cowley, Jericho and Summertown)	198,629	28 practices (146 GPs)	29%	• Health inequalities • Teenage pregnancies • Suicide • Health effects of exam results • Students
South East (Covers area from Wheatley in the north to Sonning Common in the south and from Wallingford in the west to Henley in the east	Just over 78,000	9 practices	12%	• Rural area - large proportion of wards classified as villages or smaller • Ageing population • Highest percentage of registered patients with dementia in Oxfordshire • Highest number of registered patients with cancer in Oxfordshire
South West (Covers	c 136,000	14 Practices (96 GPs)	13%	• Older population - sometimes

[6] Source: Oxfordshire Clinical Commissioning Group website (http://www.oxfordshireccg.nhs.uk/default.aspx) accessed 24/11/11

Localities	Population	Practices	Approximate Share of Oxon PCT funding	Particular Issues for Locality
Abingdon, Clifton Hampden, Berinsfield, Didcot, Wantage and Faringdon)				geographically isolated. • Growing population • Diverse population • Problems accessing services
West (Covers Witney, Burford & Carterton)	78,043	9 Practices (52 GPs)	11%	• Older population - sometimes geographically isolated • Growing population • Diverse population • Problems accessing services

25. This assessment, together with analysis carried out by the OUH, emphasises the need for the Trust's strategy to respond to changes in the population for which we provide services. The most prominent feature of this is the ageing population.

Oxfordshire's Joint Health and Wellbeing Strategy

26. As required by the Health and Social Care Act 2012, a Health and Wellbeing Board has been set up in Oxfordshire with responsibility for improving the health and wellbeing of people in the county through partnership working. The Board is a partnership between Local Government, the NHS and the people of Oxfordshire. Members include local GPs, councillors, the Local Involvement Network and senior officers from Local Government. Organisations responsible for providing health care are not members of the Health and Wellbeing Board.

27. A Joint Health and Wellbeing Strategy[7] has been published which emphasises the need for the organisations that provide care in the county to work together to meet the challenges faced in a way that is more "meshed" together.

28. OUH has a particularly important role to play in five of the Strategy's suggested priorities, in particular:

> **Priority 1 – All children have a healthy start in life and stay healthy into adulthood –** suggested outcomes for 2013/14[8] include a high percentage of women who have seen a midwife or maternity health care professional by 13 weeks of

[7] https://publicinvolvementnetwork.oxfordshire.gov.uk/gf2.ti/f/29474/66693.1/PDF/-/Oxfordshire%20Joint%20HWB%20strategy%20final.pdf accessed 11/6/13

[8] https://publicinvolvementnetwork.oxfordshire.gov.uk/gf2.ti/f/29474/66661.1/PDF/-/JHWBS%20consultation%20document.pdf accessed 11/6/13

pregnancy.
Priority 5 – Living and working well: adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential – suggested outcomes for 2013/14 include an increase in the number of people with a long-term condition who feel supported to manage their condition and a reduction in the number of emergency admissions for people with long term conditions. It is estimated that one in seven local people have a long-term condition and that the prevalence and incidence of long-term conditions is rising.
Priority 6 - Support older people to live independently with dignity whilst reducing the need for care and support – suggested outcomes for 2013/14 include a reduction in delayed transfers so that Oxfordshire's performance is out of the bottom quarter; development of a model for matching capacity to demand for health and social care, to reduce delays in transfers of care, by September 2013; 60% of the expected population with dementia to have a recorded diagnosis; improvements in relation to reablement; reduction in the number of emergency admissions for older people; bereaved carers' views on the quality of care in the last three months of life and the proportion of adults who use health care that say they receive their care in a timely way
Priority 7 – Working together to improve quality and value for money in the Health and Social Care System - suggested outcomes for 2013/14 include achieving above the national average of people satisfied with their experience of hospital care; a reduction in the number of emergency admissions to hospital; a reduction in the number of emergency admissions for acute conditions that should not usually require hospital admission; and a reduction in unplanned hospitalisation for chronic ambulatory care sensitive conditions.
Priority 8 – Preventing early death and improving quality of life in later years – suggested outcomes for 2013/14 relate to the uptake of bowel screening, NHS Health checks and smoking cessation.

29. A new proposed priority is:

Priority 12 – Commission safe, high quality, efficient health and social care services for the people of Oxfordshire"- suggested outcomes for this priority include the use of a range of reported outcomes measures and a review of quality assurance systems.

NHS Trust Development Authority (TDA) – "Towards High Quality, Sustainable Services": Planning Guidance for NHS Trust Boards for 2013/14[9]

30. The NHS Trust Development Authority's planning guidance states that non Foundation Trusts should develop plans for the year ahead and the medium to long term which integrate:

    30.1. Delivering high quality services, learning the lessons from the public enquiry into Mid Staffordshire NHS FT, meeting basic quality standards and delivering CQUIN schemes.

    30.2. Delivering core standards and contracts agreed with commissioners

    30.3. Ensuring financial sustainability within the resources available.

Improvement Priorities

31. Part of the TDA's stated role is to reduce variation between the performance of Trusts. As part of this it has asked every NHS Trust to identify five key areas of delivery where there is a significant variation from the top performers in the NHS and to set out an improvement plan to bridge that gap in the coming year. The OUH has identified the following areas:

	Improvement Priority	Improvement Plan
1.	To improve mortality benchmarking	Medical Director chairing a clinical review group to ensure performance improves
2.	To reduce delayed transfers of care	Eight point action plan agreed with commissioners
3.	To improve data quality	To improve the percentage of valid data in respect of admitted patient care
4.	To improve dementia care	To improve the assessment and care of patients via enhanced psychological medicine service
5.	To improve cancer waits	To build service sustainability in the treatment of cancers, with particular investment in radiotherapy

[9] NHS Trust Development Authority, December 2012, Towards High Quality, Sustainable Services": Planning Guidance for NHS Trust Boards for 2013/14
https://www.wp.dh.gov.uk/ntda/files/2012/04/NHS-TDA_Planning-Guidance-2012-13.pdf

Development Priorities

32. The TDA has also asked each Trust to identify a small number of high priority support and development needs. The Trust has identified the following needs:

1.	To support the strengthening of the Trust's integrated performance report, particularly in respect of quality
2.	To support the further development of the Trust's patient feedback framework
3.	To support the development of the Electronic Patient Record as a vehicle for service transformation
4.	To support the further development of the Trust's staff engagement activities
5.	To support the development of a clinically and financially sustainable future for the Horton General Hospital

Part Two – The Trust's Strategy

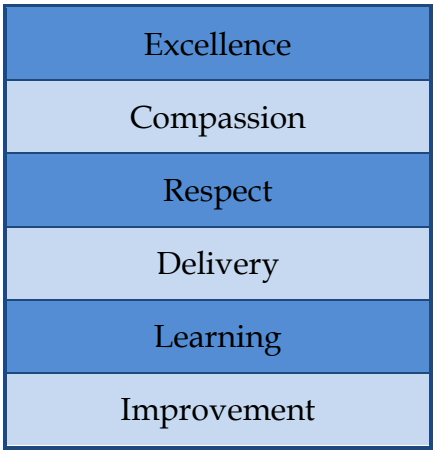
Vision and Values

33. The Trust's mission is:

> To improve health and alleviate pain, suffering and sickness for the people we serve
>
> through providing high quality, cost-effective and integrated healthcare and the constant quest for new treatment strategies and the development of our workforce

34. The Trust's Vision and Strategy have been developed in the context of its core corporate values. These values were generated through an exercise which took place from September to November 2011. Feedback was received from over 750 staff, the Trust Board, a number of management committees and from focus groups held with our Patient Panel and partners. Discussions were held on all sites and centred on what individuals, teams and departments said was important to them.

35. The Trust's core values are set out in the table below:



36. **Collaboration and Partnership** are also central to the Trust's approach, particularly in the delivery of the fundamental activities of patient care, teaching and research.

37. The Trust's vision is:

> to be at the heart of a sustainable and outstanding, innovative academic health science system, working in partnership and through networks locally, nationally and internationally to deliver and develop excellence and value in patient care, teaching and research within a culture of compassion and integrity.

38. This vision is underpinned by the Trust's founding partnership with the University of Oxford.

39. The vision reflects OUH's position as a provider of healthcare both for local people and for a wider population.

40. The patient is at the heart of everything the Trust does. OUH is committed to delivering high quality care to patients irrespective of age, disability, religion, race, gender and sexual orientation, ensuring that its services are accessible to all, but tailored to the individual.

41. Central to the Trust's vision are its staff. OUH aims to recruit, train and retain the best people to espouse its values and achieve its vision.

42. OUH strives for excellence in healthcare by encouraging a culture of support, respect, integrity and teamwork; by monitoring and assessing its performance against national and international standards; by learning from its successes and setbacks; by striving to improve what it does through innovation and change; and by working in partnership and collaboration with all the agencies of health and social care in the area it serves.

43. The Trust is committed to be an active partner in healthcare innovation, research and workforce education, with the aim of forming an effective bridge between research in basic science and in healthcare service provision, and the delivery of evidence-based, best practice care, turning today's discoveries into tomorrow's care.

Strategic Milestones

44. The Trust has developed a new strategy for the organisation. Key milestones in this process have been:

    44.1. Achieving integration between the Oxford Radcliffe Hospitals NHS Trust and Nuffield Orthopaedic Centre NHS Trust (achieved 1st November 2011).

    44.2. Creation of the Clinically Led organisation in November 2011.

    44.3. Signing of a Joint Working Agreement with the University of Oxford (came into effect 1st November 2011).

Achieving NHS Foundation Trust status

45. The next key step is to achieve NHS Foundation Trust (FT) status. NHS Foundation Trusts (FTs) were established by legislation in 2003 and now operate under the Health Act 2006. Although they are NHS organisations which provide NHS services to NHS patients in accordance with the core principles of the NHS – care that is free and based on need, they differ from non FTs in that they are:

    45.1. authorised and regulated by an independent regulator, known as Monitor, which is accountable directly to Parliament;

    45.2. accountable to their local communities through a system of local ownership with members and elected governors - the governors being elected by the members;

    45.3. not required to break even each year, although they must be financially viable. They can borrow money within limits set by the regulator, retain surpluses and decide on service development for their local populations;

    45.4. free from central government control and NHSTDA performance management;

    45.5. required to lay their annual reports and accounts before Parliament each year.

46. As an FT, OUH will:

    46.1. be part of the NHS and **provide NHS care** to the best current standards;

    46.2. be **accountable** to local people and the communities it serves via an active membership and Council of Governors;

    46.3. take its **own decisions** to deliver services within a framework set by regulators and as part of a 'family' of local health and social care organisations;

    46.4. be able to **respond quickly and imaginatively** to the challenges of the economic environment and the opportunities offered through the skills of its staff, its

facilities and networks, and its strong partnership with the University of Oxford;

46.5. be able to use **joint ventures** with commercial, academic, health or social care partners to provide benefit for the patients of tomorrow in new ways – and to minimise the cost to commissioners of integrated care within a teaching centre;

46.6. **invest and borrow**, with spending no longer dominated by an artificial annual cycle but by requirements to be financially viable; and

46.7. be required by the regulator to demonstrate that it is **well-governed** and **financially viable**.

47. In November 2012 the Trust submitted the two main components of its application to become a FT, the Integrated Business Plan and Long Term Financial Model to the Strategic Health Authority. The SHA has now passed the Trust's application to the NHSTDA.

Becoming part of an Academic Health Science Network and Academic Health Science Centre

48. Alongside the OUH's ambition to become an NHS Foundation Trust is its participation in the Oxford Academic Health Science Network (AHSN). AHSNs were announced in December 2011 by "Innovation, Health and Wealth" as a vehicle for aligning education, clinical research, informatics, training and healthcare delivery. The goal of AHSNs is to improve patient and population health outcomes by translating research into practice and developing and implementing integrated health care systems. AHSNs will act as a gateway for any NHS organisation needing support or help with innovation, and will provide industry with focused points of access to the NHS. The Oxford AHSN was recently formally designated by NHS England as one of 15 Networks across the country. More information about the Oxford AHSN can be found at http://www.oxfordahsn.org

49. The Trust also aims to become part of an Academic Health Science Centre (AHSC). In April 2013 the Department of Health invited NHS providers and their university partners in England to apply to become Academic Health Science Centres (AHSCs). Designation will be for five years from 1 April 2014, and the role of the new AHSCs will be to:

49.1. increase strategic alignment of NHS providers and their university partners, specifically in world-class research, health education and patient care

49.2. improve health and healthcare delivery, including through increased translation of discoveries from basic science into benefits for patients

Strategic Objectives

50. The Trust's vision and values inform its six strategic objectives:

SO1	To be a patient-centred organisation, providing high quality, compassionate care with integrity and respect for patients and staff – **"delivering compassionate excellence"**
SO2	To be a well-governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs - **"a well-governed and adaptable organisation"**
SO3	To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – **"delivering better value healthcare"**
SO4	To provide high quality general acute healthcare to the people of Oxfordshire, including more joined-up care across local health and social care services – **"delivering integrated local healthcare"**
SO5	To develop extended clinical networks that benefit our partners and the people they serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialist care for the people of Oxfordshire and beyond - **"excellent secondary and specialist care through sustainable clinical networks"**
SO6	To lead the development of durable partnerships with academic, health and social care partners and the life sciences industry to facilitate discovery and implement its benefits - **"delivering the benefits of research and innovation to patients"**

Three Year Priorities

51. The Trust has identified the priorities to deliver each of its Strategic Objectives over the next three years. These are set out in the table below, together with signpost milestones by which progress will be measured.

	13/14	14/15	15/16
SO1	**To be a patient-centred organisation, providing high quality, compassionate care with integrity and respect for patients and staff – "delivering compassionate excellence"**		
Priority	**Improve Patient Safety**		
Signpost milestones	• Year on year reductions in patient and staff harmful events • Year on year reduction in avoidable mortality		
Priority	**Improve Quality**		
Signpost milestones	Year on Year improvement in net promoter score as measured through Friends and Family Test		
Priority	**Improve Clinical Effectiveness and Outcomes**		
Signpost milestones	Define outcome measures for all clinical services	Start measuring	Demonstrate improvement
	Improvement against defined outcome measures		
	Sustain and improve the level of staff engagement		
Signpost milestones	• Year on year improvement in staff survey • Listening into Action (LiA) methodology facilitating staff engagement and service quality improvements • Implementation of values based recruitment, appraisal and customer care	Year on year improvement in staff survey	• Year on year improvement in staff survey • Staff empowered to make service and quality improvements • Values embedded across the organisation
SO2	**To be a well-governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs – " a well-governed and adaptable organisation"**		
Priority	**Introduce new Foundation Trust Governance arrangements**		
Signpost milestones	Prepare for implementation	Implement new arrangements	Measure effectiveness and impact on organisation

	13/14	14/15	15/16
Priority	**Improve NHSLA accreditation level**		
Signpost milestones	To be confirmed	To be confirmed	To be confirmed
Priority	**Continue to realise the benefits of the introduction of the Electronic Patient Record**		
Signpost milestones	Roll out of ADT (Admissions, Discharges and Transfers) and order communications functionality across the whole Trust	Roll out of Medicines Management and Critical Care functionality	Reprocurement of system
SO3	**To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – "delivering better value healthcare"**		
Priority	**Improve productivity**		
Signpost milestones	Work to implement extended day and 6 and 7 day working	• Introduce extended day and 6 and 7 day working from 1st April 2014 • Introduce productivity based job plans • Work to introduce allocations for outpatients, theatres and endoscopy	Full extended 7 day working, including for emergency care
	Reductions against Reference cost index		
Priority	**Work with commissioners to deliver QIPP requirements**		
Signpost milestones	Achieve Year 1 QIPP, including £1.5m reduction in outpatient follow ups	Achieve Year 2 QIPP	Achieve Year 3 QIPP
SO4	**To provide high quality general acute healthcare to the people of Oxfordshire including more joined-up care across local health and social care services – "delivering integrated local healthcare"**		
Priority	Agree system-wide Integrated Discharge Plan		
Signpost	Agree	Implement	Consolidate

	13/14	14/15	15/16
milestones			
	To support the development of a clinically and financially sustainable future for the Horton General Hospital		
Signpost milestones	Agree consultation proposal	Implement outcome of consultation	Consolidate
SO5	**To develop extended clinical networks that benefit our partners and the people they serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialist care for the people of Oxfordshire and beyond – "excellent secondary and specialist care through sustainable clinical networks"**		
Priority	**Develop and implement Cancer Surgery Network**		
Signpost milestones	Develop plans	Implement plans	
Priority	**Extend Cardiac Surgery network**		
Signpost milestones	Increase from 600 to 1,200 referrals p.a.		
Priority	**Fully Implement Vascular Network**		
Signpost milestones	To be confirmed		
Priority	**Continue implementation of radiotherapy modernisation plan, including provision of satellite radiotherapy facilities**		
Signpost milestones	Approval of outline business cases	Approval of full business cases and opening of first satellite unit	Opening of second satellite unit
Priority	**Maintain and develop portfolio of specialised services**		
Signpost milestones	Fully identify shortfalls against designation criteria for specialised services and develop associated business cases for investment	Respond to final designation criteria	
	3% income growth from non Oxfordshire commissioners		
SO6	**To lead the development of durable partnerships with academic, health and social care partners and the life**		

	13/14	14/15	15/16
	sciences industry to facilitate discovery and implement its benefits – "delivering the benefits of research and innovation to patients"		
	Become part of Academic Health Science Centre		
Signpost milestones	Submit Pre-qualifying Questionnaire (by 31st May 2013)	Establish AHSC from 1st April 2014, if application successful	Achieve Year 1 objectives
Priority	**Participation in Academic Health Science Network**		
Signpost milestones	Establish the Oxford Academic Health Science Network (AHSN) as an entity independent of the Oxford University Hospitals	Work with partners to achieve Business Plan objectives	

Part Three - Corporate Objectives for 2013/14

52. The Trust has identified ten draft priority corporate objectives which it needs to deliver in 2013/14 to progress its longer term Strategic Objectives. These are set out in the table below:

SO1: To be a patient-centred organisation, providing high quality, compassionate care with integrity and respect for patients and staff – "delivering compassionate excellence"		
1.	Delivering Compassionate Excellence	Respond to the recommendations of the Public Inquiry into the Mid Staffordshire NHS Foundation Trust (the Francis Report)
		Maintain/deliver national and local performance standards
		Strengthen nursing care (linked to recommendations of Francis report)
2.	Patient Engagement	Engage with patients to establish what really matters to them
3.	Staff Engagement	Sustain and improve staff engagement and empowerment
4.	Quality Strategy	Deliver agreed quality priorities across the three quality domains: • Domain 1: Safety • Domain 2: Patient Experience • Domain 3: Effectiveness and Outcomes
SO2: To be a well-governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs – " a well-governed and adaptable organisation"		
5.	Foundation Trust	Achieve NHS Foundation Trust Status
6.	Electronic Patient Record	Continue to realise the benefits of the introduction of the Electronic Patient Record
SO3: To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – "delivering better value healthcare"		
7.	Delivering Financial Plans, including Cost Improvement Programmes	Increase productivity and delivery of CIPs year on year in line with the agreed financial strategy and within the agreed performance framework/compacts

SO4: To provide high quality general acute healthcare to the people of Oxfordshire, including more joined-up care across local health and social care services – "delivering integrated local healthcare"		
8	Delayed Transfers of Care	Work with partners to reduce the number of system wide delayed transfers of care (DTOCs)
SO5: To develop extended clinical networks that benefit our partners and the people they serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialist care for the people of Oxfordshire and beyond – "excellent secondary and specialist care through sustainable clinical networks"		
9.	Excellent secondary and specialist care	Implement radiotherapy modernisation plan
		Complete expansion of neonatal services
		Progress the plan for the regional provision of vascular surgery
SO6: To lead the development of durable partnerships with academic, health and social care partners and the life sciences industry to facilitate discovery and implement its benefits – "delivering the benefits of research and innovation to patients"		
10.	Academic Health Science Centre/Academic Health Science Network	Establish the Oxford Academic Health Science Network (AHSN)
		Achieve Academic Health Science Centre status

53. A set of more detailed corporate objectives has been developed for 2013/14. These are described in the table below under the strategic objectives that they address.

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
SO1	**To be a patient-centred organisation, providing high quality, compassionate care with integrity and respect for patients and staff – "delivering compassionate excellence"**			
1.1	**Respond to the recommendations of the Public Inquiry into the Mid Staffordshire NHS Foundation Trust (the Francis Report)**	Agree actions that the Trust should take in response to the report and implement	• Agreed action plan • Report on implementation	Medical Director
		Clarify and refresh reporting of nurse sensitive indicators from "Ward to Board"	Indicators and reporting	Chief Nurse

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
1.2	**Sustain and improve staff engagement and empowerment**	Create alignment of individual, team and Trust objectives	Year on year improvement in staff survey results	Director of Workforce
		Listening into Action (LiA) methodology adopted at Divisional, directorate and departmental level	Demonstrable service and quality improvement from LiA	Director of Workforce
		Complete implementation of values based recruitment, appraisal and customer care training	Staff receiving regular feedback about behaviours and performance	Director of Workforce
		Identify values based interviewing implications for ward leadership	Implications identified	Chief Nurse
		Align the "6Cs"[10] into Trust values work	Document indicating alignment	Chief Nurse
1.3	**Improve Quality**	Deliver agreed quality priorities across 3 quality domains	As per Quality Account	Medical Director & Chief Nurse
a)	**Domain 1: Safety**			
	Minimise Healthcare Associated Infection	Ensure a Post Infection	• Incidence of MRSA	Medical Director

[10] Care, Compassion, Competence, Communication, Courage, Commitment

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		Review is carried out for all MRSA infections	and *Clostridium difficile* infections	
	Increase percentage of patients free from harm as assessed by NHS Safety Thermometer	Reduce harm from pressure ulcers	• Achieve NHS "Safety Thermometer" CQUIN	Chief Nurse
	Minimise venous thromboembolism	Continue to improve VTE assessment	• Achieve CQUIN	Medical Director/Director of Clinical Services
b)	**Domain 2: Patient Experience**			
	Introduce Friends and Family Test	• Introduce test for: - All inpatients and ED patients from Apr 13 - Women who have used maternity services from Oct 13 • Complete procurement for wider patient feedback system	• Achieve CQUIN	Chief Nurse

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
	Improve Dementia Care	• Improve screening for dementia • Improve referral to specialist services of identified patients • Clinical leadership and training • Support to carers	• Achieve CQUIN	Medical Director Chief Nurse
	Improve service to patients requiring a wheelchair	Develop an action plan to improve processes for timely referral and assessment of children requiring wheelchair equipment	• Meet requirements of 'Child in a Chair in a Day' CQUIN prequalification	Director of Clinical Services
c)	**Domain 3: Effectiveness and Outcomes**			
	Develop/extend the use of intra-operative fluid management technologies for patients during and after surgery		Meet requirements of CQUIN prequalification	Director of Clinical Services
	Improve medical outreach to older people with complex needs who are patients in surgical areas		Achieve CQUIN	Director of Clinical Services
	Build capacity in the organisation for clients with learning disabilities, dementia and vulnerabilities.	• Identify champions • Training	• Number of Learning Disability champions	Chief Nurse/Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		• Increase neurologist involvement in management of people with learning disabilities who present with seizures	who have attended training • Achieve CQUIN • Improved outcomes for vulnerable patients	
1.4	**Maintain/deliver national and local performance standards**			
	• Referral to treatment waiting times for non-urgent consultant-led treatment	• Delivery of theatres workforce plans	• ≥ 90% admitted patients to start treatment within 18 weeks • ≥ 95%non-admitted patients to start treatment within 18 weeks • ≥ 92% incomplete pathways within 18 weeks • No referral to treatment times >52 weeks	Director of Clinical Services
	• Diagnostic test waiting times	• Introduce 6 day working in endoscopy • Review ultrasound and musculoskeletal MRI provision	<1% of patients waiting 6 weeks or more for a diagnostic test	Director of Clinical Services
	• A&E waits and Ambulance Handovers	• Agree and	• ≥ 95% patients	Director of Clinical

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		implement action plan to support delivery • Respond fully to recommendations of Emergency Care Intensive Support Team • Ensure all patient pathways are clearly defined and effective • Ensure all Divisions are engaged • Establish Therapies Rapid Response Service, working with SHDS to avoid admissions • Ensure there is a process in place to escalate potential breaches to the appropriate level of management • Consolidate and develop Children's Urgent Care Pathway	admitted, transferred or discharged within 4 hours of their arrival in ED • Maximum 12 hour trolley wait in ED • Handovers between ambulances and ED Department within 15 minutes • Achieve CQUIN ("Emergency Care Intensive Support Team Action Plan")	Services
	• Cancer Waits	• Introduce 7 day working on linear	• 93% of patients seen within 2 weeks of an	Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		accelerators • Achieve agreement for the Outline Business cases to expand radiotherapy capacity	urgent GP referral for suspected cancer • 96% of patients receiving 1st definitive treatment within 1 month of cancer diagnosis • 85% of patients receiving 1st definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer • Where subsequent treatment is radiotherapy 94% of patients receiving treatment within 31 days	
	• Cancelled operations	Review theatre utilisation and list management/planning	• All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within	Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
			28 days, or the patient's treatment to be funded at the time and hospital of their choice • No patient to be cancelled for a second time for an urgent operation	
1.5	**Strengthen nursing care (linked to recommendations of Francis report)**		Achieve Nursing CQUIN	Chief Nurse
		• Evaluate and benchmark ward based nurse staffing levels at least annually	Evaluation and benchmarking	
		• Progress Modernising Nursing Careers plan in relation to Band 8 nurses and midwives	Agreed Competency framework	
		• Review and relaunch Band 7 Leadership Programme	At least 2 cohorts of the programme run	
		• Review and expand Healthcare Assistant Academy	Run monthly programmes	
1.6	**Optimise Configuration of Patient Services**	• Consult on future		Director of Clinical

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		delivery of emergency surgery across the Trust, develop plan and implement		Services
		• Maximise the use of the Horton General Hospital to improve services in the north of Oxfordshire	• Undertake public consultation with CCG on the future of the Horton General Hospital	Director of Clinical Services
		• Resolve mixed sex accommodation issues	• Mixed sex accommodation breaches	Director of Clinical Services
		• Relocate respiratory inpatients and Cystic Fibrosis service to the JR site • Relocate and reorganise respiratory day case and outpatient service on Churchill site	• Agreement of business case (Summer 2013) • Relocation by end of March 2014	Director of Clinical Services
		• Relocate Clinical Genetics to NOC site	• Agreement of business case (Summer 2013)	Director of Clinical Services
		• Review outpatient capacity on the	• Identify clinic requirements	Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		Churchill site with objective of vacating old estate	• Relocate services	
SO2	**To be a well-governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs – " a well-governed and adaptable organisation"**			
2.1	**Achieve NHS Foundation Trust Status**	• Progress application	• Submit updated Integrated Business Plan and Long Term Financial Model • TDA support • Monitor assessment	Director of Planning and Information
2.2	**Continue to improve Governance and Assurance systems**			Director of Assurance
a)	**Ensure the continued provision of a legal services department which meets the needs of the Trust**	• Undertake a review of the legal services department • Present a proposal to TME on proposed changes • Implement changes as identified through the review	• Review to be completed by 31 December 2013 • All changes to be implemented by 1 April 2014	Director of Assurance
b)	**Review and implement changes to the policy management framework**	• Use LiA methodology to support the review • Seek approval from the Trust Board to implement changes	• LiA event to be held in July 2013 - Completed • Trust Board to consider revised approach	Director of Assurance
c)	**Continue to implement action plans to**	• Ensure evidence is	• Full evidence sets to	Director of Assurance

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
	ensure continued compliance with CQC outcomes and other regulations	populated on Health Assure at clinical service level • Quality assess the evidence and make recommendations for improvements • Implement inspection team	be available	
2.3	**Continue to realise the benefits of the introduction of the Electronic Patient Record**	• Agree future development path	• Agree future roll-out plan • Agree reprocurement approach	Director of Planning and Information
2.4	**Develop and support OUH leadership community to deliver**	Create a Leadership Strategy (Framework) and Plan which supports the on-going development of leaders	Strategy and Plan developed	Director of Workforce
		Introduce a 360º feedback process into appraisals to support personal development planning	360º feedback mechanism in place	Director of Workforce
		Commence a training needs analysis of leaders on a phased basis	Training needs analysis completed for ward sisters and other priority groups	Director of Workforce
2.5	**Carry out Trust's legal obligations with regard to Medical Revalidation**	• Ensure each doctor	• All doctors have	Medical Director

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		has a quality-assured annual appraisal. • For those doctors who have revalidation dates within 2013/14 make revalidation recommendation	quality-assured annual appraisal • Revalidation recommendations made for the 20% of doctors with revalidation dates Apr 13-March14	
SO3	**To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – "delivering better value healthcare"**			
3.1	**Increase productivity and delivery of CIPs year on year in line with the agreed financial strategy and within the agreed performance framework/compacts**	• Deliver agreed Financial Plan	Financial plan	Director of Finance and Procurement supported by Director of Clinical Services
		• Deliver Cost Improvement Programme	Cost Improvement Programme	
		• Downsize commensurate with commissioner QIPP delivery	QIPP delivery	
3.2	**Maximise the utilisation of resources through extending hours and increasing 6 and 7 day working**	• Business case for 23 hour day surgery unit • Develop weekend gynae scanning and Saturday theatre sessions • Pilot 7 day		Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		radiotherapy service • Review scope to extend working hours in theatres		
3.3	**Develop workforce plans that respond flexibly to activity levels within the affordable financial envelope whilst maintaining quality standards**	Improve workforce and capacity business planning capability to reduce reliance on temporary workers during peak periods of activity	Workforce expenditure in line with agreed budgets	Director of Clinical Services/Director of Workforce
		Align job plans, shift arrangements and rotas to service requirements Improve staff retention and reduce turnover and sickness absence	Achieve agreed turnover, sickness absence and recruitment KPIs	Director of Clinical Services Director of Workforce
		Improve the effectiveness of the recruitment process to avoid pressures associated with high vacancy rates		Director of Workforce
3.4	**Improve utilisation of Trust's estate**	Reconfigure theatre and critical care facilities across sites, refurbishing facilities where required		Director of Development and the Estate

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
3.5	**Use IM&T to improve quality and efficiency**			
	Reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions	• Project to reduce antenatal visits for gestational diabetics • Project to improve physical outcomes post myocardial infarction	Meet requirements of "Digital First" CQUIN prequalification	Director of Clinical Services
	Work with Oxford Health NHS FT and Oxfordshire Social Services to increase the use of telemedicine to provide whole system care delivery close to home	• Agree plan for use of telehealth/telecare to support more accurate assessment of patients who have become acutely unwell in community settings	Meet requirements of "3millionlives" CQUIN prequalification	Director of Clinical Services
	Extend ICE on-line ordering to radiology requesting/reporting	• Roll out ICE to radiology requesting/reporting	Meet requirements of "Digital First" CQUIN prequalification	Director of Planning and Information
	Prepare for paperless referrals in NHS (target date March 2015)	• Strengthen underpinning IT infrastructure	Update clinic templates to support Directly Bookable Services	Director of Planning and Information
3.6	**Develop initiatives to reduce length of stay**	• Extend Enhanced Recovery After Surgery • Extend use of minimally invasive surgery		Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		• Improve provision of specialist support for medicine patients with GI bleeds		
3.7	**To change OUH from an expenditure-led service line reporting organisation to an income-led Service Line Management organisation with a focus on positive contribution**	• Promote the use of Patient Level Information and Costing System (PLICS) and Service Line Reporting (SLR) information throughout the organisation allowing the Divisions to more effectively manage services and costs • Encourage Divisions to improve accuracy of clinical coding and optimise clinical productivity, including job planning • Undertake specific work with NTSS and S&O Divisions to analyse factors driving performance	• SLR and Reference costs used in Divisional Performance reviews • SLR analysis included in evidence within business case submissions and improvements in SLR performance included in criteria for approving change	Director of Finance and Procurement

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		with objective of making recommendations for reducing costs and improving financial performance		
3.8	**Introduce internal trading for Radiology and Pathology**		• Implement 1st April 2013 • Monthly data distributed • Quarterly review meetings in place for all Divisions	Director of Clinical Services
SO4	**To provide high quality general acute healthcare to the people of Oxfordshire including more joined-up care across local health and social care services – "delivering integrated local healthcare"**			
4.1	**Work with partners to reduce the number of system wide delayed transfers of care (DTOCs)**	• Expand Supported Home Discharge Service (SHDS) • Roll out joint pilot between Therapies team and SHDS in ED to help reduce admissions • Develop a night care service to reduce admissions • Expand service provided to Abingdon	• 75% of patients to have an 'estimated date of discharge' (EDD) documented within 36 hours of admission • Meet Local CQUIN payment criteria	Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		Community Hospital • Joint audit with Oxford Health FT to identify how urgent care is used (April-June) • Develop single point of access (availability of advice from expert nurse)		
4.2	**Develop relationships with local GPs, both as commissioners through CCG and its localities and as providers**	• Agree joint Work Programme • Individual workstreams agree objectives and deliverables		Director of Planning and Information
4.3	**Continue implementation of review of Acute and General Medicine**	• Develop model for Emergency Medical Unit (EMU)/Acute Ambulatory Multidisciplinary Unit at the JR and Horton sites	Agreed business case	Director of Clinical Services
		• Increase availability of intensive observation, treatment and nursing facilities	Develop business case for a Medical HDU on JR site	Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		within Trust		
4.4	**Continue to improve psychiatric liaison and access to psychological support for the Trust's patients**	• Establishment and full integration of the new Psychological Medicine Service in Acute General Medicine and Geratology • Consider the future requirements for psychological input into specialist services in line with NHSCB draft service specifications	• Meet CQUIN payment criteria	Director of Clinical Services
4.5	**Prepare Genitourinary Medicine (GUM) services for a tender exercise for all GUM services under the new commissioning regime within the local authority**	• Review costs and provision of existing service • Consider how to propose future service provision • Submit tender return (Aug 13)		Director of Clinical Services
4.6	**Improve the care of Diabetes patients**	• Develop multidisciplinary foot protection team and Diabetic Footcare Pathway	• Meet criteria for local CQUIN payments • Reduced length of stay for inpatients with diabetes	Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		• Improve care of inpatients with diabetes • Improve support for young adults (16 -25 year olds) with diabetes	• Compliance with NICE guidance • Benchmarked performance in Diabetes inpatient audit	
4.7	**Improve the care of Stroke patients**		• 80% spend 90% of stay on a Stroke Unit • 90% admitted within 4 hours • 100% scanned within 24 hours • 95% screened for swallow problems • 95% have Physiotherapy and OT assessment within 72 hours	Director of Clinical Services
4.8	**Provide enhanced community-based palliative care service for Oxfordshire, in collaboration with Katharine House Hospice and Sue Ryder**	• Establish "hospice at home" and a community respite/step down facility • Agree model for retention of in-patient services, including widening		Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		of End of Life Care to non-oncology interventions		
4.9	**Develop the Trust's role in preventing as well as treating ill health in accordance with the "Every Contact Counts" initiative**	• Participate in Maternity services pilot		Chief Nurse
SO5	**To develop extended clinical networks that benefit our partners and the people they serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialist care for the people of Oxfordshire and beyond – "excellent secondary and specialist care through sustainable clinical networks"**			
5.1	**Continue implementation of radiotherapy modernisation plan, including potential for satellite radiotherapy facilities**	• Develop outline business case for increased radiotherapy capacity (as above) • Expand use of IMRT in line with agreed business case • Implement prostate brachytherapy • Implement stereotactic body and brain radiotherapy • Develop business case for High Dose Rate radiotherapy		Director of Clinical Services
5.2	**Expand satellite haemodialysis provision**	• Agree business case for Swindon		Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
5.3	**Continue to deliver specific network service development initiatives:**			
	• Complete the expansion of neonatal services	• Completion of construction • Commission building • Expanded service operational		Director of Clinical Services
	• Progress the plan for the regional provision of Vascular Surgery	• Agreement of protocols and guidelines • Discuss proposals for development of Oxford as interventional radiology centre of excellence with neighbouring trusts and prepare business case		Director of Clinical Services
	• Continue to develop Oxford's role as Major Trauma Centre (MTC)	• Review implementation of MTC business case • Establish integrated Rehabilitation pathway • Improve interventional radiology provision		Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
	Continue to develop South of England Strategic Children's partnership for paediatric cardiac surgery, paediatric neurosurgery and paediatric critical care in association particularly with University Hospital Southampton FT	• Implementation of a Health Information Exchange		
	Continue to develop relationships with surrounding Trusts particularly through joint clinical appointments and the delivery of care locally	• Appoint to agreed Urology and lung clinical oncology posts • Develop business cases for further joint posts		Director of Clinical Services
	Review the service specifications published by the NHS England and prioritise investment in response			Director of Clinical Services
	Develop Transplantation Service	• Develop business case for Renal Medicine and Transplant Centre • Consider extension of transplantation portfolio, (including proposals for islet autotransplantation and liver transplantation)	• Complete Full Business Cases • Implement if agreed	Director of Clinical Services
	Review intestinal failure service provision	• Await outcome of		Director of Clinical Services

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		national assessment process • Develop full business case for future provision of service		
SO6	**To lead the development of durable partnerships with academic, health and social care partners and the life sciences industry to facilitate discovery and implement its benefits – "delivering the benefits of research and innovation to patients"**			
6.1	**Establish the Oxford Academic Health Science Network (AHSN)** as an entity independent of the Oxford University Hospitals. The AHSN is currently hosted by OUH	Advertise and appoint a qualified Chief Executive to direct the actions of the AHSN	• Advertisement in March/ April 2013 • Interview May 2013 • Appointment June 2013	Chief Executive (interim accountable officer and deputy chairman)
6.2	**Publish an 'innovation scorecard'** to show compliance with NICE guidance on new drugs and treatments or explain why there is a delay	Compile composite innovation scorecard of all NHS AHSN members regarding NICE compliance Publish local formulary	• Confirm NHS membership of AHSN • Agree standards for monitoring NICE compliance and returns and publication of local formularies	Chief Executive (interim accountable officer and deputy chairman)
6.3	**Pre-qualification High Impact Innovation for CQUIN under International & commercial activity**	Demonstrate that clear plans are in place to exploit the value of commercial intellectual property – either standalone or in	• Assure that clear plans are in place • Publish International & Commercial Activity	Chief Executive (interim accountable officer and deputy chairman)

Ref	Objective	Key Actions	Milestones/Measures	Accountable Director
		collaboration with Academic Health	strategy either as a Trust or AHSN joint strategy • Agree standardised Intellectual Property and Clinical Trials policy across NHS AHSN members	
6.4	**Apply for Academic Health Science Centre status**	• Submission of prequalifying questionnaire	• 31st May 2013	Chief Executive
6.5	**Progress the shared agenda with the University of Oxford and Oxford Brookes University**			Chief Executive
6.6	**Progress the strategies set out in the successful renewal bids for the Biomedical Research Centre and Unit (BRC/U)**	• Make progress in strategic development of BRC, establishing appropriate priorities	• 2 yearly review of all themes and working groups	Medical Director

Part Four – Financial Plan

Background

54. There is a continuing requirement for the NHS as a whole to make efficiency savings of £15-20 billion by 2014/15 for reinvestment back into services. This is usually referred to as the Quality, Innovation, Productivity and Prevention (QIPP) challenge and 2013/14 will be the third year for the delivery of these plans.

55. Within this context the NHS Commissioning Board (now known as NHS England) and the Trust Development Authority (TDA) issued their respective planning guidance for NHS Trusts for 2013/14 in December 2012, as described above. As well as setting out the agenda for quality and reform for the coming year, these documents also laid out the financial and business rules within which NHS Trusts are to operate. They emphasised that strong financial management and control needs to continue to be exercised.

56. The tariffs for NHS services for 2013/14 represent a reduction in prices, while the use of Best Practice tariffs continues.

Planning Context

57. The planning framework from the NHSCB in its document *Everyone Counts*, and from the TDA in *Towards High Quality, Sustainable Services*, included the following matters that need to be taken into consideration by Trusts when setting their financial plans for 2013/14:

    57.1. Commissioners must plan for a 2% recurrent surplus by the end of 2013/14.

    57.2. There is also a requirement for all commissioning organisations to set aside 2% of funding for non-recurrent expenditure.

    57.3. Clinical Commissioning Groups (CCGs) must hold a contingency of at least 0.5%.

    57.4. The national provider requirement for tariffs is 4%, offset against estimated provider cost inflation of 2.7%, leading to a net tariff reduction of 1.3%. The TDA provided an amendment to this which said that tariff prices will increase on average by an additional 0.2% in recognition of other underlying costs faced by providers so that the change in tariff is a reduction of 1.1%.

    57.5. The 30% marginal tariff for non-elective admissions above the 2008/9 baseline will continue.

    57.6. There will be a contractual fine for referral to treatment waits of more than 52 weeks.

    57.7. There will be contractual fines for A&E handovers that take longer than 30 minutes and a further fine for delays over an hour.

57.8. Trusts will continue to not be paid for emergency readmissions within 30 days of discharge from an elective admission.

57.9. Any reinvestment decisions regarding the funds realised from the application of marginal rates, or from the non-payment for emergency readmissions, will be jointly owned by both providers and commissioners.

57.10. No Trust is to plan for an operating deficit in 2013/14 or beyond.

57.11. Commissioners must enforce use of the terms set out in the NHS Standard Contract, including the financial consequences for under-performance or failure to provide data used to assess performance.

57.12. As described above, Commissioning for Quality and Innovation (CQUIN) payments will be set at 2.5% of contract. One fifth of this will be linked to four national CQUIN targets (for "Friends and Family" test, the NHS "Safety Thermometer", improving dementia care and venous thromboembolism (VTE) standards).

57.13. CQUIN payments will only be made to providers that meet the minimum requirements of the high impact innovations set out in the Department of Health's publication, Innovation, Health and Wealth, as described above.

58. The commissioning picture changed on 1 April 2013. Some services that were previously commissioned by Primary Care Trusts (PCTs) became the responsibility of CCGs from 1 April 2013 whilst others are now commissioned by NHS England, via the Wessex Local Area Team.

59. In addition, £622m has been transferred at a national level for Social Care to use in a way that benefits health. This is in addition to £300m reablement funding already earmarked for transfer and also affects the commissioning picture.

The OUH's own Planning Context

60. The Trust delivered a £3.6m surplus against its breakeven duty in the financial year 2012/13.

61. The planned surplus for 2012/13 was reduced by £4m following the settlement of the contract with NHS Oxfordshire and hence was lower than 1% of planned turnover. The Trust needs to demonstrate on-going financial stability, and to strengthen its liquidity position, as part of its preparation for Foundation (FT) status. The Trust's Long Term Financial Model therefore proposes that the organisation should restore its planned retained surplus to 1% of its turnover. Based on its current estimates of planned revenue, this equates to £8.4m, and a surplus of £10.9m against its breakeven duty for 2013/14.

62. The financial plans for 2013/14 take into account the following previously agreed service developments:

62.1. The full year effect of the development of the Trust's neonatology service, and the expansion of Intensive Care costs; and

62.2. The full year effect of being designated as a Major Trauma Centre with the region.

63. Financial pressures may also arise next year in the following ways:

63.1. Levels of over-performance against contracted levels are paid at marginal rates.

63.2. Marginal tariff is applied to emergency admissions.

63.3. CQUIN payments are not received at all because the Trust fails to meet minimum requirements.

63.4. The Trust meets the minimum requirements for CQUIN payments but does not achieve all criteria for receiving full payment for commissioners.

63.5. Penalties are applied by commissioners because key quality and other performance measures are not met.

63.6. There are inflation increases to agreed contract values – for example, there will be annual increases to the three private finance initiative (PFI) contracts that are linked to the retail price index (RPI). RPI is higher than the level of inflation assumed within the tariff.

63.7. It costs more to provide the same level of service as a result of (for example) incremental pay drift; expenditure on agency staff; patient, clinical or quality decisions leading to an increased use of high cost drugs; and backlog maintenance needing to be carried out.

63.8. The NHS clinical negligence scheme changes the way it calculates the contributions paid by its members. The intention is to narrow the gap between payments made into the scheme and payments made out on behalf of its members. As a result the Trust's contribution is increasing from £17.1m in 2012/13 to £18.1m for 2013/14.

63.9. The Department of Health has introduced tariffs for the provision of education and training. It is currently estimated that the Trust will lose £4.8m funding for the training of undergraduate medical students.

63.10. Capital charges rise, partly as a result of increases in the value of the Trust's land and buildings as assessed by the District Valuer and partly from the investment the Trust makes in fixed assets through its capital programme.

64. Given these significant challenges a general contingency of 1% of turnover has been recommended. An additional reserve to mitigate against commissioner-applied penalties and denials has also been set aside.

Commissioner Income

65. The majority of the Trust's predicted income will come from contracts with commissioners. The table below summarises the levels of income agreed with each of the Trust's main commissioners.

Commissioner	£
NHS Oxfordshire CCG	277,555
Other CCGs	72,860
Subtotal CCG income	**350,415**
NHS England (Wessex Area Team)	**339,965**
Total	**690,380**

Income and Expenditure (I&E) Account Budget 2013/14

66. The Trust revenue budget for the 2013/14 financial year is summarised in the table below.

	Plan 2012/13 £000	Outturn 2012/13 £000	Plan 2013/14 £000
Operating Income			
Commissioning Income	645,820	672,334	690,380
PP, Overseas & RTA Income	13,558	12,028	13,699
Other Income	129,359	137,343	136,901
Total Income	**788,737**	**821,705**	**840,980**
Operating Expenditure			
Pay	(443,684)	(450,411)	(469,679)
Non-Pay	(279,529)	(302,477)	(297,439)
Total Expenditure	**(723,213)**	**(752,888)**	**(767,118)**
EBITDA	**65,524**	**68,817**	**73,862**
Non-EBITDA Items	(61,922)	(65,171)	(62,991)
Break Even Surplus	**3,602**	**3,646**	**10,871**

Savings Plans

67. In order to meet the financial challenges for 2013/14 the Trust expects to need to save at least £44.7m next year. This is 5.5% of planned turnover.

68. A Cost Improvement Programme has been developed by the clinical Divisions with programme management development support. The programme is set out in the table below:

	£k	
Cross Divisional Schemes		
Blood Product Orders	300	
Diagnostic Tests	89	
Medicines Management	1,535	
Non Elective Flow	1,200	
Outpatients	500	
Procurement	4,279	
R&D & Training & Education	5,700	
Switchboard	50	
Theatres	1,979	
Waiting List Initiative	1,000	
Workforce	7,789	
Other	655	
Subtotal		**25,076**
Divisional Efficiency		**14,524**
Full Year Effect of schemes initiated previously		**5,130**
TOTAL		**44,730**

69. Design and delivery is overseen by a Steering Committee comprising Divisional Directors, Divisional Nurses and Divisional General Managers. The Committee is chaired by the Director of Clinical Services. All schemes have been quality assured by the Medical Director and Chief Nurse.

Capital Plan 2013/14

70. It is assumed that the sum invested in new capital projects in 2013/14 is equal to the cash generated from depreciation less the repayments of principal that the Trust has to make on its PFI contracts and finance lease agreements.

71. It is currently also assumed that funds generated from the surplus will not be invested in capital expenditure but will be used to strengthen the Trust's liquidity position.

72. The table below shows the current proposals for the capital programme for 2013/14 and the draft plans for the following three years.

OUH Capital Plan	2013/14 Plan £000s	2014/15 Plan £000s	2015/16 Plan £000s	2016/17 Plan £000s
Maintenance - medical and surgical equipment	2,600	2,704	8,768	9,119
Maintenance - IT/EPR	1,560	1,622	1,687	1,755
Maintenance - general estates	1,040	1,082	6,441	10,000
Maintenance - ward relocations	1,040	-	-	-
Maintenance - laboratories block 4	1,865	-	-	-
Maintenance - laboratory IT system replacement	1,040	541	-	-
Maintenance - other schemes below £1m	1,976	1,460	1,519	2,814
Maintenance - JR theatre 2 remodelling	-	8,653	2,250	-
Radiotherapy	4,240	8,058	-	-
IMRT - rapid arc installation and upgrade	2,585	-	-	-
Other schemes below £1m	4,346	280	5,962	6,201
Total Capital Programme Spend	**22,292**	**24,400**	**26,627**	**29,889**
Donations - Medical Equipment	260	270	281	292
PFI lifecycle and Equipment Leasing (IFRIC 12)	1,697	1,697	2,730	6,432
Asset Disposal	(200)	(200)	(200)	(200)
Donations - Medical Equipment	(260)	(270)	(281)	(292)
2012/13 Capital Resource Limit	**23,789**	**25,897**	**29,157**	**36,121**

Monitor Financial Risk Ratings 2013/14

73. Although the financial regimes for NHS Trust and Foundation Trusts are different, it is regarded as good practice for NHS Trusts to have certain policies and systems that meet the Foundation Trust regime where appropriate. One way of doing this is for the Trust to calculate the ratios used by Monitor to assess an organisation's financial risk rating. The risk rating scores for the Trust, based on its financial operating plans for 2013/14 are shown in the table below:

			Scores					Plan 2013/14	
Financial Criteria	**Risk Rating**	**Weight**	**5**	**4**	**3**	**2**	**1**	**Metric**	**Score**
Underlying Performance	EBITDA margin	25%	11%	9%	5%	1%	<1%	9.3%	4
Financial Efficiency	Net return after Financing	20%	3%	2%	(0.5%)	(5%)	< (5%)	1.2%	3
	I & E Surplus Margin	20%	3%	2%	1%	(2%)	< (2%)	1.0%	3
Liquidity	Liquid ratio (days)	25%	60	25	15	10	<10	27	4
Weighted Average									**3.20**
Overall Rating (see rules below)									**3**

Monitor - Rules Used to Adjust the Financial Risk Rating

Situation	Maximum Rating
Plan not submitted on time	3
Plan not submitted complete and correct	3
PDC dividend not paid in full	2
One financial criterion scored at '1'	2
One financial criterion scored at '2'	3
Two financial criteria scored at '2'	2
Two financial criteria at '1'	1
Unplanned breach of Prudential Borrowing Code (PBC)	2
Previous year's annual rating worse	No more than 2 points better than previous year
Less than 1 year as an NHS Foundation Trust	4
Deficit forecast in year 2 or 3	3
Deficit forecast in both years 2 and 3	2

Part Five – Monitoring the Plan

Integrated Performance Report (IPR)

74. The Trust Board monitors key performance metrics through the Integrated Performance Report which is produced monthly. The first two pages show performance 'at a Glance' across four domains **Operational**, **Finance**, **Quality** and **Workforce**. The following pages highlight areas of red and amber exceptions for the month with more detailed narrative to explain underperformance and actions taken to improve performance.

75. The IPR is being refreshed to ensure that it provides the Trust Board with key information, not only in relation to the key national performance standards described in this document, but also in relation to:

    75.1. **Quality** – to monitor:

    - progress in delivering the Trust's Quality Strategy
    - performance in relation to the new National Quality Dashboard; and
    - achievement in relation to the CQUINs agreed with commissioners.

    75.2. Performance in relation to operational standards included in contracts with commissioners, failure against which will incur **contractual penalties**

    75.3. **Workforce** metrics

    75.4. Performance in relation to **Monitor's Compliance framework**. As the Trust progresses its application to become an NHS Foundation Trust it provides a self-certification against Monitor's reporting standards to the Trust Development Authority.

    75.5. Performance in relation to the **Trust Development Authority's** wider **Accountability framework**, including the **Workforce Assurance tool**.

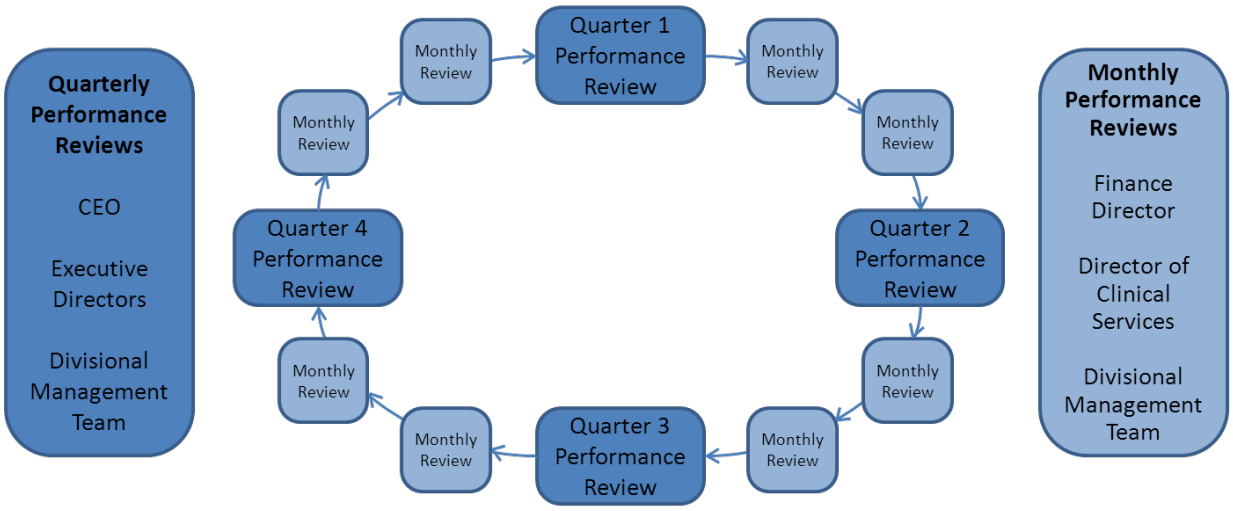
    75.6. Delivery of the **strategic objectives** set out above.

Review of Corporate Objectives

76. Reports on progress with delivery of the corporate objectives described in Part 3 will be brought to the Board after six and 12 months.

Divisional Performance Review

77. Each Division has produced a Divisional Business Plan for 2013/14 which includes a set of quality priorities. The Divisional Business Plans have been formally signed off at compact meetings between the Divisional management teams and corporate executive directors. The process to review delivery against these plans is shown in the diagram below.



Divisional Performance Review Process

78. Monthly performance meetings take place with each division led by the Director of Finance and Procurement. At quarterly divisional performance meetings, financial and non-financial performance measures (of quality, activity and workforce) are reviewed in detail by the Executive Team and actions agreed to mitigate emerging risks and to manage performance. These meetings provide an opportunity for divisions to explain performance and for corporate functions to offer support where required.

Part Six – Risk Management

79. The Trust Board will continue to monitor the principal risks to the delivery of the strategic objectives set out in Part Two through the Board Assurance Framework and Corporate Risk Register. Both of these have been reviewed in detail, with each risk owner, as a result of the transition to the new financial year. This review considered:

    79.1. The need to restate the strategic objectives and ensure the key risk areas reflect the contents of this Business Plan.

    79.2. The need to re-score the current risks following an assessment of the controls in operation during 2012/13 and the operational delivery achieved at the year-end.

79.3. The setting and monitoring of target risk scores going forward into the new financial year.

79.4. Work to strengthen the analysis of actions needed to close the gap between the current risk score and the target risk score.

79.5. The validity of risk proximity scores, the relationship with the risk target and risk proximity changes over time.

Principal Risk	Lead Director	Manifestation	Mitigation
1. Failure to maintain the quality of patient services	Medical Director	**Potential Cause:** • Failure to meet the Trust's Quality Strategy goals • Failure to deliver the quality aspects of contracts with the commissioners • Patient experience indicators show a decline in quality • Breach of CQC regulations. • CIPs impact on safety or unacceptably reduce service quality • Poor Bed Management processes impact on patient safety. **Potential Effect:** • Poor patient experience and standards of care • Inaccurate or inappropriate media coverage **Potential Impact:** • Potential loss of licence to practice • Potential loss of reputation • Financial penalties may be applied • Poor Monitor Governance Risk Rating	Focus on quality issues and the use of meaningful benchmarks • Quality metrics in monthly Divisional Quality Reports • 'Safety Thermometer' data • 'Observations of care' reviews • Patient feedback via complaints & claims and via the Friends & Family test • Incident reporting • Quality Strategy and clear quality priorities • CQUIN & Contract monitoring process • Quality impact review process of all CIP plans • Morbidity & Mortality / clinical governance meetings at service level • Benchmarked outcomes data • Quality meetings between executives and CCG • Pressure Ulcer Reduction Plan Staff engagement and awareness of required standards • Promotion of Trust Values • Whistleblowing policy • Appraisal / revalidation Close liaison with NHSLA and CQC to build trust and confidence Development of positive profile for OUH services in the media
2. Failure to maintain financial sustainability	Director of Finance and Procurement	**Potential Cause**: • Failure to deliver the required levels of CIP	• Two-year rolling CIP with contingencies in place. • Divisional ownership of schemes. • Programme office support of schemes.

Principal Risk	Lead Director	Manifestation	Mitigation
	Director of Development and the Estate	• Failure to effectively control pay and agency costs • Failure to generate income from non-core healthcare activities • Failure to manage outstanding historic debt • Services display poor cost-effectiveness **Potential Effect**: • Additional CIPS may need to be identified and delivered • Poor environment for patients **Potential Impact:** • Reductions in services or the level of service provision in some areas • Potential loss in market share and or external intervention	• Contingency plans for strategic disinvestments and sale of assets in place • Performance Management Regime in place • Budget setting & business planning processes • Quality Impact Assessment process • Contract monitoring process • Patient Level Information and Costing System in place – Trust part of DH PLICs based reference costing pilot • Space utilisation review • Implementation of Estates Strategy • Estates 6 facet survey underway
3. Failure to maintain operational performance	Director of Clinical Services	**Potential Cause**: • Failure of national performance target (ED, cancer, RTT) • Failure to reduce delayed transfers of care in the changing NHS environment • Failure of accurate reporting and poor data due to implementation of EPR **Potential Effect:** • High numbers of people waiting for transfer from inpatient care • Delays in patient flow, patients not seen in a timely way • Reduced patient experience • Failure of KPI's and self- certification. **Potential Impact**: • Services may be unaffordable • Quality of care provided to patients may fall • Loss in reputation	• Monthly Programme Board, with representation from OUH, social services and the PCT at Chief Executive level • Bi-weekly Project Team meetings at Chief Operating Officer/Director of Clinical Services level • Internal weekly DToC meetings • Supported Discharge Service in place with 8 work streams • Provider Action Plan (DTOC) • Monthly Chief Executives meetings • A&E Action Plan • Internal Urgent Care Programme Board • Urgent Care Task Force • Diagnostic Waits Action Plan • Close liaison and planning with social care • Collaborative work on care pathways, education and training

Principal Risk	Lead Director	Manifestation	Mitigation
		• Failure to meet contractual requirements • Failure to gain FT status • Requirement to maintain additional beds	
4. Mismatch with commissioners' plans	Director of Planning and Information	**Potential Cause:** • Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels • Lack of robust plans across healthcare systems • Loss of Commissioner support • Inability to respond to requirements to flex capacity **Potential Effect:** • Loss of existing market share • Stranded fixed costs due to poor demand management / QIPP • Difficult to manage capacity plans **Potential Impact:** • Reduced financial sustainability • Inability to meet quality goals • Reduced operational performance	• Strategy developed with commissioners • Compliant Contracts in place for 13/14 • Commissioner alignment meetings in place • Contingency plans for withdrawal from services developed • Quarterly review against plan. • Monthly meetings with CCG • Creating a Healthier Oxfordshire Board • Lavender statements in place
5. Loss of share of current and potential markets	Director of Planning and Information	**Potential Cause:** • Loss of existing market share • Failure to gain share of new markets • Negative media coverage relative to our competitors) • Lack of support for business cases **Potential Effect:** • Poor staff morale • Stifles innovative developments / ability to redesign services **Potential Impact:** • Reduced influence/ reputation across the health economy • Reduction in overall income, reduced	• Commissioner approved Network Strategies • Clinical Network meetings • Oxford Health collaborative arrangements • Contingency plans for withdrawal from services • Continued monitoring and engagement with local economy partners as set out in Risk 3 • AHSN Programme

Principal Risk	Lead Director	Manifestation	Mitigation
		financial stability	
6. Failure to sustain an engaged and effective workforce	Director of Workforce	**Potential Cause:** • Difficulty recruiting and retaining high-quality staff in certain areas • Low levels of staff satisfaction, health & wellbeing and engagement • Insufficient provision of training, appraisals and development **Potential Effect:** • Low levels of staff involvement and engagement in the trust's agenda • Higher than average vacancy rates • Failure to deliver required activity levels / poor staff effectiveness **Potential Impact:** • Poor patient experience and outcomes • Poor CQC assessment results • Poor patient survey results • Loss of reputation • Reduced ability to embed new ways of working	• 'Values into Action' / Listening into Action Programme in place • Improved recruitment and induction processes • Staff engagement and awareness programme in place • Divisional Staff Survey Action Plans • Value based interviewing project • Education and development processes in place • Appraisal compliance and training attendance monitored
7: Failure to deliver the required transformation of services	Director of Clinical Services	**Potential Cause:** • Failure to maintain the development of organisational culture • Failure to maintain capacity and focus on longer term planning • Organisational barriers impede the Trust's ability to apply research to innovative models of care and patient pathways **Potential Effect:** • Low levels of staff involvement / engagement in service redesign. • Failure to increase utilisation of high value resources and inability to reduce	• Quality Strategy and Implementation Plan • Strategy to be built in to recruitment, appraisal and performance management processes • Clinical management structure • Learning & development framework • Job planning and Appraisal processes • Leadership programmes • Enhanced patient involvement • Service Improvement Programmes • Workforce Strategy • Implementation Programmes for key strategic documents

Principal Risk	Lead Director	Manifestation	Mitigation
		delivery costs • Failure to deliver new patient pathways • Failure to obtain the clinical advantages from EPR • Failure to embed robust governance and assurance processes **Potential Impact:** • Patient experience • Operational performance • Services fail to achieve long term sustainability	
8: Failure to deliver the benefits of strategic partnerships	Director of Planning and Information	**Potential Cause:** • Failure to establish sustainable regional networks • Failure to provide adequate support for education • Failure to support research and innovation **Potential Effect:** • The emergence of more effective or innovative leaders elsewhere • Failure to develop innovative services **Potential Impact**: • Threat to sustainability of specialist services. • The possible requirement to scale back some services	• Joint working agreement with Oxford Universities • Strategic Partnership Board 1/4ly meetings (Joint Chair Dame Fiona Caldicott) • Education and training strategy • Lead role in AHSC – Local Oxford partners • Lead role in AHSN – Wider network partners • Clinical network groups • Engagement strategy • DoC Trust Lead with CCGs, Oxford Health, SS in relationship management process

Appendix A – NHS Outcomes Framework Measures
which the NHS Commissioning Board and CCGs will use to track progress[11]

1. Preventing People from Dying Prematurely
Potential years of life lost from causes considered amenable to healthcare
Under 75 mortality rate from cardiovascular disease
Under 75 mortality rate from respiratory disease
Under 75 mortality rate from liver disease
Under 75 mortality rate from cancer
2. Enhancing quality of life for people with long term conditions
Health-related quality of life for people with long-term conditions
Proportion of people feeling supported to manage their condition
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)*
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s*
Estimated diagnosis rate for people with dementia
3. Helping people to recover from episodes of ill health or following injury
Emergency admissions for acute conditions that should not usually require hospital admission*
Emergency readmissions within 30 days of discharge from hospital
Total health gain assessed by patients i. Hip replacement ii. Knee replacement iii. Groin hernia iv. Varicose veins
Emergency admissions for children with Lower Respiratory Tract Infections*
4. Ensuring that people have a positive experience of care
Patient experience of primary care i. GP Services ii. GP Out of Hours services
Patient experience of hospital care
Friends and Family test
5. Treating and caring for people in a safe environment and protecting them from avoidable harm
Incidence of healthcare associated infection i. MRSA *ii. Clostridium difficile*

*Will be used as part of a composite measure on emergency admissions

[11] NHS Commissioning Board, December 2012, Everybody Counts: Planning for Patients 2013/14, p35

Appendix B – Locally Agreed CQUINs

Local Commissioners (CCGs)		Specialised Commissioners (Wessex Local Area Team)	
Psychiatric Liaison Service	Plan for future of service	**Specialised Clinical Dashboard**	Submission and use of data for required specialised services quality dashboards
Baseline data for frail elderly patients+ DTOC	• DTOC audit – inpatient discharge pathway • Whole system audit	**Highly Specialised Services**	Participation in collaborative audit workshop (submission of appropriate analysed outcome data and attendance at workshop)
Medical support for complex patients in surgery	Continue existing pilot and evaluation	**Renal Transplant – cold ischaemic time**	Progress towards targets of: • Maximum of 18 hours for donation after brainstem death donor transplants • Maximum 12 hours for donation after circulatory death donor transplants
Emergency Admission Navigators	Single point of access expert nurse to phone with eventual reduction in admission rate for ambulatory care sensitive conditions	**Haemophilia**	Actions aimed at increasing the numbers of severe and moderate haemophilia A and B patients for whom clotting factor usage data are provided via the Haemtrack electronic monitoring system
Nursing	Nurse leadership programme 1. Peer review ward audits 2. Exit interviews, resulting actions and reduction in staff turnover	**Intravenous Immunoglobulin (IVig)**	Approval of immunoglobulin infusions by regional immunoglobulin panel – entry of patients and complete data onto database

Local Commissioners (CCGs)			Specialised Commissioners (Wessex Local Area Team)	
	3. Discharge processes 4. Length of stay			
Diabetic foot disease	Multidisciplinary foot protection team and pathway, in line with evidence based care bundle		**Major Trauma**	• % of patients with definitive cover of severe open lower limb fractures within British Orthopaedic Association Standards for Trauma (BOAST) 4 guidelines within 72 hours of injury • % of patients who have one or more long bones stabilised within 24 hours of injury
Learning Disability	Identification to ensure receive correct care Increased neurologist involvement where present with seizures		**Neonatal Intensive Care – Complex Discharge**	Identification of babies with a gestational age under 36 weeks who may be suitable for short-term nasogastric tube feeding at home whilst breast or bottle feeding is established and provision of outreach service to allow this to happen
Diabetic support for young adults (19-25 year olds)	To be developed			
ECIST (Emergency Care Intensive Support Team) report – Action plan	Action plan addressing issues highlighted by ECIST and King's Fund report			