

Trust Board Meeting in Public: Wednesday 11 May 2016
TB2016.50

Title	Trust Business Plan 2016/17
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Status	For approval
History	<p>This is the third draft of the Trust Business Plan. The first draft was discussed by the Trust Board on 23rd March 2016. The second draft was discussed by the:</p> <ul style="list-style-type: none"> • Trust Board at its Seminar on Wednesday 27th April 2016 • Council of Governors on 28th April 2016 • Trust Management Executive on 28th April 2016

Board Lead(s)	Mr Andrew Stevens, Director of Planning and Information			
Key purpose	Strategy	Assurance	Policy	Performance
	The Trust Business Plan incorporates all these elements			

Executive Summary

1. This is the third and final draft of the Trust Business Plan for 2016/17. The Plan has been developed in the context of the Operational Plan which the Trust has submitted to NHS Improvement. The purpose of this Plan is to set out in one document for staff, members and other stakeholders:
 - The Trust's Vision and Values
 - The Strategic Context, including delivery of 2015/16 objectives and the Trust's Strategic Review
 - The Trust's approach to maintaining and improving Quality
 - How the Trust will recruit, retain and develop the right Workforce
 - The Financial Plan
 - A set of Corporate Objectives for 2016/17
 - How delivery of the Plan will be monitored
 - How risks to the Plan will be managed
2. This third draft incorporates comments on the previous two drafts. The main changes since the second draft are:
 - Additional information on how the Trust will recruit, retain and develop the right workforce
 - Information on the Commissioning for Quality and Innovation indicators that the Trust has agreed with its commissioners
 - The Financial Plan for delivering the objectives described
 - The approach to managing the risks to delivery of the plan
3. **Recommendation**

The Trust Board is asked to approve the Trust Business Plan.

Business Plan 2016/17

**Delivering
Compassionate
Excellence**

learning
respect delivery
excellence
compassion improvement

ABBREVIATIONS AND ACRONYMS

AAU	Adams Ambulatory Unit
AHSC/N	Academic Health Science Centre/Network
AKI	Acute Kidney Injury
BAF	Board Assurance Framework
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CH	Churchill
CIP	Cost Improvement Programme
COO	Chief Operating Officer
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSW	Clinical Support Worker
CUR	Clinical Utilisation Review
DDA	Disability Discrimination Act
DTOC	Delayed Transfer of Care
DTR	Default Tariff Rollover
EAU	Emergency Assessment Unit
EBITDA	Earnings before interest, tax, depreciation and amortisation
ED	Emergency Department
EDPS	Emergency Department Psychiatric Service
EOLC	End of Life Care
EPR	Electronic Patient Record
FBC	Full Business Case
FT	Foundation Trust
GMC	General Medical Council
HEETV	Health Education England Thames Valley
HCV	Hepatitis C Virus
I&E	Income and Expenditure
IR	Interventional Radiology
JR	John Radcliffe
KPI	Key Performance Indicator
LIFT	Local Improvement Finance Trust
LTFM	Long Term Financial Model
MAU	Medical Admissions Unit
MDT	Multi-Disciplinary Team
MEPG	Medical Equipment Priority Group
MRI	Magnetic Resonance Imaging
NHSE	NHS England
NHSI	NHS Improvement
NIHR	National Institute for Health Research
NOC	Nuffield Orthopaedic Centre
OCCG	Oxfordshire Clinical Commissioning Group
ODN	Operational Delivery Network
PCMI	Precision Cancer Medicine Institute
PDN	Practice Development Nurse
PET/CT	Positron Emission Tomography–Computed Tomography
PFI	Private Finance Initiative
PLICS	Patient Level Information and Costing System
PPE	Property, Plant and Equipment
PPI	Patient and Public Involvement

PROM	Patient Reported Outcome Measure
QIPP	Quality, Innovation, Productivity and Prevention
SACT	Systemic Anti-Cancer Therapy
SCN	Strategic Clinical Network
SEND	System for Electronic Notification and Documentation
SEU	Surgical Emergency Unit
SFIs	Standing Financial Instructions
SIFT	Service Increment for Teaching
SIRI	Serious Incident Requiring Investigation
SOs	Standing Orders
S&T	Sustainability and Transformation
STP	Sustainability and Transformation Plan
TDA	Trust Development Authority
TME	Trust Management Executive
TTO	To Take Out (medication)
WTE	Whole Time Equivalent

Introduction

1. Oxford University Hospitals NHS Foundation Trust

- 1.1. Oxford University Hospitals is a world renowned centre of clinical excellence, one of the largest NHS teaching trusts in the UK and a centre for high quality clinical research and education, supported by its collaboration with the University of Oxford. In 2014/15 the Trust's turnover was £916m, while the Trust employed 12,163 staff across its three sites in Oxford and one site in Banbury.
- 1.2. The OUH achieved NHS Foundation Trust status on 1st October 2015, at the same time welcoming a new Chief Executive, Dr Bruno Holthof.

2. Vision and Values

- 2.1. The Trust's mission, as set out in our application for NHS Foundation Trust status, 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.

- 2.2. The Trust has defined a set of core values which are set out in the table below:

Excellence
Compassion
Respect
Delivery
Learning
Improvement

- 2.3. **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.

- 2.4. Our 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

Strategic Context

3. Delivery of our 2015/16 Business Plan

- 3.1. The Trust's Business Plan for 2015/16 described a set of priority objectives for the organisation for the last financial year. These are set out in detail in Appendix A, together with a description of what we have delivered with regard to each.
- 3.2. In addition to achievement of NHS Foundation Trust status, key achievements included:
 - Delivery of quality initiatives, (these are described in detail in the Trust's Quality Report, published in May 2016)
 - Achievement of the 18 week maximum referral to treatment time standard and cancer standards
 - An increase in the substantive workforce, reducing our reliance on bank and agency staff
 - Approval of the full business case for the provision of a satellite radiotherapy unit at Swindon
 - Delivery of the Trust's 'stretch target' breakeven duty surplus of £5.3m.
- 3.3. The Trust has not met the standard that 95% of patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department during 2015/16. This will be an area of ongoing focus with health and social care partners in 2016/17.

4. National Strategic Context

- 4.1. The national strategic context in which OUH has developed this plan continues to be one of growing demand for health services, driven in particular by the needs of the ageing population, the implications of unhealthy lifestyle choices and increased patient expectations. At the same time healthcare continues to change with developments in treatments, technologies and care delivery. These factors combine to put continued pressure on NHS resources, while recent failings in the NHS have emphasised the importance of not losing sight of the imperative to maintain the safety and quality of care.

5. Local Strategic Context

- 5.1. The particular challenges for the Oxfordshire Health and Social Care system include the continued growth of the local population due to inward migration, including to new housing developments for example in Bicester, combined with increasing life expectancy, caused in part by the development of successful treatments for cancer and cardiac disease.

- 5.2. This growth is accompanied by demographic change, with a marked increase in the older population. Oxfordshire's 65 and over population grew by 18% from 2001 to 2011, while the number of people aged 85 and over rose by 30%. This growth is predicted to continue and is coupled with age-associated co-morbidity, with an 'epidemic' of frailty, cognitive impairment, such as dementia, and 'frailty syndromes', such as falls and immobility.

6. The Five Year Forward View¹

- 6.1. In October 2014 'The Five Year Forward View' was published, setting out a national vision for how the NHS should address the demands described above. Key elements of the vision set out were:

A focus on prevention and public health, underpinned by the building of new relationships with patients and communities
Giving patients greater control of their own care
The development of new and diverse models of care, facilitated by the removal of barriers between different organisations
Exploiting the information revolution
Acceleration of useful healthcare innovation
Driving efficiency and productive investment

7. Delivering the Five Year Forward View

- 7.1. In December 2015 'Delivering the Forward View'² was published, providing planning guidance for NHS organisations for the period 2016/17-2020/21. The guidance followed the Spending Review which included an £8.4 billion real terms increase in funding for the NHS by 2020/21. The NHS is now tasked with using this funding to implement the Five Year Forward view, while restoring and maintaining financial balance and delivering core access and quality standards for patients.

National 'must dos' for 2016/17

- 7.2. NHS organisations have been given a set of priorities for 2016/17 which reflect the Government's Mandate to NHS England which sets out national objectives and measurable deliverables for the current Parliament. The 'must dos' relevant to the OUH are set out in the table below:

¹ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

² <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>

Financial balance through efficiency savings
Contribute to returning the system to aggregate financial balance by delivering efficiency savings. This includes actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement.
A&E Standard
Ensure that 95% of patients wait no more than four hours in A&E.
Referral to Treatment Time
Improve and maintain performance against the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.
Cancer Standards and Survival
<p>There are three elements to this:</p> <ul style="list-style-type: none"> i) Delivering the NHS Constitution standard of a maximum 62 day wait for first treatment from referral for suspected cancer, including securing adequate diagnostic capacity. ii) Continuing to deliver the standard of a maximum 31 day wait for subsequent treatment. iii) Improving one year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one or two and reducing the proportion diagnosed following an emergency admission. <p>In relation to the third element, which is new, we are continuing to work with Oxfordshire CCG on streamlining access to investigations for patients in our catchment area. As well as speeding up the suspected cancer pathway, we are working up options for patients to go straight to test from primary care to achieve earlier diagnoses. One example of this work is the project we are setting up in the ACE (Accelerate, Coordinate, Evaluate) Programme 2nd wave.</p> <p>We have undertaken an audit (with the help of Cancer Research UK and NHS England) of emergency presentations of cancer to identify tumour, patient and system factors in why they came to attention by this route. This involved all 6 trusts in the region and 83 practices. We will be working with the CCG and the Cancer Strategic Clinical Network to disseminate learnings from the exercise.</p>
Dementia Diagnosis
Continue to meet a dementia diagnosis rate of at least two thirds of the estimated number of people with dementia.
Learning Disabilities
Deliver actions set out in local plans to transform care for people with learning disabilities.
Quality Improvements
This includes annual publication of avoidable mortality rates.

- 7.3. In addition, there is a continued focus on provision of **seven day services**. NHS England published ten clinical standards for seven day services in 2013, following the publication of the Francis report into failings at Mid Staffordshire. We have made significant progress with how our clinical teams hand over patients out of hours and have a programme to complete this work on all of our hospital sites by the end of March 2017.
- 7.4. The national self assessment programme for NHS England's four core clinical standards for seven day services has identified the Trust as a high achiever with the Trust assessed as being within the top quartile for the four critical standards. These standards include how quickly a consultant reviews a patient after admission, how quickly a patient receives diagnostic tests, how quickly patients get interventions requested by their consultant (such as MRI) and how often a consultant reviews patients on an ongoing basis, particularly those who have been critically ill. In March 2016 the Trust Management Executive approved the action plan to mitigate the risks for the small number of areas of non-compliance. Actions include improving weekend access to medicines reconciliation, dispensary opening times and TTO performance, introducing a 'real time' centrally-coordinated electronic medical rostering system and reviewing options for providing assessment of all emergency inpatients by a multi-disciplinary team within 14 hours of admission. The Trust has been designated nationally to be a Phase 1 Flagship site.
- 7.5. Care 24/7 is one of the Trust's Quality priorities for 2016/17. This work will include:
- Continuing to make improvements to the way clinical staff hand over care between teams 'out of hours' and ensuring that critically ill patients are seen by a consultant twice a day.
 - Working with clinical teams to define areas in the hospital that are high dependency.
 - Carrying out six monthly audits of patient records against the four priority standards as part of the national work programme. The audit data will help us identify improvements we need to make to provide seven day services.
- 7.6. It is anticipated that the Trust will be fully compliant with the four critical standards as a Phase 1 flagship site by March 2017.

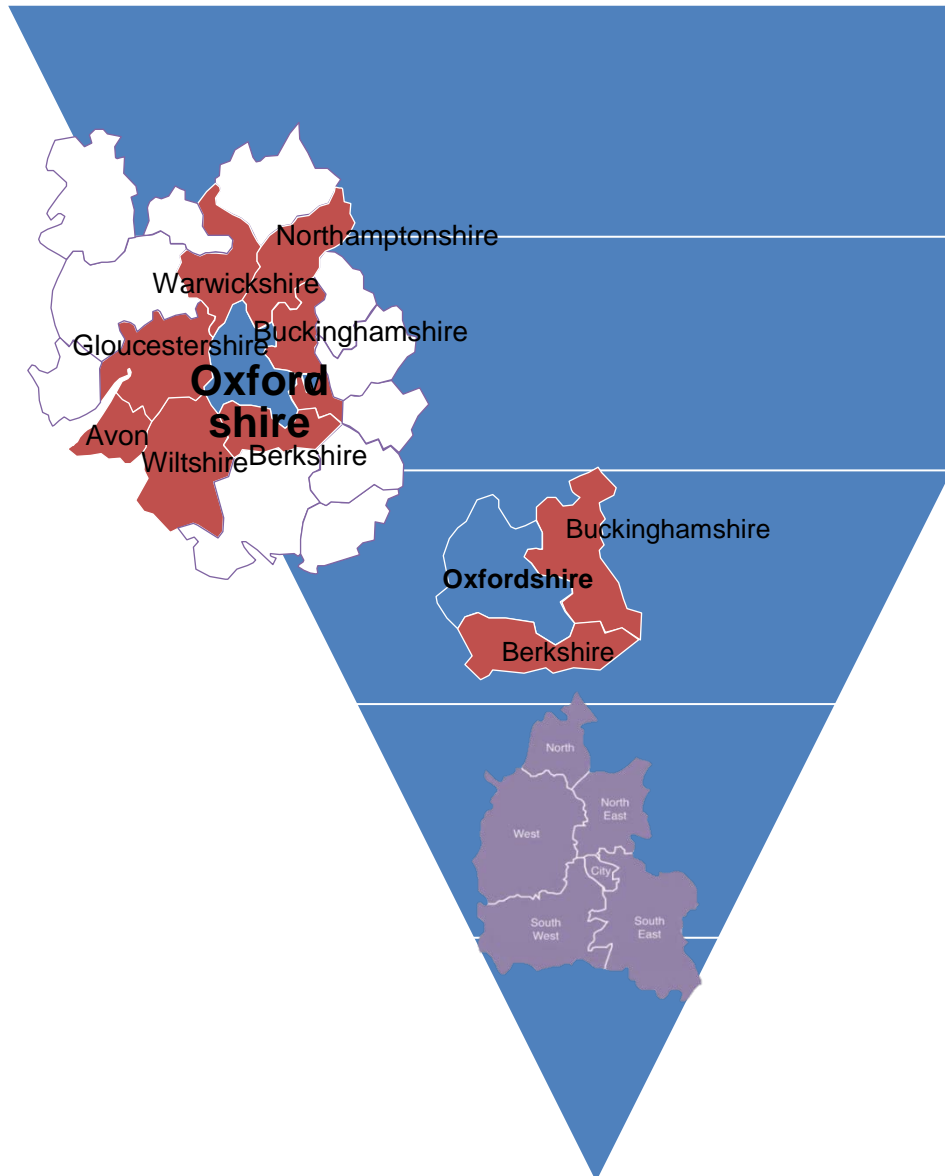
Sustainability and Transformation Plans

- 7.7. The planning guidance includes a requirement for NHS organisations to work with other organisations in their health and care system to create a local blueprint for accelerating implementation of the Forward View. Systems have been asked to

produce a five year, place-based Sustainability and Transformation Plan (STP) by the end of June 2016.

- 7.8. The footprint for the STP which the OUH is part of is Oxfordshire, Buckinghamshire and West Berkshire, but will link to a number of different footprints as illustrated in the figure below.

STP footprint



Services designed/planned on an England or UK-wide footprint (Highly Specialised Services)
 e.g. liver transplant services, enzyme replacement therapy, and secure forensic mental health services for young people

Services designed/planned Alliance+ footprint (specialised commissioning)
 e.g. chemotherapy, radiotherapy, complex rehabilitation

Services designed/planned on a Buckinghamshire, Berkshire and Oxfordshire Alliance footprint
 e.g. urgent and emergency care network; development of the integrated clinical hub and 111

Services designed/planned on a CCG footprint
 e.g. planned care, maternity

Services designed/planned on a locality-footprint
 e.g. new models of care; customisation of CCG models for long-term conditions,

7.9. The initial projects and workstreams include:

Urgent and emergency care
Specialised commissioning
Workforce Resilience
Digital Innovation
Clinical Thresholds
Primary Care Provider development
Procurement
Provider landscape strategic oversight

7.10. Part of the STP is the **Oxfordshire Transformation Programme**, led by the local Transformation Board and involving the OUH and local partners - Oxford Health NHS FT, Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, PML Federation³, South Central Ambulance Service and Ox Fed (Oxfordshire Federation for General Practice and Primary Care).

7.11. In Oxfordshire the work to design new models of care, as described by the Five Year Forward View, is being organised around seven service area workstreams:

1.	Urgent and Emergency Care for the general adult population
2.	Planned (Elective) care
3.	Integrated care for frail older people and adults with Long Term Conditions (encompassing End of Life care)
4.	Maternity/paediatrics - this will include consideration of the National Maternity Review, published in February 2016 ⁴
5.	Specialist
6.	Mental Health Services
7.	Learning Disabilities Services

7.12. Following submission of the STP in June the proposals contained in it will be the subject of a public consultation.

³ A federation of 35 GP practices in Oxfordshire and 16 GP practices in Northamptonshire

⁴ <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

- 7.13. The STP will need to demonstrate that the local system is prepared to rapidly deliver prevention programmes and care redesign in order to obtain transformation funding.
- 7.14. The process has commenced to select a network of **Champions of Change** across the OUH and the other providers of healthcare in Oxfordshire who will be tasked with delivering the outcomes of the STP programmes. Their key objective will be to catalyse action, to begin implementing change which will improve the quality of care for patients, while reducing the consumption of resources, improving operational performance and realising financial savings for re-investment.
- 7.15. In addition to the work on the transformation of local services, the OUH will be discussing the provision of more specialised services with the other acute hospitals covered by the STP footprint. This discussion will include how the **provision of specialised services through networks** can be strengthened, for example through increased joint consultant appointments, the delivery of clinics in different locations or investment in satellite facilities, such as the new satellite radiotherapy facility in Swindon which recently received approval from NHS England.

8. OUH Strategic Review

- 8.1. Within the strategic context described above, the Trust has initiated a review of its clinical services in collaboration with the University of Oxford and other partners. The review was launched at an event on 24th February 2016, involving over 100 delegates comprising key clinical and non-clinical Trust staff along with other Oxfordshire health providers and commissioners and representatives from the University of Oxford, Oxford Brookes University, Oxfordshire County Council and NHS England. This strategy building workshop developed a shared understanding of the role of OUH in future Oxfordshire healthcare provision by setting the strategic scene in which plans are to be developed, promoted a wider sign up to strategic objectives from partner organisations and gained agreement on a methodological framework in which future strategic service provision decisions and planning for OUH strategy will be made.
- 8.2. A meeting was subsequently held on 2nd March 2016 to discuss the OUH strategic review with partners from the Academic Health Science Network, together with the STP work on the provision of specialised services through networks. This meeting agreed action in two areas:

- **Clinical service reconfiguration**

- 8.3. A number of issues were identified as being pressing problems shared across a number of partners within the network. These will serve as initial areas of focus to pilot a strengthened way of collaborative working across the network. Suggested topics included:

Acute/interventional emergency services
Cancer services
Ophthalmology
Dermatology
Children's services (including emergencies)
Orthodontics
Referral processes (including the process of repatriating patients to their local hospital when they have been admitted to a specialist centre)

- **Joint initiatives**

- 8.4. It was also agreed that cooperation across other domains of activity could be beneficial. Suggested issues included:

Back office functions, e.g. IT and procurement
Developing joint approaches to strengthening social care
Undertaking shared recruitment and development initiatives

- 8.5. A follow up meeting took place in April 2016.

- 8.6. There are five themes to the OUH strategic review:

“Home Sweet Home” (Local Health Integration)

- 8.7. We see the best healthcare in the future being provided to patients across Oxfordshire as close to their homes as possible. We believe this requires a wider collaboration and pooling of resources with other local health providers under more devolved responsibility with more flexibility to allocate resources across the health system.
- 8.8. This vision requires our OUH staff to be mobilised in a way that allows them to support more care being offered outside our hospitals, with patients' homes as a default, but other locations to also be considered, for example GP surgeries or community hospitals.
- 8.9. As a first step, in December 2015 a system-wide **Oxfordshire joint patient transfer plan**, involving health and social care providers was implemented to rebalance capacity across Oxfordshire so that patients who no longer needed hospital care would be transferred

to be cared for either in care homes or in their own homes with care. This rebalancing of capacity should not only improve the quality of care for patients, but also support sustainable delivery of the four hour A&E standard, whilst releasing resources which can be used for other elements of care.

- 8.10. The delivery of care closer to home will be addressed through the development of the STP described above which will consider the most suitable place for care to be accessed and delivered. This will cover a variety of locations, including the patient's own home, GP surgeries and other hubs located in the community, ideally in centres of existing population density or growth. As emphasised by the Five Year Forward View, public health and prevention will be an important element of this.
- 8.11. As part of this work the OUH will assess what services it should be delivering in what location and the implications for resources and infrastructure. This will include determination of a **vision for the Horton hospital**, with the aim of creating healthcare facilities fit for the 21st century. An analysis has indicated that if patients were seen at the site closest to their home, the number of patients seen at the Horton could be doubled, reducing the number of visits to the Headington sites by 10%.

“The Master Plan” (long term estates planning)

- 8.12. The outcomes of the STP will also have significant implications for the infrastructure required by the OUH and its partners across Oxfordshire. This will apply to buildings, transport and housing for our staff. The OUH already faces considerable challenges in this regard. Although we benefit from some high quality estate, other areas are ageing and posing increasing challenges for the delivery of 21st century healthcare, while building costs in Oxford are significant.
- 8.13. Access to the Headington sites is challenging as the transport infrastructure is not designed to accommodate the number of staff and patients travelling to the three OUH Oxford sites and parking is restricted by local authority transport policy. There is also a shortage of affordable housing for staff, with Oxford officially recognised as the least affordable town/city to live in the country, as the cost of living is not reflected in a geographical allowance element of staff salaries as it is in London and its environs. Analysis has demonstrated that the affordability and travel issues have a significant impact on recruitment and retention of OUH staff.
- 8.14. Developing a vision for a “Master Plan” for the future development of and investment in our estate is therefore essential to ensure we have the facilities and infrastructure in place to deliver our clinical strategy. The future vision is to maximise the clinical utilisation of the parts of the estate which are either new or improved, vacating buildings which are inefficient, old, tired and in need of replacement. This will involve relocating administrative functions

from expensive clinical space to cheaper locations, allowing the vacation and demolition of our worst estate.

- 8.15. The Master Plan needs to be driven by an understanding of which services are best delivered where, as determined through the STP work. Delivering care closer to home will release space on the acute sites. This has been demonstrated by the initiative to reduce delayed transfers of care which has already released sufficient space at the John Radcliffe to enable the relocation of respiratory services from the Churchill. The plan for the best location of services will also inform the required infrastructure for transport and staff housing, with the relocation of services away from the Headington sites having advantages for both.
- 8.16. The OUH will work with its Academic Health Science Centre partners, (the University of Oxford, Oxford Brookes University and Oxford Health NHS FT) so that a joint approach can be taken to development across all of the members' sites, with a longer term aim to work towards joint buildings. The organisations will also need to work with local authorities with regard to transport and housing infrastructure.

“Go Digital” (digital transformation)

- 8.17. Alongside the physical infrastructure, development of the Trust's digital infrastructure will be key to transforming the way in which we deliver care and work with our patients and partners, exploiting the information revolution, a theme of the Five Year Forward View. This has the potential to support care models, including using telehealth to support the objective to move care closer to home where appropriate, as described above. This has already been seen in the use of tablets in care homes to facilitate the joint patient transfer plan. Technology can also be used to improve quality and safety and maximise the use of resources, as was demonstrated by the Trust's ground-breaking digitisation of the blood transfusion process.
- 8.18. The Trust has followed an accelerated pace for the introduction of its Electronic Patient Record (EPR), moving into joint first position in the Clinical Digital Maturity Index. The OUH was named 'Digital Hospital of the Year' in 2015 and 'Building the digital hospital' is a theme of the BRC, examining how technological innovations can have a positive impact on patient care. Electronic prescribing has been rolled out to all areas with the exception of maternity services at the JR where it is due to be implemented in June 2016. The Trust will now work to improve the functionality of EPR, moving towards a paperless hospital, something which has already been achieved at the Nuffield Orthopaedic Centre.
- 8.19. The OUH will work to progress this strategic theme through the AHSC and AHSN. A key element of this will be connecting the patient records held by different care providers on different IT

systems including the Trust's Electronic patient records, systems in GP surgeries and records in hospitals which refer patients to the OUH for specialised care. The aim is that clinicians would have access to a patient's notes wherever they are with these also being accessible to the patient if they wish.

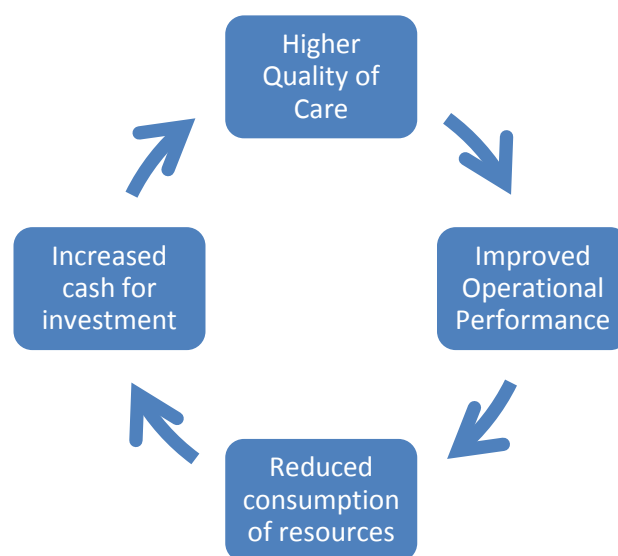
“Focus on Excellence” (prioritising investment in services, to develop world class excellence)

- 8.20. Under its license to operate as a NHS Foundation Trust the OUH is obliged and committed to provide general services to our local Oxfordshire population. In addition to these services, the OUH provides some services for a regional or national catchment population. We wish to support the development of genuinely world class excellence, but recognise that resources are finite and this will require choices to be made, to prioritise investment, and determine the appropriate strategy for developing services.
- 8.21. This is within a national context, set out in the Five Year Forward View, whereby there is a recognition that for some services there is a strong relationship between the number of patients treated and the quality of care received, supporting consolidation of some services in fewer centres. In this context commissioners continue to review the provision of specialised services, while NHS Improvement and NHS England review the payments for them.
- 8.22. In the first quarter of 2016/17 the Trust will therefore be undertaking a process to review its specialties/services and their ability to satisfy a range of criteria developed on the basis of discussions at the Strategic Workshop held on 24th February. The outcome will be to determine the appropriate strategy for individual specialties/services. This may include the need to identify options for robust and sustainable service models in respect of elements of the service which cannot be prioritised for investment. This may require us to develop alternative service models in partnership with other providers.
- 8.23. This work is being led by a **Clinical Reference Group** which includes clinicians nominated from each of the clinical divisions.

“Good Quality Costs Less” (delivering continuous service improvement)

- 8.24. We believe that it is very important to identify initiatives aimed at improving the quality of care, the delivery of which will reduce the Trust's 'footprint' or consumption of resources, for example through reducing the patient's length of stay. This should improve our operational performance, and should also realise the efficiency savings required by the planning guidance, contributing to the level

of EBITDA⁵, which represents the amount available for investment in the future development of our services.



- 8.25. Such initiatives may be taken at a system-wide level, as is being done to reduce the level of delayed transfers of care. This has the primary aim of delivering care to patients in the optimal environment, but also has reduced the Trust's footprint, making an estimated contribution to EBITDA of over £1m, as well as helping patient flow which should help the delivering of operational standards including the maximum four hour wait in the Emergency Department.
- 8.26. Other initiatives are being coordinated through the Trust's Transformation programme, for example the improved efficiency of theatres. This has the primary aim of reducing the number of cancellations suffered by patients but, with improved efficiency, it should be possible to reduce the number of theatres used, with the potential to make a contribution to EBITDA of over £1m, as well as making savings in relation to reduced weekend working and outsourcing of operating lists.
- 8.27. The Trust wishes to encourage local adoption of such initiatives, an example of which is Enhanced Recovery After Surgery at the Churchill site. The aim of this initiative is to put in place processes to ensure that patients are as fit and prepared for their surgery as possible and have everything in place to recover as quickly as possible from it, so that they can return home. This should reduce length of stay, improving quality of experience for patients and their carers, whilst releasing resources associated with bed days. The Champions of Change will be trained and empowered to drive such initiatives locally.

⁵ Earnings before interest, tax, depreciation and amortisation

- 8.28. Following the Strategic Workshop held on 24th February, two events are being organised on 24th May to extend engagement to a wider cross section of staff groups and the public and further develop the vision for the future of the OUH. Discussions will be focused around patient pathways, related to the STP work-streams.

Our Quality Priorities for 2016/17

9. Development of Quality Priorities for 2016/17

- 9.1. For 2016/17 we have agreed that work will continue on most of our previous quality priorities, particularly in five areas where we wish to avoid patient harm and deterioration wherever possible, and in our focus on partnership and patient experience.
- 9.2. Our Divisions have been involved in identifying quality priorities through discussion in our Clinical Governance Committee and have developed Divisional quality plans as part of the business planning process for 2016/17. A patient and public engagement event was held on 19th April 2016.
- 9.3. The suite of quality priorities for the coming year, described in the table below, is part of a wider work plan to deliver high quality care to all of our patients. All quality improvement work is monitored closely by our Clinical Governance and Quality committees and we regularly report our performance to our commissioners and regulators.
- 9.4. Over the year ahead, we aim to prioritise the delivery of quality improvements across a range of projects and services. There are four high level Trust wide quality priorities. There have been several drivers in the development of these projects:
- Priorities set for the NHS nationally, particularly the nine national 'must dos' described above.
 - Priorities included in the Trust's contracts with its commissioners, particularly the CQUINs described below.
 - Priorities arising through feedback the Trust has received from service users and our local Healthwatch organisation.
 - Priorities set from a review of incidents and internal audit reports – the Toft review as described below.
 - Priorities articulated in our Quality Strategy and this Business Plan
- Toft review into Oxford University Hospitals NHS FT Never Events***
- 9.5. A Never Event is described as a serious, largely preventable patient safety incident that should not occur if the available preventive measures have been implemented by healthcare providers. There are 14 types of incidents categorised as such by NHS England.

- 9.6. In 2015/16 Oxford University Hospitals NHS Foundation Trust reported seven incidents that met these criteria during this financial year, as follows:
- Wrong Site surgery: Wrong spinal disc removal
 - Retained foreign object: swab from surgery
 - Wrong Site Surgery: Emergency craniotomy
 - Wrong Site Surgery: Wrong side Portacath removal (event occurred during 2014-15 but reporting was delayed by clinical team)
 - Wrong Site Surgery: Wrong Site incision for an Oesophagectomy
 - Wrong Site Surgery: Wrong Site nerve block
 - Wrong Site Surgery: Wrong Site nerve block
- 9.7. In response to these events and Never Events in prior years the Trust has developed a wide ranging Never Event action plan which is regularly monitored both within the Trust and with commissioners. Other actions included the external review described below which is available on the Trust's website⁶.
- 9.8. Professor Toft was commissioned in 2015/16 by the Chief Executive Officer to carry out an external review of the Investigation reports into seven Never Events reported by Oxford University Hospitals in financial year 2014/15 (one of which related to an error in the previous financial year).
- 9.9. An overall set of conclusions and recommendations was provided at the end of the review. The review concluded that no evidence had been found to suggest that a patient safety problem exists within the Trust and the evidence strongly suggests that the Trust has a proactive safety culture. Additionally, the review found that the Trust's commitment to openness with respect to SIRIs (Serious Incidents Requiring Investigation) and 'Never Events' is exemplary.

Commissioning for Quality and Innovation (CQUIN)s

- 9.10. The CQUIN scheme is a national initiative intended to deliver clinical quality improvements and drive transformational change. The contracts that the Trust has with its commissioners include provision for incentive payments if CQUIN indicators are achieved. The indicators are intended to impact on reducing inequalities in access to services, the experiences of those using them and the outcomes achieved.
- 9.11. The design of the 2016/17 scheme has been influenced by the Five Year Forward View. There are three categories of CQUIN Goals:
- i) Indicators which are set nationally;
 - ii) Indicators that are selected locally; and

⁶ <http://www.ouh.nhs.uk/about/publications/documents/toft-report.pdf>

- iii) Those applying to specialised services.

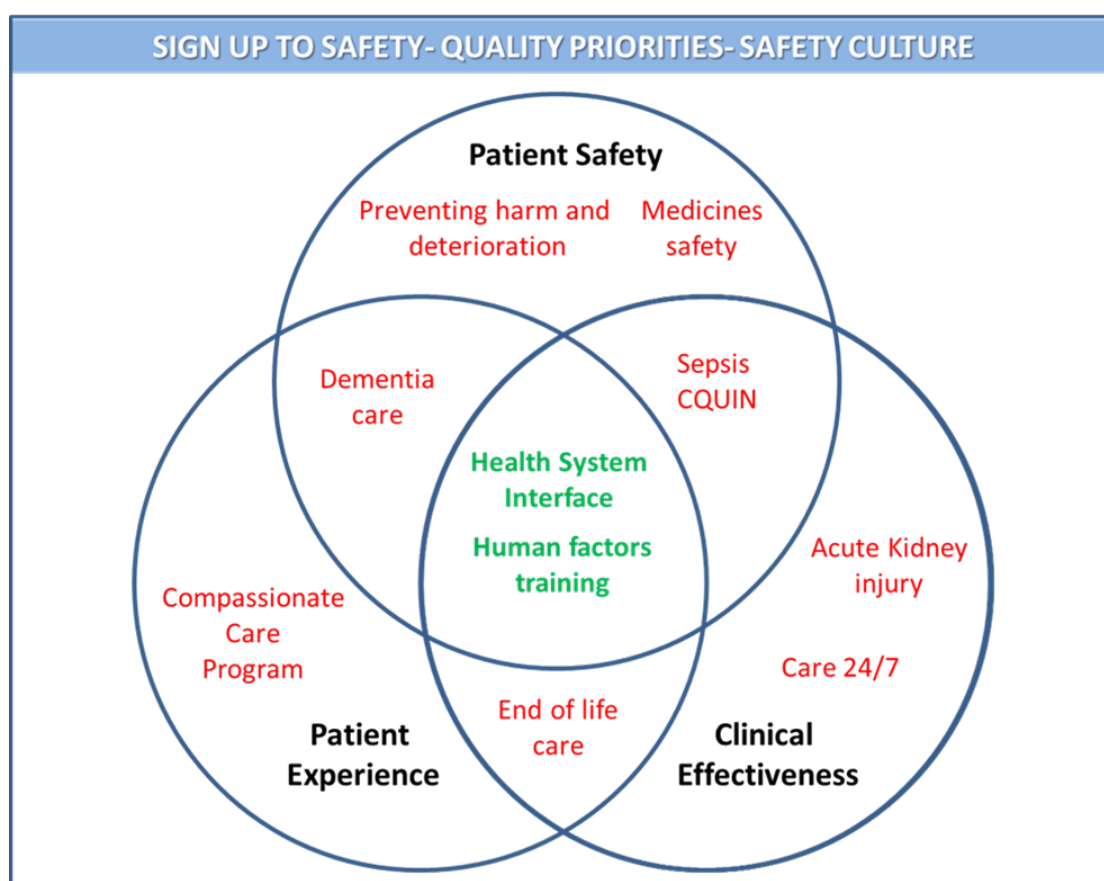
9.12. The potential value of the CQUINs is approximately £7m for the Trust's contract with its local commissioner, Oxfordshire CCG and approximately £8m for the Trust's contract with NHS England for specialised services. The proposed CQUINs for OUH are set out in Appendix B.

10. Our Quality Priorities for 2016/17

1.	Preventing harm and deterioration
	Five priorities have been identified which all aim to detect patient deterioration at the earliest time and provide a rapid response to minimise both harm from health care errors and progression of the patient's illness that could have been avoided by prompt delivery of the best standard of care. This priority seeks to build on last year's work to create digital systems and innovative data gathering to identify key opportunities to intervene and deliver safe care
a)	Medication safety In response to a review of medication incidents in 2015/16, with an emphasis on: <ul style="list-style-type: none"> • Safe anticoagulation • Safe use of insulin • Antimicrobial stewardship (national CQUIN) • Prompt antimicrobial administration in severe sepsis (National CQUIN and supports 1 c)
b)	Acute Kidney Injury (AKI) Improved recognition, prevention and management of patients with AKI
c)	Recognition and treatment of sepsis (national CQUIN)
d)	Care 24/7 (NHS national priority) – described above
e)	SEND Project – detecting and acting on deterioration through nationally recognised iPad based collection of patient observations with track and trigger analysis
2.	Following the expert external review of our investigations of Never Events described above:
a)	Further Human Factors Training to enhance the lessons learned from adverse events
b)	Improving our systems for sharing learning within and between teams across the Trust
c)	Improving our systems for ensuring knowledge of and compliance with essential policies
3.	More effective care with better patient experience, including programmes for:
a)	End of life care
b)	Dementia care
c)	Our Compassionate Care programme to improve patient experience throughout the Trust

4.	Stakeholder engagement and partnership working
	<p>This will include:</p> <ul style="list-style-type: none"> • Working collaboratively with partner organisations to involve stakeholders in the design of future strategy which takes a whole systems approach. This will include production of the STP described above. • Continuing our response to issues raised by GPs concerning the interface between GPs and the hospital, particularly with regard to the rapid electronic distribution of discharge summaries and endorsement of test results on EPR. • Continuing to work with partners on the Delayed Transfers of Care programme, described above, to ensure that patients are cared for in the right place

10.1. The diagram below illustrates how these priorities interrelate.



Learning Disabilities

10.2. The “Big Plan”, Oxfordshire’s joint Learning Disability Strategy for 2015 – 2018, has been developed jointly by Oxfordshire County

Council and Oxfordshire CCG. This proposes “the integration of provision of mental and physical health care for people with learning disabilities into mainstream health services, so that everyone in Oxfordshire gets their physical and mental health support from the same health services – whether or not they have a learning disability”. OUH is currently working with commissioners to understand the implications of the emerging strategy for the Trust’s services and how it can best support implementation. This is part of the Sustainability and Transformation Plan work. The Trust is also leading on flagging and tracking patients with learning disabilities for improved integration of physical and learning disabilities.

10.3. Additional information can be found in the Trust’s Quality report which will be published at the end of May 2016.

10.4. Work in the above areas will be integrated with work on the STP care programmes described above.

11. Quality Implications of increased volume pressures

11.1. The Trust is monitoring the quality implications of the increased volume pressures that we are currently working under through:

- Crowding audits
- Review of incidents where delay is mentioned
- Tracking the number of serious incidents and their relationship to activity volume

Recruiting, Retaining and developing the right Workforce

12. Workforce Transformation

12.1. The realisation of local strategic priorities relies upon the ability of OUH and its partner organisations to attract, retain and develop high quality multi-disciplinary staff, who are able to work flexibly and operate effectively across the healthcare system. Hence workforce transformation is key in establishing appropriate and sustainable service models.

12.2. A Workforce Group has been established by the local Transformation Board to lead this workstream, with membership from the Transformation Board’s participant organisations as well as Health Education England Thames Valley. Representation will also be sought from the local voluntary sector and relevant education providers.

12.3. The workstream has three main strategic themes:

- Shaping the environment strategically, in order to ensure we are able to attract, recruit and retain staff in sufficient numbers.

- Identifying the requirements to develop new roles and redesign existing roles that will support the future needs of the healthcare system.
- Recognising the challenges associated with the national and local labour markets, capitalising on the potential to engage an alternative 'untapped' workforce (e.g. older workers, non-employed workforce and semi-formal caring roles).

12.4. In support of these strategic themes, the Workforce Group will pursue the following key areas of work:

- Commission the modelling of the changes required in the system's workforce, in order to increase and maintain the capacity to provide more care outside the acute setting (supporting 'care closer to home'), to include role redesign;
- Scope, prioritise and fund the development and delivery of training programmes and interventions, in support of new and revised workforce roles, (e.g. integrated nursing and therapy roles, integrated carer training and development and interface medicine);
- Identify and fund the delivery of cross-system change management skills in support of transformation;
- Effectively engage with Health Education England Thames Valley (HEETV) in order to ensure that maximum benefit is derived from its remit to support local system change in areas of:
 - System leadership and network development
 - Workforce information, planning and intelligence
 - Job design
 - Education and curricula development
 - Skills development
- Develop and implement integrated recruitment and retention strategies

13. Recruitment and Retention

13.1. Issues associated with the availability of affordable housing and with transport and their impact on the recruitment and retention of staff have been described above. Alongside the work being undertaken through the multiagency Workforce Group the OUH has a number of initiatives to address these issues:

Travel Issues

All staff were offered the opportunity to participate in a travel survey in early 2016. The Trust Board will consider an analysis of the survey responses and use this to prioritise investment in travel options and review the current car parking policy and provision.

<p>Local Affordability</p> <ul style="list-style-type: none"> • At its March 2016 meeting the Trust Board agreed the implementation of a Living Wage supplement to be applied to the Trust's lowest paid members of staff from April 2016. This will directly benefit over 1,300 employees, including healthcare assistants, administrators, housekeepers and porters. • We are reviewing what financial incentives should be made available for specific groups of staff where there are particular recruitment and retention issues. • The Trust is facilitating fast-track career progression from Band 5 to 6 in support of clinical staff whose role develops quickly following graduation and requires them to make autonomous decisions. This is proving beneficial in retaining staff at Band 5 who would otherwise seek promotion to Band 6 in other organisations. • We are in discussion with local councils, both in and around Oxford and across Oxfordshire, about the potential for the inclusion of key worker housing in planned housing developments.
<p>Education and Training opportunities</p> <p>We are exploring ways of increasing the educational and training opportunities available to staff, to enable staff to take full advantage of the opportunities that Oxford offers as a centre for learning to build their knowledge and skills and fulfil their ambitions for career progression locally. This includes implementation in early 2016/17 of a training grant of £500 per annum for all Band 5 clinical staff, conditional on completion and maintenance of core competencies.</p>
<p>Workforce Supply</p> <p>The Trust has negotiated with Oxford Brookes University for an increase in the number of nurse training places.</p>
<p>Creating an environment in which staff want to stay for longer</p> <p>The Trust continues to work on improving staff engagement, responding to staff feedback provided via the annual staff survey and regular pulse surveys; pursuing our 'Values Into Action' initiatives; supporting line managers in the basics of people management and leadership and improving and promoting staff recognition. This will be complemented by involving significant numbers of staff in the strategic review work and Champions of Change initiative described above. The Retention Strategy Group is also leading on establishing a social infrastructure for our EU and other non-UK staff.</p>

14. Magnet Accreditation

14.1. The Trust is aiming to achieve Magnet Accreditation which should also aid recruitment and retention. This involves freeing up nurses to nurse, finding practical ways to help nurses focus on providing direct care and support to patients. The objective of the Magnet programme is to create a working environment where clinical staff are given freedom, space and time to think about the quality of care

they provide and the autonomy to make changes to the way things are done, based on their experience, expertise and judgement (thereby complementing the Champions for Change initiative described above).

- 14.2. An accredited Magnet hospital is one where nursing delivers excellent patient outcomes, nurses have a high level of job satisfaction and there is a low nurse turnover rate. Magnet status also indicates nursing involvement in data collection and decision-making in patient care delivery. Magnet nursing leaders are recognised as truly valuing their staff, involving them in shaping research-based nursing practice, and encouraging and rewarding them for advancing in their profession. Magnet hospitals have open communication between nurses and other staff, and an appropriate skill mix to attain the best patient outcomes and staff work environment.

15. Agency Staffing

- 15.1. OUH adheres to the NHS Mandate's cap and rules on agency spending with a very small number of reported exceptions. The Trust has factored further tightening of these rules into its plan for 2016/17.
- 15.2. The national rule on agency costs has supported OUH in its aims to achieve substantive recruitment, develop in-house bank staffing as an alternative to agency usage and reduce agency staffing costs.

16. Staff Health and Wellbeing

- 16.1. The Trust's Occupational Health and Wellbeing service continues to provide an increasing level of support to staff. A key initiative has been a focus on recognising and responding to issues relating to stress and anxiety. In 2016/17 health and wellbeing initiatives will be linked to the new NHS Staff Health and Wellbeing CQUIN, described above.
- 16.2. We recently introduced an Employee Assistance Programme which has been very well received by staff.

Financial Plan

17. The OUH's Financial Planning Context

- 17.1. The Trust delivered its 'stretch target' breakeven duty surplus of £5.3m for 2015/16. This included significant non-recurrent measures (including a land disposal) and represented an underlying retained deficit of £23.2m.
- 17.2. The Trust needs to both demonstrate on-going financial stability, and to strengthen its underlying position, within its 2016/17 plan. The plan is for the Trust to deliver an underlying balanced income and expenditure position in 2016/17 (nil retained surplus).

- 17.3. The Trust has been set a control total of £33.9m by NHS Improvement (excluding donated accounting adjustments). In agreeing to deliver this control total the Trust is planning for receipt of £20.4m from the General Element of Sustainability and Transformation (S&T) national funds. The receipt of these funds is subject to delivery of operational performance trajectories and standards, financial control targets and STP development milestones throughout the year.
- 17.4. The remaining gap to deliver the control total (and access the S&T funds) of £13.5m will be delivered by non-recurrent means.
- 17.5. The following factors are also included in the financial plan for 2016/17:
- i) Cost inflation assumptions reflecting national guidance, with an overall 3.1% cost inflation, including pay inflation, incremental drift and pension costs of 3.3%, drugs of 4.5% and other non-pay of 1.7%.
 - ii) Income tariff changes as a result of moving from the DTR tariff to 16/17 tariffs (neutral impact overall excluding pass through inflation).
 - iii) The achievement of CQUINs (at an assumption of 80% achievement against CQUIN targets) with a net value of £12.6m.
 - iv) Income growth from services (including strategic developments and pass through cost growth) with a bottom line surplus benefit of £2.6m.
 - v) Penalties are not applied by commissioners because key quality and other performance measures are not met.
 - vi) A Development fund of £5.0m to help deliver transformational changes within the Trust's plans.
 - vii) Saving plans of £50.9m required to deliver an underlying nil surplus position. A further £13.5m of specific non-recurrent savings measures are also included in the plans to deliver the control total surplus, giving a total saving plan of £64.4m.
- 17.6. The financial context within which the Trust will operate next year presents significant challenges and the Trust is therefore planning to continue to hold a general contingency of 1% of operating expenditure. No other I&E contingencies have been planned for.

18. Commissioner Income

- 18.1. The majority of the Trust's predicted income will come from contracts with NHS commissioners. Achievement of the overall control total remains dependent upon a satisfactory conclusion to discussions with the main commissioners in respect of 2016/17. These discussions were still on-going at the point that the financial plan was submitted to NHSI, but have since had agreements

reached for both NHS England, which purchases specialised services from the Trust, and Oxfordshire CCG. Both agreements leave the Trust with risks to over performance, with neither agreement including required levels of activity to meet its performance trajectories in the contract baseline values. As such these will be paid as over performance in year.

19. Income and Expenditure Plan 2016/17

19.1. The Income and Expenditure plan is summarised in the table below.

	units	Forecast Out- turn 2015-16	Plan 2016-17
Summary Income and Expenditure Account			
Operating income (inc. in EBITDA)			
NHS Clinical income	£m	782.521	851.836
Non-NHS Clinical income	£m	11.234	10.355
Non-Clinical income	£m	151.535	150.259
Total operating income, inc. in EBITDA	£m	945.290	1,012.450
Operating expenses (inc in EBITDA)			
Employee expense	£m	(536.619)	(556.023)
Non-Pay expense	£m	(323.973)	(320.047)
PFI / LIFT expense	£m	(27.777)	(37.334)
Total operating expense, inc. in EBITDA	£m	(888.369)	(913.404)
EBITDA	£m	56.921	99.046
<i>EBITDA margin %</i>	%	6.0%	9.8%
Operating income (exc. from EBITDA)			
Donations and Grants for PPE and intangible assets	£m	0.470	0.300
Operating expenses (exc. from EBITDA)			
	£m	(26.766)	(36.976)
Non-operating income	£m	10.009	0.000
Non-operating expenses	£m	(28.379)	(28.470)
Surplus / (Deficit) after tax	£m	12.255	33.900
Memorandum Lines:			
One off income/costs	£m	19.682	(0.200)
Normalised Surplus / (Deficit)	£m	(7.427)	34.100
<i>Normalised surplus/(deficit) margin %</i>	%	(0.8%)	3.4%

(Surplus before removing donated asset accounting and technical adjustments)

20. Transformation and Efficiency Targets

20.1. In order to be able to make the necessary investment in growth, quality and service development, whilst achieving nationally required efficiency, the Trust will need to continue to release savings through transformation and improved efficiency.

20.2. In 2015/16 the Trust delivered £49.8m in savings which represented 96.1% of the plan for the year.

- 20.3. The financial plan for the Trust sets out how the Trust will need to identify £64.4m next year in savings to meet the cost pressures that the Trust has identified will occur in 2016/17. This includes £13.5m of non-recurrent measures required to deliver the control total surplus of £33.9m (excluding donations adjustments). The recurrent savings required within the Trust are therefore £50.9m to deliver the plan. The Trust has identified themes totalling this amount, although some of these themes may be challenging to deliver in year. The targets for the themes are set out in the table below.

CIP Summary	Total (£000s)
Local – expenditure	9,149
Local – Income/Activity	5,060
Medicines Management	2,600
Procurement	6,000
Transformation	5,165
Workforce	9,416
Operational Benchmarks – Beds	6,006
Operational Benchmarks – Outpatients	500
Operational Benchmarks – Theatres	4,000
Estate Reconfiguration	3,000
CIP total (excluding non-recurrent £13.5m)	50,896
(A target of 6%)	

21. Capital Plan

- 21.1. The table below sets out the proposed capital programme for 2016/17.
- 21.2. The total planned capital programme spend (before technical items) for 2016/17 is £35.3m, an increase in planned expenditure of £3.2m due to the increased slippage late in the previous financial year. This planned expenditure is set out in more detail by scheme in Appendix C.
- 21.3. Appendix C also shows how £19.3m of this plan (55%) is due to slippage or previously agreed business cases. A further £7.6m is allocated against areas of the capital programme where capital is required to be allocated each year (termed 'business as usual' capital). This includes allocations for medical equipment, IT and Operational Estates expenditure⁷ as well as a 'small schemes' (individually less than £100k) contingency.
- 21.4. This leaves £8.4m available to allocate out to new schemes. Some of this has been badged as indicative amounts against high priority

⁷ MEPG equipment, IT and Operational Estates expenditure is then to be prioritised within these available allocations.

issues, for example the Renal ward and the ED Resus bays. There is therefore only limited remaining capital of c.£5m to allocate out against any new agreed business cases.

- 21.5. In addition to ongoing investment in the Estate, medical equipment and IT, the most significant element of the capital programme relates to the Trust's Clinical Strategy, including the development of satellite radiotherapy facilities in Swindon and Milton Keynes. The other major component is investment for services that are currently provided from facilities which are suboptimal, either because they are not designed for modern models of care or because they are simply ageing or both. This component includes the Churchill Day Surgery Unit, Horton Endoscopy, Horton CT, Renal ward and the JR2 theatres. The third major component is ongoing investment in the Electronic Patient Record.

OUH Capital Programme 2016/17	2016/17 Plan £000s
<i>Gross Capital Spend</i>	
Medical and Surgical Equipment	2.6
Lease Buyouts	0.7
Estates General and Ward Relocations/Refurbishments	11.0
Major Equipment including CTs, ultrasounds etc	4.5
Small Schemes	1.0
IT/EPR	2.3
Estates New Development Works	4.0
R&D	0.4
Donations	0.3
JR Theatre Remodelling - Trust funded element	0.3
Adult Critical Care - Trust funded element	0.1
Radiotherapy: Milton Keynes - Trust funded element	0.1
Radiotherapy Swindon	5.3
EPR Reprourement	2.7
Total Capital Programme Spend	35.3
PFI Lifecycle	5.8
Finance Leases	0.5
Energy Centre	
Total Other Capital Spend	6.3
Gross Capital Spend	41.6

2016/17 Corporate Objectives

22. Corporate Objectives

22.1. We have developed a set of priority objectives for the coming year which are described in the table below.

Ref.	Objective	Milestones/Measurables	Accountable Director
1.	Strategy		
1.1	Produce Sustainability and Transformation Plan (STP) in conjunction with partners	<ul style="list-style-type: none"> April and May 2016 – OUH events based on STP workstreams 27th May - completion of 1st draft 17th June - completion of 2nd draft End of June 2016 – submission to NHS Improvement Autumn 2016 - undertake public consultation with partners on proposals contained in STP 	Director of Planning and Information
1.2	Review OUH clinical services in conjunction with the University of Oxford and other partners ('focusing on excellence')	<ul style="list-style-type: none"> 1st April 2016 – circulation of template for completion by specialties/services and guidance on the process End of April 2016 – completion of templates May/June 2016 – Initial internal review 	Director of Planning and Information
1.3	Develop options for the future of the Horton Hospital for formal consultation	<ul style="list-style-type: none"> June 2016 – finalisation of outline concepts 	Director of Clinical Services
1.4	Continue to develop clinical networks with partner hospitals and use them to transform patient pathways	Swindon Radiotherapy <ul style="list-style-type: none"> Aug 16 – commencement of enabling works Dec 16 – enabling works complete Jan 17 – commencement of main scheme June 18 – 'Go-Live' 1st linac 	Director of Clinical Services
1.5	Agree a joint 40 year 'Master Plan' for the development of local infrastructure in conjunction with Oxford Academic Health	<ul style="list-style-type: none"> December 2016 	Chief Executive

Ref.	Objective	Milestones/Measurables	Accountable Director
	Science Centre partners		
2.	Quality		
2.1	Prevent harm and deterioration	Deliver measurables in Quality Report in relation to: a) Medication Safety b) Acute Kidney Injury c) Recognition and treatment of sepsis d) Care 24/7 e) SEND project	Medical Director
2.2	Respond to expert external review of our investigations of Never Events	Deliver measurables in Quality Report in relation to: a) Provision of further Human Factors Training to enhance lessons learned from adverse events b) Improving our systems for shared learning within and between teams across the Trust c) Improving our systems for ensuring knowledge of and compliance with essential policies	Medical Director
2.3	To provide more effective care with better patient experience	Deliver measurables in Quality Report in relation to: a) End of life care b) Dementia care c) Our Compassionate Care programme	Medical Director
2.4	Improve stakeholder engagement and partnership working	Deliver measurables in Quality Report	Medical Director
2.5	Deliver CQUINs	As described in the table in Appendix B	As described in the table in Appendix B
2.6	Continue to work with patients and their advocates to support patients with learning disabilities	Work with Oxfordshire County Council and OCCG to implement their 'Big Plan' – Oxfordshire's Joint Learning Disability Strategy for 2015-18, linked to	Chief Nurse

Ref.	Objective	Milestones/Measurables	Accountable Director
		the STP work	
3.	Operational Performance		
3.1	Deliver the agreed trajectory for performance against the standard that more than 95% of patients wait no more than four hours in A&E		Director of Clinical Services
3.2	Deliver the agreed trajectory for performance against the standard that 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment		Director of Clinical Services
3.3	Deliver the maximum 62 day wait standard for first treatment from referral for suspected cancer		Director of Clinical Services
3.4	Deliver the maximum 31 day wait standard for subsequent treatment.		Director of Clinical Services
3.5	Increase diagnostic capacity	<ul style="list-style-type: none"> • May 16 – Trust Board approval of business case for additional endoscopy capacity at the John Radcliffe • June 16 – works commence • Oct 16 - completion 	Director of Clinical Services
3.6	Improve one-year cancer survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one or two and reducing the proportion diagnosed following an emergency admission.	<ul style="list-style-type: none"> • Continue to work with OCCG on streamlining access to investigations including establishment of 2nd wave ACE⁸ Programme • Work with CCG and Strategic Clinical Network for Cancer to disseminate learning from audit of emergency presentations of cancer 	Director of Clinical Services
4.	Finance		
4.1	Deliver financial plan		Director of Finance and Procurement

⁸ Accelerate, Coordinate, Evaluate

Ref.	Objective	Milestones/Measurables	Accountable Director
4.2	Continue to use findings from the Carter review to inform work on procurement and productivity savings		Director of Finance and Procurement
5.	Service Improvement ('Good Quality Costs Less')		
5.1	Deliver a development programme for Champions of Change to equip them to deliver the outcomes of the STP programmes and lead transformational improvements locally	May 16 – start of programme implementation	Director of Organisational Development & Workforce
5.2	Continue to reduce delayed transfers of care	Work with partners on the continued: <ul style="list-style-type: none"> • use of beds in care homes for intermediate care • implementation of a single system for the management of post acute patients • increased domiciliary care capacity 	Director of Clinical Services
5.3	Improve theatre utilisation to reduce weekend working and outsourced operating lists		Chief Nurse
5.4	Improve the utilisation of the Trust's estate, maximising clinical use of high quality facilities	<ul style="list-style-type: none"> • Summer 2016 - Relocate non front line staff to off-site accommodation • By end of December 2016 - demolish poor quality estate, particularly at the Churchill 	Chief Nurse
6.	Workforce		
6.1	Generate a Trust-wide workforce plan	<ul style="list-style-type: none"> • End of June 16 – first outputs from Divisional work 	
6.2	Implement initiatives to recruit and retain the workforce the Trust needs	<ul style="list-style-type: none"> • Spring/Summer 2016 – review analysis of staff travel survey responses and agree priorities for investment in travel options and revised car parking policy • Implement Living Wage • Review financial incentives for groups of staff 	Director of Organisational Development & Workforce

Ref.	Objective	Milestones/Measurables	Accountable Director
		with specific recruitment and retention issues <ul style="list-style-type: none"> Work with local councils to identify affordable key worker housing opportunities 	
6.3	Work towards Magnet accreditation	<ul style="list-style-type: none"> Leading Great Care Programme May 16 – Launch Career Passport Oxford Learning Academy 	Chief Nurse
6.4	Staff Health and Wellbeing	Deliver CQUIN	Director of Organisational Development & Workforce
6.5	Succession Planning		Director of Organisational Development & Workforce
7.	Research and Education		
7.1	Secure renewal of the Biomedical Research Centre and Unit	If shortlisted: June 16 – submit full application July 16 - interviews	Medical Director
8.	Digital Transformation		
8.1	Appoint a Chief Information and Digital Officer		Chief Executive
8.2	Improve the functionality of EPR		Director of Planning and Information
8.3	Work with partners to improve the connectivity of local provider systems		Director of Planning and Information

Monitoring Delivery of our Plan

23. Integrated Performance Report (IPR)

23.1. The Trust Board monitors key performance metrics through the Integrated Performance Report which is produced monthly. This includes a summary of performance across four domains **Operational, Quality, Finance** and **Workforce**, with exception reports for areas where performance is below that expected.

24. Board Quality Report

24.1. Progress against the Trust's Quality Strategy is monitored through a monthly report, presented alternately to the Trust Board or to the Quality Committee. This includes:

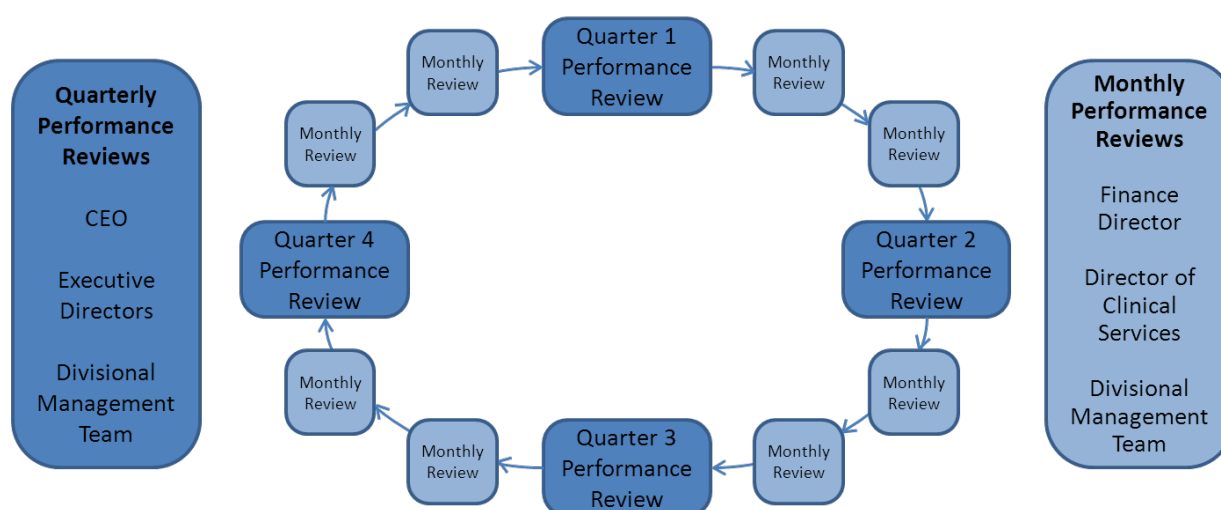
- a progress report on the Trust's Quality priorities
- performance against 32 key quality metrics linked to the quality of clinical care provided across the organisation
- patient experience metrics, including responses to the Friends and Family test

25. Review of Corporate Objectives

25.1. Reports on progress with delivery of the corporate objectives will be brought to the Board after six and 12 months.

26. Divisional Performance Review

26.1. Each Division has produced a Divisional Business Plan for 2016/17. The Divisional Business Plans will be 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

26.2. 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.

Managing Risks to the Plan

27. Board Assurance Framework (BAF)

27.1. The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives described in this Business Plan. Assurance may be gained from a wide range of sources, but wherever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the corporate objectives.

27.2. The Trust Board will monitor the principal risks to the delivery of the Trust's strategic objectives through the Board Assurance Framework which is set out in Appendix D. This has been updated to reflect the contents of this Business Plan so that it is structured around:

The Trust's 'business as usual' themes:

- Maintaining and improving quality
- Delivering financial obligations
- Maintaining and improving operational performance

The Trust's Emerging Strategic themes

- 'Home Sweet Home (Local Health Integration)
- 'The Master Plan' (long term estates planning)
- 'Go Digital' (digital transformation)
- 'Focus on Excellence' (prioritising investment in services, to develop world class excellence)
- 'Good Quality Costs Less' (delivering continuous service improvement)

Key enablers in relation to these themes include recruiting, retaining and developing the right workforce.

27.3. The BAF will be developed further as the themes of the Trust's strategic review advance.

Appendix A – Delivery of 2015/16 Corporate Objectives

	Objective	Delivery
1.	Strategy	
1.1	Establish the methodology for a refresh of the Trust's strategy	This is described in section 8
2.	Quality	
2.1	Consistently deliver safe, harm-free quality care to all patients	<p>Preventing avoidable patient deterioration and harm in hospital</p> <ul style="list-style-type: none"> • SEND (System for Electronic Notification and Documentation) electronic track and trigger project for recording and displaying patient vital signs rolled out on time. It is fully implemented in all acute areas across the Trust and in all areas at the NOC and Churchill. • Cardiac arrest reduction strategy updated - clinical areas with high levels of cardiac arrest call outs are being piloted with facilitated recognition training and proactive SEND monitoring. <p>Partnership working to improve urgent and emergency care</p> <ul style="list-style-type: none"> • All ED staff completed a local induction providing information on how to refer when patients present from alcohol intoxication or dependency and another on the mental health pathway. • Monthly clinical meetings held with ED Psychiatric Service (EDPS) to improve way we diagnose and support patients. • Multi agency shared management plans supported by GP, Turning Point⁹ and EDPS held on OUH patient record system and discussed with patient. <p>Improving recognition, prevention and management of acute kidney injury (AKI)</p> <ul style="list-style-type: none"> • Task and Finish group established to plan and implement necessary changes in Trust wide working. • Electronic alert system for automatically identifying AKI and its severity launched. • AKI care bundle updated, available on the intranet, embedded into EPR

⁹ Drug and alcohol services in Oxfordshire

	Objective	Delivery
		and will be triggered automatically in patients with AKI e-alert.
2.2	Provide high quality evidence-based care that is effective and ensures best possible outcomes for patients	<p>Learning from deaths to improve outcomes</p> <ul style="list-style-type: none"> • An analysis of the Divisional mortality reports for April to December 2015 indicates that 85% of deaths were formally reviewed. • Quarterly mortality reports are prepared by each Division. • A trust wide mortality review group has been established to take on the responsibility, formerly sitting with the clinical effectiveness committee. <p>Management of patients presenting with sepsis</p> <ul style="list-style-type: none"> • An inter-disciplinary Sepsis Group has been established with patient involvement. • The group has signed up to the UK Sepsis Trust for information and is part of the UK Sepsis Nurses national forum. • A paper 'sepsis screening tool' has been agreed and rolled out to be used initially in ED, EAU/MAU and SEU. Separate versions have been developed for paediatrics and maternity.
2.3	Provide an excellent quality healthcare experience for all patients, carers and visitors	<p>End of life: improving peoples' care in the last few days and hours of life</p> <ul style="list-style-type: none"> • An End of Life Care Group is chaired by the Medical Director and attended by stakeholders, including the CCG. • An EOLC symposium was held in Nov 15 and attended by 200 staff with national speakers. One of the Trust's consultants, Dr Bee Wee has been reappointed as National Clinical Director of End of Life care. • Training packages for clinical and non clinical staff have been developed, but not yet rolled out. • A survey has been sent out to relatives of those who died at the OUH. Feedback has been positive. • Children's and maternity bereavement pathways have been reviewed. • Cancer and palliative care public and patient partnership groups meet regularly. • The Trust received feedback from

	Objective	Delivery
		four regional Islamic funeral directors that the Trust's bereavement service provides an exemplary service.
2.4	Ensure there is a clear assessment process to support compliance with the Care Quality Commission regulations	<ul style="list-style-type: none"> • CQCAssure system has been developed and full self-assessment of compliance with the CQC regulations has been completed at Clinical Service Unit level across all five Clinical Divisions. Phase 1 Assurance review has also been completed in line with the prescribed deadlines. • Results of the self-assessment process and assurance process have been reported to TME and the Quality Committee in year. • Peer Review Programme has been fully reviewed and modified for implementation at clinical directorate level. The revised process has been reported to TME and Quality Committee. A rolling programme has commenced with effect from beginning of March 2016. Results from these reviews will be reported on a regular basis to TME and Quality Committee once completed.
3.	Integration	
3.1	Progress the Alliance Programme in collaboration with Oxford Health NHS FT and commissioners to transform urgent healthcare services for older people and adults who have complex health problems across Oxfordshire	Joint Board approvals for progressing the Alliance were agreed in 2015 and the framework for progressing the governance arrangements and organisational structure is in place. Current contracting discussions for 2016/17 and beyond will determine whether the Alliance structure remains the preferred model for better integration of service delivery.
3.2	Work with Oxford University to establish the clinical framework for the Precision Cancer Medicine Institute (PCMI) and the delivery of the Genomic Medical Centre	Proposals to incorporate the Genetic and Molecular Diagnostic laboratories which underpin the Genomic Medical Centre have been agreed. These will be further developed subject to the University of Oxford's confirmation that the PCMI will proceed.
4.	Specialty Review	
4.1	Review the sustainability of the Trust's services, particularly its specialised services portfolio, in the light of likely tariff changes and the NHS England review of specialised services	This is part of the Trust's strategic review, described in section 8.

	Objective	Delivery
5.	Pathways	
5.1	Complete the Outpatient Improvement Programme to improve patient experience and waiting times	Complete and achieved the objective of the creation of an additional 30,000 appointment slots.
5.2	Continue to develop clinical networks with partner hospitals and use them to transform patient pathways	<ul style="list-style-type: none"> Joint working with Buckinghamshire Healthcare NHS Trust has progressed and agreement has been reached for delivery of the final element of the vascular network which will be operational in June 16. A joint neonatal retrieval service is in place. Additional joint appointments have been made with partner trusts and partner trusts are fully engaged in the broader strategic review being led by the OUH Chief Executive.
5.3	Progress business cases for provision of satellite radiotherapy units at Swindon and Milton Keynes	<ul style="list-style-type: none"> The full business case for the Swindon unit has been approved and signed off by NHS England. Work will commence on the Great Western Hospital site in August 16. The FBC for the Milton Keynes unit is in final draft form and currently subject to discussion between the two trusts. The final version of the business case will go to the Trust Boards in July 16.
5.4	Continue to develop a strategy for the Horton, including moving services for people from the north of the county and neighbouring communities to the Horton where clinically and financially sustainable	Production of a strategy for the development of the Horton is underway and proposals will be fully developed by June 16 and will be linked to the system-wide STP.
6.	Performance	
6.1	Deliver 18 week maximum referral to treatment waiting times	Achieved. Nationally the 18 week performance standards were amended during 2015/16 to focus on the incomplete standard. The Trust achieved the incomplete standard in every month during 2015/16 ¹⁰ .
6.2	Work with System Resilience Group to improve system processes and overall capacity to deliver the 4 hour Emergency Department standard and improve the flow of patients through the hospitals	The ED standard has not been achieved during 2015/16.
6.3	Deliver cancer standards	Q1 – all cancer standards achieved

¹⁰ April 15 – Feb 16, March 16 position not yet reported at time of writing

	Objective	Delivery
		except for 62 day standard. All cancer standards achieved in Q2 and Q3. ¹¹
7.	Workforce	
7.1	Increase substantive workforce capacity	The Trust has successfully increased its substantive workforce by over 600 WTE (a 6.3% increase). Our overall vacancy level at the end of March 16 was down to 3.57% (against our 5% target). Within the main staff groups vacancy levels are now all below 5% (e.g. Nursing and Midwifery 4.8% and Clinical Support Staff 4.7%) and in only one Division (Surgery and Oncology) is the vacancy rate above 5%.
7.2	Improve staff retention, reducing and maintaining overall staff turnover to 10.5% or below	Although our overall level of turnover has not shown any significant improvement during the course of the year, nevertheless the increase in substantive workforce capacity is having a positive impact upon vacancy levels, which in time will also assist in reducing turnover.
7.3	Reduce reliance and expenditure on contingent workforce, reducing expenditure on contingent workforce (bank and agency) to 13/14 outturn levels	The Trust has maintained intense focus upon reducing its reliance upon agency staff whilst at the same time building its internal bank capacity. We have taken all measures to ensure we adhere to new national rules governing the use of agency staff. ¹² Throughout 2015/16, OUH achieved a marked decrease in non-framework nursing agency spend (from 19% of total agency expenditure in Month 1 to almost zero). In late Nov 15 nationally mandated maximum hourly rate caps for all agency staff were implemented. Subject to monitoring, the maximum rates will be further reduced in Apr 16, such that by Apr 16 no agency worker should be rewarded more than an equivalent substantive member of staff. This initiative is expected to have a significant impact in reducing the Trust's expenditure on agency staff

¹¹ Quarter 4 data will not be reported until May 2016

¹² Under a new rule introduced in Oct 15, all trusts were mandated to reduce nurse agency expenditure to a prescribed ceiling in Q3, Q4 and beyond. The imposed ceiling for OUH is 8% (i.e. expenditure on nurse agency capacity must not exceed 8% of the total nurse pay bill). A second rule dictates that, from Oct 15, trusts must secure agency staff via four government approved frameworks only.

	Objective	Delivery
		and in eliminating any agencies which refuse to comply with the rate caps. To 31 st Jan 16 expenditure on Bank & Agency was at its lowest monthly level since 2013/14. Expenditure on Bank & Agency in Jan 16 was below the level in Jan 15 and Jan 14. This reflects the national cap and continued local leadership, combined with the application of national hourly rate caps.
7.4	Implement the Nursing and Midwifery Strategy	<ul style="list-style-type: none"> • Year One milestones completed. • Oxford Institute of Nursing and Allied Health Research complete with approx. 6 new PhD projects. • Quality improvement Practice Development Nurse roles implemented in areas of high priority to improve clinical practice in falls, pressure ulcers etc. • Academy increased Clinical Support Worker intake to approx. 300 p.a. • Foundation programme consolidated with 50% increase. • Magnet programme funding achieved until 2018, including areas identified for shared governance pilot. • Grand rounds increased to fortnightly to meet quality priority
8.	Estates	
8.1	Transfer medical sub-specialties from the Churchill to the JR to support the strengthening of acute services	The respiratory service transferred to the John Radcliffe in March 2016.
8.2	Develop solutions for facilities which are not designed for modern models of care or are simply ageing	<ul style="list-style-type: none"> • Business cases for the Churchill Day Surgery Unit and Horton Endoscopy have been approved and the schemes are under construction. • A business case for the refurbishment of the JR2 theatres is currently being prepared. • Clinical Genetics offices are programmed to move to the 'ACE' building on the NOC site in summer 2016. • A ward has been released on the JR site and a business case to relocate the Renal Ward to this facility will be submitted to TME in July for approval.
8.3	Agree a framework for developing a revised capital investment strategy (including theatres, critical care and	A revised approach for capital allocation has been prepared for consideration by TME and subsequent

	Objective	Delivery
	the replacement of major estates infrastructure)	approval by the Board.
9.	IT	
9.1	Achieve transfer of the contract for the Electronic Patient Record	The transfer of the contract was successfully achieved before the October 2015 deadline. The exit from the BT Data Centre was effectively completed in July 2015 with minimal disruption.
9.2	Complete the electronic prescribing roll-out	Electronic prescribing was rolled out to all areas in line with the timetable, with the exception of maternity services at the JR, which, because of operational pressures, requested a postponement. Implementation has been rescheduled for June 2016.
9.3	Agree strategic priorities for future developments	Priorities for future investment, developed through a consultative process, were signed off by the Board in January 2016. Individual business cases will identify detailed benefit realisation plans.
9.4	Agree a benefit realisation programme for delivering in 2015/16	Benefits realisation project completed with assistance of the Health and Social Care Information Centre. Benefits of relevant schemes captured as part of the Transformation and CIP Programme signed off by the Trust Management Executive.
10.	Research, Development and Education	
10.1	Prepare for the anticipated Biomedical Research Centre renewal competition in 2016	The prequalifying questionnaire (PQQ) has been submitted and agreed by NIHR. The full application will be submitted and interviews will be held in July 2016.
10.2	Increase the number of patients participating in clinical trials and the impact of clinical trials on patient care	During 2015/16 OUH achieved 100% against the 70 day benchmark for initiation of clinical trials - the best performance of any large research-active hospital in England.
10.3	Through the provision of appropriate education and training, develop staff capability and capacity in order to meet the needs of patients and service users	The OUH Learning and Education Strategy was developed in consultation with staff, approved by the Trust Board in Nov 15 and is now being taken forward for implementation. The 6 key themes are: career-enhancing education; talent and leadership development; quality and patient safety; innovative learning; learning together, and inspiring learning environments.

	Objective	Delivery
11.	Finance	
11.1	Deliver the financial plan	The Trust delivered its 'stretch target' breakeven duty surplus of £5.3m for 2015/16. This included significant non-recurrent measures (including a land disposal) and represented an underlying retained deficit of £23.2m.
12.	Partnerships	
12.1	Develop a Patient and Public Participation Strategy	<ul style="list-style-type: none"> • Patient engagement strategy completed, including consultation across 'hard to reach' groups. • Significant increase in Friends & Family test response rates in all areas, with introduction of SMS messaging. • PPI groups provided with toolkits for local development and leadership programmes for support.
12.2	Address service issues raised by GPs	Endorsement of test results: In Mar 16 63% of test results were signed off within 7 days with ongoing work to enhance monitoring of performance at Directorate and Divisional level. Achieving the 95% target has been challenging with a concerted effort to achieve improvements against this measure, including incorporation of the data onto the new information system (Tableau).
13.	Organisational	
13.1	Achieve NHS Foundation Trust status	Achieved 1 st October 2015.

Appendix B - OUH CQUINs for 2016/17

Indicator Name	Description	Lead Director
National CQUINs		
NHS Staff Health and Wellbeing		
Introduction of health and wellbeing initiatives	Implementation of a plan to introduce physical activity schemes for staff, to improve access to physiotherapy services for staff and to introduce mental health initiatives for staff	Director of Organisational Development and Workforce
Healthy food for NHS staff, visitors and patients	Submission of a data return regarding contracts with franchise holders for food and drink suppliers during the delivery of four specific step changes in the health of food supplied	Director of Clinical Services
Improving the uptake of flu vaccinations for front line staff	75% of frontline clinical staff to have received flu vaccinations by Dec 16	Medical Director
Identification and early treatment of Sepsis		
Timely identification and treatment for sepsis in emergency departments	Thresholds for screening and treatment for sepsis in ED	Medical Director
Timely identification and treatment for sepsis in acute inpatient settings	Thresholds for screening and treatment for sepsis in acute settings	Medical Director
Antimicrobial Resistance and Antimicrobial Stewardship		
Reduction in antibiotic consumption per 1,000 admissions	1% reduction in antibiotic consumption per 1000 admissions across three measures: <ul style="list-style-type: none"> • Total antibiotic consumption • Consumption of carbapenem • Consumption of piperacillin-tazobactam 	
Empiric review of antibiotic prescriptions	Monthly empiric review of the percentage of antibiotic prescriptions reviewed within 72 hours	Medical Director
Local CQUINs		
Human Factors Training	Expansion of human factors training programme along with audit of attendees three months after training to assess impact on practice	Medical Director

Indicator Name	Description	Lead Director
ED and Ambulatory Pathways	Increase the number of patients managed in Adams Ambulatory Unit and not admitted to an inpatient bed	Director of Clinical Services
Stroke	Implementation of revised stroke care model with increase in proportion of patients managed by Early Supported Discharge	Director of Clinical Services
End of Life Care	Roll out of the Swan scheme ¹³ to all acute medical wards and implementation of 7 day palliative care ward rounds of ED and EAU	Medical Director
Specialised Services		
Clinical Utilisation Review (CUR)	CUR is a software approach which can prevent unnecessary hospital admissions and reduce length of stay for patients by determining the most suitable level of care according to clinical need	Director of Planning and Information
Hepatitis C Virus (HCV)	Supports the infrastructure, governance and partnership-working across healthcare providers working in HCV networks	Director of Clinical Services
Automated Exchange Transfusion for Sickle Cell Disease Patients	Aims to incentivise the use of automated exchange for transfusions by specified specialist centres in order to improve patient experience and use of clinical resources	Director of Clinical Services
Haemoglobinopathy - improving pathways through Operational Delivery Networks (ODNs)	To improve appropriate and cost effective access to appropriate treatment for haemoglobinopathy patients by developing ODNs and ensuring compliance with ODN guidance through MDT review of individual patients' notes	Director of Clinical Services
Nationally Standardised Dose Banding Adult Intravenous Systemic Anti-Cancer Therapy (SACT)	A national incentive to standardise the doses of SACT in all units across England in order to increase safety and efficiency and to support parity of care across providers	Director of Clinical Services
Multi-system Auto-immune Rheumatic Diseases MDT clinics, data collection and policy compliance	To support the development of coordinated MDT clinics for patients with multisystem auto-immune rheumatic diseases, and to ensure data collection and compliance with existing NHS England commissioning policies	Director of Clinical Services

¹³ This scheme alerts staff that a patient is dying, so cleaning can be done with sensitivity, relatives are offered some comfort supplies and a patient's property is treated with respect after their death as illustrative examples of the scheme

Indicator Name	Description	Lead Director
Haemophilia	Partnership working with District General Hospitals	Director of Clinical Services

Appendix C – 2016/17 Capital Plan

Name of Scheme	2015/16 Outturn	2016/17 projection (per Monitor plan)	2016/17 slippage impact	2016/17 previously agreed cases	2016/17 "business as usual"	2016/17 "indicative amount"	2016/17 Total
Neonatal Intensive Care completion from 2012/13	10,800	11,200	11,200				11,200
Radiotherapy: Milton Keynes	83,183	100,000				100,000	100,000
Radiotherapy: Swindon	177,619	5,290,000	3,371,381	1,918,619			5,290,000
Respiratory Ward revised plan	1,505,856	138,553	138,553				138,553
Bronchoscopy	1,471						0
Respiratory Outpatients to JR	91,157						0
Clinical Genetics Relocation to NOC and NOC Offices	50,046	560,367	560,367				560,367
Ultrasound JR	-97,759						0
PET/CT Scanner	3,212						0
Refurbishment of Level 7 wards	952						0
Day Surgery Unit Churchill remodel or 23 hour unit	355,166	1,490,048	847,048	643,000			1,490,048
Outpatient Horton (Paeds)	-504						0
Outpatient/Day Surgery Horton (Ward E)	0	0				0	0
Cardiology-Echo Scheme	906						0
Pre operative assessment - Churchill TDA	-1,867						0
Expansion of EAU Phase 1	33,187						0
Expansion of EAU Phase 2	821,521	3,336	3,336				3,336
Renal Satellite Dialysis Extension: Swindon Phase 2	34,709						0
Angiography/Anaesthetic room link to vascular IR room	-150,224	5,000	5,000				5,000
Kadoorie final elements	-863						0
Centralisation of Switchboard	52,757						0
Centralisation of Switchboard (Horton reception)	36,965	11,371	11,371				11,371
Pathology Automation	-5,075	30,000		18,000	12,000		30,000
ID Ward Relocation	0	0				0	0
JR 2 theatre remodelling (IR/Trauma/Cardiac)	27,829	250,000				250,000	250,000
Adult critical care JR	22,943						0
Critical Care Interim Case	26,625	131,800	31,800	100,000			131,800
Renal Inpatient CH	0	1,000,000				1,000,000	1,000,000
Maternity Theatre Ventilation and Refurbishment	255,905						0
Cardiac Gamma Camera	0	0				0	0
Replacement Renal Dialysis Machines	0	500,000		500,000			500,000
Small schemes - various	1,390,514	1,000,000			1,000,000		1,000,000
Medical and Surgical Equipment	1,870,991	2,007,087	7,087		2,000,000		2,007,087
EPR Implementation and staff capitalisation	999,744	900,000			900,000		900,000
IT General	1,105,310	1,000,000			1,000,000		1,000,000
Estates general: maintenance, utilities, demolition, signage, DDA, bed replacement	1,189,482	2,250,000	250,000		2,000,000		2,250,000
General JR	-4,954						0
Fluroscopy JR	732,498	50,000	50,000				50,000
BRC Capital	70,175	354,825	354,825				354,825
Prior Year slippage	-206						0
EPR Reprourement	523,079	2,694,667	1,350,667	1,344,000			2,694,667
Shower Legionella	143,403	156,827	156,827				156,827
Other	0	5,166,725				5,166,725	5,166,725
Divisional Equipment and Corporate IT	1,357,033						0
Nursing Technology and Safer Wards Safer Hospitals	3,301						0
Maternity Care Fund	50,383	1,096	1,096				1,096
Lease Buyouts	0	720,000			720,000		720,000
John Radcliffe	91,261						0
Churchill Hospital	-5,125						0
Horton General	45,837						0
Sterile Services Interim Case	0	400,000	400,000				400,000
Replacement of CT 2 (Transfer from 44c)	579,481	20,000	20,000				20,000
New CT (Third Scanner)	925						0
Resus Bays	0	1,000,000				1,000,000	1,000,000
Emergency Department / Radiology	0	0					0
Horton CT	128,782	2,301,272	2,221,272	80,000			2,301,272
Horton Endoscopy	691,267	1,912,109	1,912,109				1,912,109
Horton Endoscopy Changing Room	5,655	50,345	50,345				50,345
Ultrasound	0	96,000				96,000	96,000
Demolitions	134,763						0
Car Park Barriers	126,272						0
Capital Technology Fund Genomics Designation	643,263	0					0
Allocate Software	451,735						0
Churchill Equipment Library	9,897						0
JR Endoscopy Feasibility (Detailed case)	35,590	64,410	64,410				64,410
Horton Radiology Feasibility	39,844	3,000	3,000				3,000
Vascular Surgery Phase 3 Feasibility	8,263	31,737	31,737				31,737
Parental Accommodation	63,600						0
Diagnostic monitors and equipment	272,805	97,195	97,195				97,195
Defibrillators	648,094	634,100		634,100			634,100
NetCall and Remind+	115,945	75,000		75,000			75,000
Legionella - JR Ionisation Water Treatment	57,284	542,716	242,716	300,000			542,716
Legionella - JR / CH Legionella Works	861	380,000	380,000				380,000
JR Plastic surgery C - Arm	56,685						0
Interventional Radiology Equipment (Room 11 JRH)	1,639	527,184	527,184				527,184
Carbon Energy scheme variations	273,650	122,350	122,350				122,350
JR Gynae theatre stack	84,578						0
Cardiology Echo Probes JR	29,406						0
JR Endoscopy Washer Replacement (feasibility)	5,966	534,034	34,034			500,000	534,034
Sexual Health windows replacement	0	70,000	70,000				70,000
Radiology CR readers	92,094						0
Business Intelligence and Reporting Tools	107,845	233,819	233,819				233,819
Heart Failure and IHC	0	70,000		70,000			70,000
NOC Gait Lab Equipment	0	37,000		37,000			37,000
SIFT capital	29,875						0
Donations	592,007	300,000				300,000	300,000
Inflation/Contingency		0					0
Overprogramming/Slippage		-173				-173	-173
TOTAL	18,187,317	35,325,000	13,578,729	5,713,719	7,620,000	8,412,552	35,325,000
Capital Available per LTFM/TDA Plan	30,019,000	35,325,000					
Technical capital expenditure							
PFI lifecycle	2,231,548	5,791,000			5,791,000		5,791,000
Equipment leasing		500,000			500,000		500,000
Welcome Centre	3,000,000	0					0
Carbon Energy Fund		0					0
Gross Capital Expenditure per Monitor Plan 18th April 2016	23,418,865	41,616,000	13,578,729	5,713,719	13,911,000	8,412,552	41,616,000

Appendix D – Board Assurance Framework (as at 3rd May 2016)

The Assurance Framework has the following headings:

Principal Risk:	What could prevent the objective from being achieved? Which area within the organisation does this risk primarily impact on – clinical, organisational or financial?
Key Controls:	What controls / systems do we have in place to assist secure delivery of the objective?
Sources of Assurance:	Where can we gain evidence relating to the effectiveness of the controls / systems which we are relying on?
Assurances on the Effectiveness of controls:	What does the evidence tell us in relation to the effectiveness of the controls / systems which are being relied on? (To be developed)
Gaps in control:	Are there any gaps in the effectiveness of controls / systems in place? (To be developed)
Gaps in assurance:	Where can we improve evidence about the effectiveness of one or more of the key controls / systems which we are relying on? (To be developed)
Action Plans:	Plans to address the gaps in control and / or assurance and indicative completion dates

Principal Risk Description	Key Controls	Sources of Assurance	Action plan / Owner
Principal Risk 1: Failure to maintain the quality of patient services			
Potential Cause: <ul style="list-style-type: none"> • Patient experience indicators show a decline in quality. • Breach of CQC regulations. • Failure to meet the Trust's Quality Strategy goals. • Failure to reduce delayed transfers of care. • Difficulty in recruiting and retaining high-quality staff in certain areas. • Insufficient provision of appropriate education and learning development 	<ul style="list-style-type: none"> • Quality metrics in monthly Divisional Quality Reports. • 'Safety Thermometer' data. • 'Observations of care' reviews. • Patient feedback via complaints & claims. • Friends & Family test. • Incident reporting. • Quality Strategy CQUIN & Contract monitoring process. • Quality impact review process of all CIP plans. • Whistleblowing policy. • Mortality & Morbidity / clinical 	Reported to Board <ul style="list-style-type: none"> • Integrated Performance Reports (IPR) (L1). • Reports from Quality Committee to Board (L2). • Audit Committee Report to the Board (L2) • Annual Health & Safety Report (L1) Reported elsewhere <ul style="list-style-type: none"> • Annual nursing skill mix review (L1). • Picker Patient and Staff Surveys (L2). • PROMs (Patient reported Outcome Measures) (L3). 	Overall Risk Owner: Medical Director

Principal Risk Description	Key Controls	Sources of Assurance	Action plan / Owner
<p>opportunities.</p> <ul style="list-style-type: none"> Failure to sustain effective regional networks. <p>Potential Effect:</p> <ul style="list-style-type: none"> Poor patient experience and standards of care. Inaccurate or inappropriate media coverage. <p>Potential Impact:</p> <ul style="list-style-type: none"> Potential loss of licence to practice. Potential loss of reputation. Financial penalties may be applied. Poor Monitor Governance Risk Rating. 	<p>governance meetings at service level.</p> <ul style="list-style-type: none"> Benchmarked outcomes data. Quality meetings between executives and CCG. Appraisal / revalidation. Quality Assurance priorities. Pressure Ulcer Reduction Plan. Public Health Strategy. Patient feedback system to be implemented. Dementia Strategy. 	<ul style="list-style-type: none"> GMC Trainee survey (patient safety) (L3). National Clinical Audits/ (L3). Audit Committee review Clinical Audit (L2) Network meetings (L2). Update reports from Community Partnership Network (L2). 	
Principal Risk 2: Failure to maintain financial sustainability			
<p>Potential Cause:</p> <ul style="list-style-type: none"> Failure to deliver the required levels of CIP. Failure to effectively control pay and agency costs. Services display poor cost-effectiveness. <p>Potential Effect:</p> <ul style="list-style-type: none"> Additional CIPs may need to be identified and delivered. <p>Potential Impact:</p> <ul style="list-style-type: none"> Reductions in services or the level of service provision in 	<ul style="list-style-type: none"> Two-year rolling CIP with contingencies in place. Divisional ownership of schemes. Transformation Team support in place. Performance Management Regime. Budget setting & business planning processes. Quality Impact Assessment process. Bi-weekly monitoring of CIP programme Transformation & CIP Steering Group established. Revised project management arrangements. 	<p>Reported to Board</p> <ul style="list-style-type: none"> Director of Finance and Procurement Reports to the Board (L1) Finance and Performance Committee (L2). Audit Committee Report to the Board (L2). HDD Report to the Board (L3). <p>Reported elsewhere</p> <ul style="list-style-type: none"> Internal Audit review of CIPs (L3). Internal audit review of Financial Management arrangements (L3). CIP reports to Quality Committee 	<p>Overall Risk Owner:</p> <p>Director of Finance and Procurement</p>

Principal Risk Description	Key Controls	Sources of Assurance	Action plan / Owner
some areas. <ul style="list-style-type: none"> Potential loss in market share and or external intervention. 	<ul style="list-style-type: none"> Contract monitoring process PLICS in place. SOs and SFIs. Declaration of Interests. 6 facet surveys completed. Investment Policy. 	(L2). <ul style="list-style-type: none"> Data Quality reviews with commissioners (L2). Assessment against Monitor Risk Assessment Framework. 	
Principal Risk 3: Failure to maintain operational performance			
Potential Cause: <ul style="list-style-type: none"> Failure of national performance targets. Potential Effect: <ul style="list-style-type: none"> 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 KPIs and self-certification. Potential Impact: <ul style="list-style-type: none"> Services may be unaffordable. Loss in reputation. Failure to meet contractual requirements 	<ul style="list-style-type: none"> Monthly Programme Board, with representation from OUH, social services and the CCG at CEO level. Bi-weekly Project Team meetings at COO and equivalent level. Internal weekly DTOC meetings. Provider Action Plan (DTOC) Monthly Chief Executives' meetings. Supported Hospital Discharge Service Clinical Services Strategy. Outpatient re-profiling. Bi weekly performance meetings 	Reported to Board <ul style="list-style-type: none"> Director of Finance Reports to the Board (L1). Integrated Performance Reports (L1) Director of Clinical Services reports re review of services (L1). Emergency Planning Annual Report (L1) Audit Committee Report (L2) Reported elsewhere <ul style="list-style-type: none"> OCCG monthly Monitoring Review meetings (L3). Chief Executives' Meetings (L2). 	N/A for action (Risk Owner : Director of Clinical Services)
Current Corporate Risk Register Risks related to new Strategic Themes – to be developed			
Potential Cause: <ul style="list-style-type: none"> Lack of robust plans across healthcare systems. Failure of accurate reporting 	<ul style="list-style-type: none"> Initial business cases for QIPP developed by OCCG OUH to sit on QIPP Steering Group External contracts to be operationalised 	Reported to Board <ul style="list-style-type: none"> CEO reports to Board (L1) Director of Clinical Services reports re review of services (L1). 	(Risk Owner : Director of Planning and Information)

Principal Risk Description	Key Controls	Sources of Assurance	Action plan / Owner
<p>and poor data due to implementation of EPR.</p> <ul style="list-style-type: none"> • Inability to meet the Trust needs for capital investment. • Failure to obtain the clinical advantages from EPR. <p>Potential Effect:</p> <ul style="list-style-type: none"> • Loss of existing market share. • Stranded fixed costs due to poor demand management / QIPP. • Difficult to manage capacity plans. <p>Potential Impact:</p> <ul style="list-style-type: none"> • Reduced financial sustainability. • Inability to meet quality goals. • Reduced operational performance. 	<p>internally</p> <ul style="list-style-type: none"> • Full involvement in commissioner led reconfiguration initiatives. • System leadership structure under development. • Strategy refresh being undertaken 	<ul style="list-style-type: none"> • Business Cases involving commissioners reported, where these occur (L1). Reported elsewhere 	