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High Quality, cost effective community services are a vital part of NHS Northamptonshire's plans for the future.

The current economic climate means that the NHS is about to enter one of the most challenging periods in its history. Our challenge as local leaders of the NHS is to deliver personalised, accessible high quality care, whilst at the same time reducing cost. This strategy seeks to respond to that challenge.

We must and will create an environment in which innovation can flourish; now is an opportune time for us as commissioners, together with our providers, to transform community services in Northamptonshire for the benefit of our patients.

Patients' expectations have changed and we must change to meet their expectations. Too many people receive hospital care, when they could be treated and recover more quickly if they were supported and cared for at home. By developing responsive community services, and better integrating with the services of General Practice, I believe that we can reduce acute hospital activity and improve patient satisfaction.

I am therefore delighted to present NHS Northamptonshire's Community Services Strategy. This document describes how high quality, personalised, accessible, value for money services and pathways of care will be commissioned and provided within your local communities.

We will, over the next 5 years, fully evaluate and review all of our community services. Where quality and value can be improved we will work with our existing providers but also not hesitate to seek alternative ones, where this is in patients' and/or taxpayers' best interests.

This document is an important element of our overall strategy for health and healthcare in the county which we published in 2008. Our challenge now is to deliver our strategic priorities designed to add years to life, and life to years, against a backdrop of reduced funding.

This is therefore a truly exciting time for community healthcare in Northamptonshire and I commend this strategy to you.

John Parkes
Chief Executive
NHS Northamptonshire
Section 1 Introduction

The need for efficient and highly effective community services has never been greater than at the present time as commissioners drive forward plans to promote good health, prevent ill-health and provide care close to home.

NHS Northamptonshire (NHSN) aims to ensure that the people of Northamptonshire have modern community health services which are accessible, personalised and enable choice. We must reduce unnecessary spend and commission high quality, cost effective care for the people of Northamptonshire.

Over the past 2 years NHSN has carried out an extensive engagement programme with clinicians, key partners, patients, carers and members of the public to determine the important issues for improvements in the delivery of health care. The NHS Next Stage Review (NSR), High Quality Care for All (2008) was put into a local context and set out in Northamptonshire - Facing the Future (2008). Our local findings reflected the national findings, with an emphasis on high quality care being provided closer to home and identified variations in provision of care.

“Localise where possible, concentrate where necessary” - this important aim captures the recent shift in emphasis within NHS planning. We anticipate the need to develop a network of modern NHS centres that can provide a very wide range of services closer to where you live. Not only will this provide services that are more convenient for individuals and help maintain people’s independence by staying at home longer but it will reduce our carbon footprint and help the environment.

Facing the Future in Northamptonshire (2008)

Our Strategic Plan 2009-2014: 5 year strategy (NHSN 2008) went further and identified the priorities for action between the period 2009-2014.

This strategy sets out the community services response to the Next Stage Review and the local 5 year strategy. It considers the changes in the financial environment that demand a structured approach to the delivery of Quality, Innovation, Productivity and Prevention (QIPP) (Department of Health - DH (2008) here in the county. In response to the financial climate NHSN have introduced a fifth element to QIPP which is ‘S’ for savings (QIPPS).

It considers and sets out the need for change through pathway redesign, and through market reform. This is all designed to drive up quality and patient satisfaction, whilst at the same time reducing overall cost.

The strategy identifies the benefits of integration of service, particularly between primary care (GP) services and community services. This is embodied in our future plans for the development of our community Provider Arm, which are considered as part of the strategy.

The level of ambition to transform community services set out in this strategy is high. However, the future economic situation will require us to be flexible in our
approach ensuring savings are delivered and financial risk is minimised. On occasions, this will require our partners to take action, for example acute hospitals to close beds as community services are developed and implemented in the community.
Section 2 Vision

Personalised, Accessible, High Quality and Affordable Integrated Care

Community services in Northamptonshire will transform to be amongst the best in the country, providing high quality, integrated, personalised care, closer to home. Care providers will integrate enabling more patients to live independent lives, with those requiring a hospital stay able to return home more quickly. We will use information and market knowledge to drive up the quality, productivity and value for money of services in order to achieve our ambitions.

To achieve our vision we will:

- Introduce new healthcare providers into Northamptonshire providing more choice and innovation in service delivery. This will be achieved by contesting 100% of services over the next 5 years. Where services fall short of measures on quality and value for money NHSN will commission alternative suppliers.

- Ensure that only complex care is undertaken in an acute setting with appropriate care being provided in the community.

- Ensure that QIPPS becomes the overarching principle used in Northamptonshire, investing for improved patient outcomes, and relentless in the pursuit of efficiency and appropriate savings.

- Ensure clinical and partner engagement to deliver our vision. Clinicians know what needs to be done to improve services, and we will work in partnership with them to get it done. Patients also know what needs to change and we will engage with them in our drive for change.

- Close the traditional division between health and social care to ensure flexible, personalised and seamless care.

QUALITY ‘A common misconception is that quality is expensive. On the contrary, quality can and should be a powerful way of cutting costs, doing things right first time without the need for repetition, and is the most effective way to reduce unnecessary cost. It’s when things go wrong that they become expensive and inefficient’ (Transforming Community Services: Ambition, Action, and Achievement (2009)).
Section 3 Context

3.1 Northamptonshire’s 2009-2014 Five Year Strategic Plan

Our Strategic Plan (NHSN 2008), together with the priorities from the Joint Strategic Needs Assessment (JSNA (2008-09)), sets out the vision, strategic themes, priority health areas and investment needed to improve the health of people in the county, as summarised in the diagram below:

The Strategic Plan provides clear direction to improve services for patients. It demonstrates a desire and commitment to improve people’s health and well-being, and the services they receive when they are ill. We have made some excellent progress over the past two years; however there is much more to do.

We will know that we have successfully implemented our strategy if:

- Our overall aim/objective to improve health outcomes has been met.
- Our citizens are more satisfied, with individuals feeling they are treated with dignity and respect, and receiving the highest levels of care.
- All partnerships are more effective in working together to deliver high quality, equitable outcomes.
- All staff feel valued, supported and personally empowered to deliver the required changes.
- We have reduced costs and increased value for money.
The population of the county is growing fast, and is predicted to grow by 7.5% by 2014 (see appendix 1). We must ensure that our community services forward plan to meet this challenge of rising demand.

Strategies for Primary and Intermediate Care are currently being developed and will address similar issues to those identified in this strategy: care closer to home; reducing unnecessary admissions to and timely discharge from hospital, integrated and personalised care. This highlights the need to integrate services much more in the future, to drive up quality, patient experience and service efficiency.

Our Market Development Strategy (NHSN 2009) supports delivery of our service strategies. It establishes a framework for evaluating existing services and delivering market reforms that improve quality, value and choice for patients.

Our local strategy for community services follows the national policy. More information can be found in appendix 2.

3.2 Financial Environment

Since 1999, the NHS has seen unprecedented growth in funding on a year on year basis, with a doubling of the budget in the period 1999-2009. However, this period of significant growth is at an end.

The King’s Fund Report (*How cold will it be? Prospects for NHS funding 2011-2017*) published in September 2009 considered three possible future funding scenarios for the NHS:

- ‘**arctic**’: real funding cuts (–2 per cent for the first three years, –1 per cent for the second three years)
- ‘**cold**’: zero real growth for six years
- ‘**tepid**’: real increase (+2 per cent for the first three years, rising to +3 per cent).

The report states “To put these prospective funding changes in a historical context, there has never been a six-year period of zero real growth in the history of the NHS, and certainly no continuous six-year period of real reductions. The average annual increase in the tepid scenario is around 2.5 per cent, and while there have been six-year periods of similar levels of growth – the early 1950s, the mid-1970s and the early 1980s – such growth is a percentage point less than the historic average, and nearly one-third of the real average annual increase over the past decade.”

Figure 2 below shows historic funding (at 2010/11 prices) from 2006/7 – 2010/11 for the NHS in England, and from 2011/12–2017/18 for the three funding path scenarios.
Whichever funding scenario ultimately prevails, we cannot, as the NHS work as we have worked in the past. This will not deliver what we need to deliver in the future. We must adopt a very different approach to commissioning, switching away from service growth to a focus on quality improvement, productivity improvement, cost reduction and savings. We will move from a culture of spending to a culture of investing in order to achieve our aims and priorities.

Community services are critical to our pursuit of greater efficiency. We must reduce our reliance on acute care, and provide care closer to home (see appendix 3). In addition, recent studies have shown community services to be inefficient for a variety of historical reasons (McKinsey and Company, March 2009). We will demand year on year improvements in productivity from our providers, as well as market test services which, through analysis, are shown to be costly without delivering differentially higher quality.

We will use a variety of levers to achieve our aims, including:

- Programme Budgeting and Marginal Analysis (PBMA) to identify inefficiencies.
- Reforming of existing contractual terms by moving away from block contracts to paying for services using currencies based on patient outcomes.
- Review of individual services / groups of aligned services over a 5 year period awarding provider contracts based on quality, innovation and value for money.
- Prioritisation of activity for those things of the greatest health benefit.
The challenge for the whole health economy, including community services, will be a major focus on productivity and cost savings. This is necessary to demonstrate quality and transformation of care alongside value for money, in line with QIPPS.

3.3 Community Services Spend

Nationally over £12billion is spent on community services.

The table below shows how much NHSN invests in community services for Northamptonshire residents:

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Northamptonshire</td>
<td>86.50</td>
</tr>
<tr>
<td>NHS Oxford</td>
<td>1.48</td>
</tr>
<tr>
<td>NHS Peterborough</td>
<td>1.01</td>
</tr>
<tr>
<td>Other in-county Trust Providers</td>
<td>(approximately) 14.56</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>103.55</strong></td>
</tr>
</tbody>
</table>

Figure 3 – The amount that NHSN invests in community services for Northamptonshire

Source: NHSN Finance and Contracting.

Appendix 4 indicates the breakdown of spend against community services in Northamptonshire, Oxford and Peterborough.

Further work will be carried out during 2010/11 to gain greater clarity on other in-county trust providers who provide community focused services.

Work is also taking place as part of the implementation of the mental health commissioning strategy to determine if any activity currently undertaken by specialist community mental health services might be more appropriately undertaken in non specialist settings.
Section 4 Delivering the Vision

Whilst our vision, to deliver high quality, personalised, accessible care with better value and a focus on prevention is simple, delivering that vision will be challenging.

We have identified a range of strategic themes, all of which are important aspects of future care delivery and commissioning here in Northamptonshire.

Our priorities, linked to the key strategic themes, are broadly set out in three categories;

- Service line/care pathway changes
- System management changes
- Changes to the organisational form of our current main provider, the Primary Care Trust (PCT) provider arm.

All of what we do to deliver the strategy must be supported and driven by effective clinical and stakeholder engagement and focused on QIPPS. Our approach is illustrated in the diagram below;

Figure 4 – NHSN required outcomes, strategic themes and priorities for community services
4.1 Strategic Themes

Our strategic themes set out what we plan to do in order to achieve our vision of improving health and community health services for the people of the County.

1) Care Closer to Home

The public have told us that providing safe and effective care closer to home should be a key priority (Northamptonshire - Facing the Future (2008)). The strategy for moving the right care into the community is based on the premise that, by utilising community services more efficiently, demand for more intensive and costly services can be reduced. We will commission seamless services to ensure the most efficient and effective use of resources and improve outcomes for our population.

2) Commissioning for Quality

We want 100% of our patients to receive the care they need by the right person at the right time, at the right place ensuring our investment has optimal benefit. NHSN has been working with clinicians on the transformation of community services, using the best practice guidance in the six Transforming Community Services Reference Guides: (Transforming Community Services: Ambition, Action, Achievement (2009)).

We will develop and agree evidence based pathways of care that we expect our providers to follow. They will include clear definitions of all key interventions for every stage of the pathway. To measure performance and outcomes on each pathway local metrics will be developed.

We will not pay for sub-optimal performance and will, over time, specify and test compliance in all service lines and contracts.

3) Integrated Community Care

Too often the health care provided to our population is fragmented leading to poor patient experience. Our objective is to promote integration of services, supported by shared information in order to personalise care for every patient along a seamless pathway.

Working with GP Federations (see NHSN Primary Care Strategy Oct 2009), Social Services and other organisations we will provide as much care as possible in the community through an integrated approach, building on the current Northamptonshire and Integrated Care Organisation (ICO) Pilot.

4) Partnerships and Integration

Collaboration and partnership working will be the corner stone of successful integration. We will build on our existing relationships with local authorities, third sector organisations, patient and carers to foster new partnerships and work together to identify need, monitor progress and find joint solutions to local problems.
5) Equitable Access

The right care in the right place at the right time is what we aspire to provide for all our patients, regardless of where they live, or their personal circumstances. Clinical need will be the determination of length of stay in both acute and community in-patient facilities.

It is unacceptable that inequity and variation in service provision still exists between localities in the county. We will address this through service and pathway redesign ensuring equity of outcome based on health need.

6) Personalisation

We believe that all care should be personalised.

Sometimes continuity of care can be mistaken for personalisation. Just seeing the same professional is not enough. Professionals need to be able to tailor care to meet the needs and preferences of individual patients.

National and international evidence tells us that tailored support and interventions for patients delivers better health outcomes, and often does this at lower cost to the payer. Personalisation will be a particularly strong feature of our future approach to long term condition management in particular, with community service providers working in an integrated way alongside general practice to deliver better outcomes.

7) Maximising Life Expectancy

We know that there are links between poor health outcomes and areas of deprivation. Figure 5 shows the Index of Multiple Deprivation (2007) for Northamptonshire. The lowest ranking (red) Lower Super Output Areas are amongst the 20% most deprived in the country.
We will work with our local partners from primary, community and social care in those identified areas in order to reduce these unacceptable variations.

8) Promoting Healthy Lifestyles

Life expectancy cannot be improved without tackling lifestyle issues and inequalities linked to deprivation. It is important for us to commission services and pathways of care that support people to make healthier and more informed lifestyle choices. Public health data will identify those localities where the greatest prevalence of ill health occurs and work will be focussed there.

Focus will also be on keeping those with long-term conditions healthy to enable them to live independent lives. We will transform our health improvement services across Northamptonshire ensuring prevention is at the forefront in any pathway/service re-design.

9) Information and Knowledge

As commissioners all our decisions need to be information driven. We intend to base our service plans and decisions on the best evidence available informed by
robust data and information.

This is essential to evaluate effectiveness and monitor outcomes.

Figure 6 below shows how patients will be at the heart of everything we do using knowledge and information to drive improvement and tailored care.

![Diagram](image)

We will ensure that systems are put in place to share data and to enable a more informed, personalised approach to care provision. We want to have individual risk assessments for each patient and tailor services which mitigate this risk and enable a healthier, longer life.

Robust benchmarking, such as Vital Signs information, will be utilised in assessing and improving performance. To purchase care more effectively we must develop new contract currencies and set tariff prices. Transparency in this area is key to opening up markets and enhancing choice.

Costing and pricing, and the contract management that follows are dependent on accurate and timely information. We will require our providers to improve their information management systems, but would expect them to want to do this anyway as part of their business development.

10) Market Development

NHSN approach to prioritising its community markets has drawn on four strands of work which have been brought together to form our strategy for market intervention. These are:

- NHSN 3-5 year strategic plan
- The initial analysis of current services
- In depth analysis of those service areas that are deemed to be weak
- The production of the NHSN Market Development Strategy (2009)
The Market Development Strategy describes a phased and prioritised approach to market reform which embodies the approach that NHSN will adopt for analysis and intervention in all health markets.

As a key component of our plans to transform services in the county, enhance choice, improve quality and deliver value for money, we have developed an analysis of each healthcare market relevant to community services. This high level analysis of each market has been used to prioritise our market intervention plans.

For each service line, performance has been assessed against quality, access and cost in relation to our strategic priorities. We will use market analysis in the commissioning of all our services to ensure better quality and value for money.

Our approach will be systematic and include:

- An overview of current market conditions.
- A detailed analysis within a number of priority key markets.
- An intervention plan to create improvements and a review cycle.

As a result of our market analysis work, we better understand our current and future provider requirements and by employing this knowledge we will effectively stimulate the market to enhance choice, value and quality.

Using the high level market analysis, the resultant early priorities for action and the requirements for further analysis, together with the priorities from our 5 year strategy, we have developed a review timeline for all community services. This is set out in detail in Appendices 5 and 6.

By the end of 2013-14 100% of community services will have undergone a rigorous process of analysis to understand which market interventions will deliver required service outcomes.

Different levers will affect a given market in different ways and therefore, NHSN will select an appropriate range of potential levers.

The range of ‘levers’ available to us can be described within three broad categories, and are detailed below in Figure 7.

- Demand side levers
- Supply side levers
- Regulatory levers
For segments that lend themselves to competition ‘for-the-market’, action will most likely focus on supply side and regulatory levers (although some demand side levers such as the encouragement of the patient and public ‘voice’ may also be relevant).

For segments that lend themselves to competition ‘in-the-market’, the blend of levers may be more diverse. In either circumstance, the use of the Any Willing Provider (AWP) procurement route to create an environment where providers ‘compete’ on the basis of both quality and price to attract patients may be appropriate.

For each of the identified range of market reform levers NHSN will evaluate both the impact and appropriateness of each in relation to understanding:

- The impact on quality
- The impact on choice
- The impact on provider economics
- The impact on commissioner spend
- Compliance with the Principles and Rules for Co-operation and Competition

By the end of October 2009, in depth analysis will have taken place on our phase 1 priorities:

- End of Life
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes

Phase 2 priorities have already been identified as:

- Intermediate care
- Rehabilitation
- Children’s services
Phase 2 will also include the repatriation of continuing community health care and community equipment (logistics) from provider service to NHSN.

Working papers have been developed to support phase 1 pathway priorities. Work on phase 2 will commence in 2010/11.

4.2 Our Priorities

We have identified a number of priorities for change and improvement. These priorities each relate to a number of strategic themes; together the priorities set out a change programme designed to Transform Community Services in Northamptonshire realising efficiency savings, supporting patient choice and driving up quality.

The matrix below (figure 8) shows the relationship between the 10 priority areas and the strategic themes i.e. that more than one strategic theme will be addressed by each priority.

![Figure 8 – The relationship between priority areas for change and strategic themes](image)

Our priorities will build on work completed to date but critically they also respond to the new economic environment. Together the initiatives set out in this strategy
have the potential to save £11.6m by 2014. This is set out in more detail in the table below (figure 9);

<table>
<thead>
<tr>
<th>Programme</th>
<th>Estimated Saving £M</th>
<th>Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of Life Care</td>
<td>0.53</td>
<td>By March 2013</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.96</td>
<td>By March 2011</td>
</tr>
<tr>
<td>COPD</td>
<td>2.10</td>
<td>By March 2011</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>1.80</td>
<td>By March 2011</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>0.80</td>
<td>By March 2012</td>
</tr>
<tr>
<td>Children</td>
<td>0.00</td>
<td>With current funding</td>
</tr>
<tr>
<td>Repatriation IPC/CHC</td>
<td>3.56</td>
<td>By April 2011</td>
</tr>
<tr>
<td>Improved Contracting</td>
<td>TBC</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Pro-active Care</td>
<td>1.85</td>
<td>Annual savings to 2014</td>
</tr>
<tr>
<td>Organisational Form</td>
<td>TBC</td>
<td>Delivered 2010/11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11.60</strong></td>
<td></td>
</tr>
</tbody>
</table>

Figure 9 – Estimated savings by programme

Early calculations around the initiatives outlined suggest a potential saving of £11.6M could be realised for service redesign and reinvestment, although this needs to be worked through and detailed costings ascertained for each of the initiatives to establish the actual net/cash-releasing savings. Work to confirm and challenge the figures will continue with NHSN partners. Partnership working will be key to realising savings, as per the example of acute beds closing as community service capacity is improved.

Traditional timescales for change implementation in the NHS will not be good enough as we move into a period of reduced funding. Change must be implemented quickly in order to release savings and where these come from reduced reliance on hospital care, provide our hospitals with the surety and confidence required to reduce their capacity.

We have identified 10 priority areas which are a combination of pathway redesign activities and system management activities, such as improved contracting, which will drive up standards, productivity and quality, increasing the range and type of providers by encouraging more competition and choice for patients securing better value for money. Our final priority is to establish a clear direction of travel towards a future organisational form for the Provider Arm of NHSN.

The diagram below (figure 10) shows how delivering on pathway and service redesign will be enabled through review, improved contracting and repatriation of appropriate functions effectively delivered through a forward thinking, innovative integrated care model.
High level analysis from our strategic plan, community service line data and recent market analysis work has enabled us to identify current service gaps from the perspectives of quality, value for money, access to services, capacity and choice.

In depth analysis has been undertaken in end of life, diabetes and COPD pathways of care. This analysis has informed our direction of travel in these key areas.

Further work on intermediate care, rehabilitation, stroke and acquired brain injury (ABI), children’s and young person’s services, repatriation of community healthcare and community equipment (logistics) is currently moving forward. An intermediate care implementation plan (appendix 6) has been developed. Plans for children’s services are nearing completion.

Supporting services aimed at underpinning this work focuses on pathway and service review, and improving contracting (agreements between commissioner and provider). Our final initiative in this section aims to create a delivery vehicle across the health economy based on an integrated care model.

4.3.1 End of Life Care

Rationale

The profile of End of Life Care has been raised significantly in Northamptonshire through the End of Life workstream of Facing the Future (2008) and the Department of Health’s End of Life Care Strategy (2008). Local work carried out in Facing the Future (2008) identified various issues and barriers, with one major issue being the difficulty in meeting patients’ choice of preferred place of care.
National and local data shows that too many people die in hospital and are unable to exercise their wish to die at home.

Figure 11 (below) shows the patient preferred place of death:  
Source: Higginson I  

<table>
<thead>
<tr>
<th>Place</th>
<th>Home</th>
<th>Hospital</th>
<th>Hospice</th>
<th>Care Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preference</td>
<td>56%</td>
<td>11%</td>
<td>24%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Figure 11 – Patient preferred place of death

Figure 12 (below) shows current data (2007) of actual place of death

<table>
<thead>
<tr>
<th>District</th>
<th>Hospital</th>
<th>Care Homes</th>
<th>Hospice</th>
<th>Elsewhere e.g. Road traffic Accident</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>count</td>
<td>%</td>
<td>count</td>
<td>%</td>
<td>count</td>
</tr>
<tr>
<td>Corby</td>
<td>272</td>
<td>58.45%</td>
<td>53</td>
<td>11.60%</td>
<td>24</td>
</tr>
<tr>
<td>Daventry</td>
<td>365</td>
<td>57.22%</td>
<td>106</td>
<td>17.20%</td>
<td>25</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>370</td>
<td>49.14%</td>
<td>177</td>
<td>25.86%</td>
<td>38</td>
</tr>
<tr>
<td>Kettering</td>
<td>426</td>
<td>52.15%</td>
<td>149</td>
<td>21.09%</td>
<td>43</td>
</tr>
<tr>
<td>Northampton</td>
<td>895</td>
<td>52.83%</td>
<td>320</td>
<td>20.60%</td>
<td>122</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>315</td>
<td>51.05%</td>
<td>113</td>
<td>21.64%</td>
<td>48</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>363</td>
<td>55.36%</td>
<td>89</td>
<td>14.85%</td>
<td>38</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3006</td>
<td>53.29%</td>
<td>1007</td>
<td>19.72%</td>
<td>338</td>
</tr>
</tbody>
</table>

Figure 12 – Actual place of death in Northamptonshire (2007)  
Source: Higginson I  

Market analysis identified that: care is provided by a variety of provider organisations, with no overall co-ordination of care at a time when patients and their families need it most; community services have limited capacity, particularly out of hours and at weekends, and there is a need for ‘low level’ support e.g. night sitters.  The quality tools – Gold Standard Framework (GSF), Liverpool Care Pathway (LCP) and Preferred Priority of Care (PPC) – are not fully embedded across all organisations and there is a lack of bereavement support.
There are two distinct markets for End of Life care – General End of Life Care and Specialist Palliative Care. Appendix 7 depicts the market diagnostic summary for each of these.

‘End of Life Care’ helps all those with advanced progressive incurable illness to live as well as possible until they die. Definition of its beginning is variable. (Information for commissioning end of life care National End of Life Care Programme (2009)).

‘Specialist Palliative Care’ refers to services provided by specialist multidisciplinary palliative care teams (National Council for Palliative Care(2007)).

The vision for both markets is that people at the end of life receive appropriate, high quality care from services and support that focus on the individual needs of them and their carers. Their wishes are identified and respected and they are enabled to live and to die with dignity and security in their communities.

General End of Life Care

Market analysis demonstrated that patients have limited choice, relatively low concentration and limited switching of provider as patients usually access their local primary and community care services. Support at home is provided by one main provider, Marie Curie. There is scope to build on rivalry (or competition) for a range of ‘low level’ support for people in the community and co-ordination of services (single point of access).

Specialist Palliative Care

Patients have limited choice of provider as they usually access hospice and day care services closest to where they live. Analysis indicated highest take up by people living closest to services e.g. Northampton and Kettering. Specialist support at home is provided by one provider, the Hospice at Home service. PCT Provider Services are the dominant provider and the concentration of current providers is therefore high. There is a high level of satisfaction with current services and little evidence of switching and limited opportunities for rivalry.

The main priorities emerging from the market analysis were to expand the scope and capacity of community based services including a 24/7 co-ordination centre (single point of access), a rapid response service to support people in the community when their condition deteriorates and ‘low level’ support. A countywide review of bed capacity for palliative care should be undertaken to determine the range and location of specialist and ‘general’ palliative care beds. Services should be underpinned by simple initiatives such as care plans and shared information as these have the potential to transform patient experience and to provide for seamless care provision.

Strategic objective

Our objective is to provide co-ordinated care for patients at the end of their life to give more information, control and choice over their decisions including their preferred place of death.
Impact

- A year on year increase to reach a target of 30% of patients enabled to die in their own home by 2013, and a significant reduction on Continuing Health Care (CHC) spend.
- The percentage of people who die in hospital will reduce by 9.7% from 53% to 43.3%. This equates to approximately an additional 600 patients per annum being supported to die outside of the acute setting. Over the three year period to March 2013 a total of £3.6m will be transferred from the acute contracts to fund the community based services.
- Based on detailed scenario planning and analysis it is likely that the number of acute admissions will reduce by 854 over the 3 year period and 476 patients will have their lengths of stay in hospital reduced.
- £3.1m will be invested over a 3 year period to enable this service transformation through investment in community services, and generate a sustainable rate of return of 21% per annum.
- Patients will have access to the Rapid Response Service between 08:00 and 01:00, 7 days per week and access to the Care Coordination Centre available 24/7 365 days of the year
- 600 additional patients per year will be supported to die at home by 2013
- 90% of people who are caring for patients at the end of life will be highly satisfied with the new service arrangements
- 90% of all patients at the end of their life co-design their bespoke patient care/management plans with professionals
- 90% of people will have an identified case manager
- 90% of patients will die on the end of a care pathway

Initiatives

Initiative 1: Patient choice

We will improve choice at end of life by providing access to a range of comprehensive services that respond to the needs of patients and carers.

Rationale: Evidence exists to support the desires of patients to receive care at the end of life, and to die in their own home or a hospice, rather than in an acute hospital. We will deliver a range of evidence-based, high impact changes including the introduction of services which will respond rapidly to patient and carer need.

Funding of new or reconfigured community provision is planned for April 2010. This will be identified through a combination of redeployment of funding currently spent in a hospital setting and potential redeployment of continuing health care funding, following an imminent review of current expenditure.

Impact: Patients will be informed of choices and by 2014 will have their preferences met. There will be less hospital use and less reliance on CHC packages.
Initiative 2: Personalised Care

All patients will have personalised case management to improve quality and outcomes, reduce emergency admissions and facilitate earlier discharge.

**Rationale:** All patients will experience the best possible care, and not be subjected to duplication and inappropriate decisions. By 2011 all patients will have a named case manager. These managers will be responsible for coordination of care and support to the individual, family and carers in their choices of care. They will plan care on their behalf to make sure that care plans are accessible and information shared appropriately and effectively.

**Impact:** A single point of access, and named manager, will be in operation from December 2011, for all patients, offering responsive and personalised care, and avoiding inappropriate admissions or delays in accessing care.

Initiative 3: Information Sharing

All people approaching end of life, regardless of diagnosis or care setting, will be identified in an end of life register. This will enable delivery of integrated care through sharing of information across partner agencies.

**Rationale:** An end of life register will be operating by 2011. It will contain shared information, care plans and choice options across all settings. This local primary care practice register will be linked into the System 1 electronic care record and be made available for all health and social care practitioners.

This will provide accurate information for care planning, promoting quality care and monitoring purposes. This initiative will be supported by the Primary Care Strategy (2009) and will integrate data from a variety of sources to personalise care for patients.

**Impact:** By 2012 all health and social care practitioners will have access to information which will improve patient choice through being able to monitor that Gold Standard Framework and Liverpool Care Pathway (Marie Curie Palliative Care Institute, 2007) are in place for all patients.

Initiative 4: Lead Organisation

A single organisation will be responsible for leading co-ordination on behalf of partners to enable people to die at the place of their choice.

**Rationale:** Access to services, including specialist support and advice, will be required 24 hours a day if people are to be supported to remain at home. Joint planning with Out of Hours and ambulance services, with access to emergency services, will be necessary.
medicines, provision of equipment and innovative delivery of care such as telephone and technological support is necessary. Respite provision, provided by social care and the third sector, is essential.

By 2011 a single organisation will take the lead in ensuring that all services are co-ordinated.

**Impact:** A comprehensive package of care will be available, co-ordinated by a single organisation by March 2011 which will improve quality of care and produce a more efficient overall service.

### 4.3.2 Long Term Conditions

Many people live with Long Term Conditions (LTC) and are able to manage their symptoms well and live life to the fullest. However for some patients disease control is difficult and they have a greater need for health services. In the UK, 5% of people with LTC account for roughly 40% of inpatient hospital days and 2% of people with LTC account for 30% of unplanned hospital admissions. Meaningful management of chronic and long term conditions is becoming important both to quality of life and management of healthcare costs. This section identifies diabetes and COPD as key pathways in need of re-design.

#### 1) Diabetes

**Rationale**

The prevalence of diabetes in Northamptonshire is 4.48% against a national average of 4.95%. The highest prevalence is found in Northampton, Wellingborough and Corby at 4.60%, 5.02% and 4.77% respectively. There is a direct correlation with ethnic minority groups particularly Asian and Afro-Caribbean communities. It is estimated that obesity is accountable for 9% of this disease; other links are smoking and hypertension.

Patients with diabetes have a 60% increased risk of premature death with cardiovascular disease being the most common cause.

We have a high level of expenditure on diabetes services (see figure 13), ranking 17 out of 152 PCTs. Compared to the national average we have a significantly higher in-patient admission rate for elective and non-elective care. Therefore the investment currently being made is not delivering a commensurately high level of quality outcomes for patients. Costs have been increasing year on year as activity has continued to be focused on acute hospitals as shown in the table below.
The table below shows that NHSN is spending more than the national and group average per patient with diabetes per year, whilst achieving poorer outcomes:

Diabetes has been identified as one of the first services to undergo market analysis as significant opportunities exist to improve patient outcomes and reduce inequity of care.

The levers we will use to create change in the market structure and drive quality are:

- promotion of self-management and targeted support to help people stop smoking and loose weight
Where gaps exist in the current supplier market, we will encourage new market entrants in to deliver elements of the diabetes pathway

Appendix 8 depicts the market diagnostic summary for the current diabetes pathway. The table below (figure 15) gives a detailed breakdown of market analysis findings.

<table>
<thead>
<tr>
<th>Quality Dimension</th>
<th>Outcome</th>
<th>Rationale</th>
<th>Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
<td>Reduce Hospital Admissions</td>
<td>NHS Northamptonshire had significantly higher admissions to secondary care (101% higher than national average for non elective and 214% higher for elective treatment).</td>
<td>Reducing admissions by 10% Year 1 would save at least £158k. Current spend on day cases amounts to £263k – this spend will be examined to assess whether this care can be provided in the community.</td>
</tr>
<tr>
<td></td>
<td>Reduce Readmissions</td>
<td>Current readmission rate for Diabetes is 18.2% at Kettering General Hospital and 15% at Northampton General Hospital (Source: Dr. Foster). The reduction of this rate will be targeted as a priority by examining the root cause and ensuring plans to reduce the readmission rate are implemented.</td>
<td>Reduce readmission rate to 10% by end of Year 1. The cost savings will be part of those savings highlighted above.</td>
</tr>
<tr>
<td></td>
<td>Improve Patient Activation Measurement (PAM) Scores</td>
<td>PAM scores for Northamptonshire fall below the England score which shows that patients want to have more involvement in their care. This reinforces the importance of the self-management strategy.</td>
<td>Improve scores to be above the England score within one year and to be within the top 10% within 3 years.</td>
</tr>
<tr>
<td></td>
<td>Increase Number of Diagnosed Patients</td>
<td>Prevalence currently 4.48% (currently 25,912 patients on the Diabetes Register). It is estimated that this prevalence rate is underestimated therefore it is key that all high risk groups are tested for diabetes. The national average for detected diabetes prevalence is 4.95%.</td>
<td>Target high risk groups for early diagnosis</td>
</tr>
<tr>
<td></td>
<td>Establish a Register for High Risk Patients</td>
<td>If the high risk population is identified screening and follow-up can be targeted. This will lead to earlier detection and the prevention of longer term complications. Interventions such as diet and exercise can be targeted</td>
<td>A register of high risk patients will be set up within first year. This group can then be tested for diabetes. It is estimated that this will detect an additional 110 cases in Year 1.</td>
</tr>
<tr>
<td>Safety</td>
<td></td>
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<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Improve Prevention of Complications</td>
<td>To prevent the onset of further complications diabetic patients need to maintain an HbA1c of &lt;7.5%. The number of patients in Northamptonshire achieving this rate is 64.5% compared to a national average of 66.6% and an Office of National Statistics (ONS) rate of 67.4%. N.b. The market analysis work does not distinguish between type 1 and type 2 diabetes. For further information on the difference see NICE guidelines.</td>
<td>Ensure that new pathway design includes processes to ensure HbA1c &lt;7%. Targets are 75% by end of Year 1, 80% Year 2 and 85% Year 3. Achievement of these targets will contribute to downstream future cost savings</td>
<td></td>
</tr>
<tr>
<td>Improve Diabetes Register to Include Tracking of Activities and Outcomes</td>
<td>If patients on the diabetes register were tracked for receiving all the recommended pathway interventions in the desired frequency this would have a positive impact on CVD as risk factors would be identified and treated where necessary.</td>
<td>This information will be invaluable to evaluate redesigned pathway. Cost savings are difficult to establish at present due to the fact that they will delivered further downstream (from Year 5 onwards).</td>
<td></td>
</tr>
<tr>
<td>Increase Number of Patients with Personalised Care Plans</td>
<td>Research has shown that 81% of patients do not have a written care plan which reinforces the need for greater penetration of Personalised Care Plans and the sharing of this information with the patient.</td>
<td>Increase number of patients with a care plan to 50% by end of Year 1, 80% by end of Year 2 and 95% by end of Year 3.</td>
<td></td>
</tr>
<tr>
<td>Reduce Standard Mortality Rates (SMR)</td>
<td>Mortality rates in Northamptonshire for all persons all ages from diabetes for 2005/07 were in the “average” quintile, compared with other PCTs in England. South Northants and East Northants are in the best 20-40% of districts compared with Kettering, Northampton, Wellingborough, Daventry and Corby, which are all in the worst 20-40% of districts in England.</td>
<td>Reduce Standard Mortality Rates to below England average. Target areas with high mortality rates i.e. Corby, Kettering, Northampton, Wellingborough, Daventry and Corby. Reducing inequities of service will contribute to reducing mortality inequities.</td>
<td></td>
</tr>
<tr>
<td>Invest in recommended commissioning</td>
<td>Investment in all the pathway interventions is critical to improve coverage of the</td>
<td>Recent research by McKinsey &amp; Co. has identified that a number of initiatives could be</td>
<td></td>
</tr>
<tr>
<td>Responsiveness</td>
<td>Meet patients needs/wants</td>
<td>A report prepared by the Picker Institute entitled, “Experience of Patients with Long Term Conditions”, highlighted less positive responses from under 45 year olds and those suffering with anxiety/depression (Picker Report). We need to address responsiveness by ensuring that patients needs/wants are meet.</td>
<td>Set up process to measure whether patients needs and wants are being met and ensure that the reasons why are captured so that plans can be put into place to address patients needs/wants.</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Ensure that time to travel for treatment fits within the following criteria</td>
<td>Northamptonshire meets the criteria for accessibility. However, from a patient’s perspective a critical issue for services is whether the hospital/clinic has affordable parking facilities and also whether it is on a bus route.</td>
<td>Ensure that redesign plans continue to meet criteria for accessibility to ensure care is closer to home.</td>
</tr>
<tr>
<td>Equity</td>
<td>Equity of Service Provision</td>
<td>There is currently inequity of service across Community Dietetic Services, Outpatients, Psychology Services and level of clinical practice of COPD. These inequities will be addressed within the pathway redesign.</td>
<td>Prioritise areas which have the highest inequities i.e. Corby to ensure that all inequities can be addressed.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Optimise Use of Available Resource</td>
<td>Inefficiencies along current pathway, inconsistencies between staffing ratios and planned activity, communication inefficiencies. These issues will be addressed within the redesigned pathway.</td>
<td>Ensure contracts are consistent and targets are SMART. Regular contract reviews and tighter contract management will ensure optimal use of available resource.</td>
</tr>
<tr>
<td></td>
<td>Reinforce Compliance</td>
<td>Analysis by NHSN Prescribing Advisory Team</td>
<td>It has estimated that up to £800k can be saved per year,</td>
</tr>
</tbody>
</table>
with Prescribing Guidelines | re-enforced by recent research by McKinsey suggests that insulin prescribing does not always follow NICE guidelines. | in Northamptonshire, if prescribing practice followed NICE guidelines.
---|---|---
Reduce Average Length of Stay (LOS) | Average LOS is 9 days (Kettering General Hospital compared to 12.4 days at Northampton General Hospital compared to a 7.4 day national average. (Source: HES 2007/08 and Dr. Foster). Length of stay will be reduced following implementation of the redesigned pathway. | Reducing LOS will contribute to the cost savings already accounted for with reduced admissions. LOS will be reduced in the first instance by targeting and reducing excess bed days.
---|---|---
Improved Management Information from Providers | Granular activity and outcome data from providers can facilitate; - Assessment of correct level of service provision and expenditure - Patient level costing and spending forecasts - Tracking of pathway activity and outcomes - Feedback to other service providers involved in pathway care provision | Improved activity and outcome data will facilitate further service improvements and more accurate data capture.
---|---|---

**Figure 15 – Market diagnostic results for Diabetes**

**Strategic Objective**

Our objective is to reduce dependency on acute care; increase numbers involved in self-directed care and ensure equitable access to services across the county, whilst reducing the overall cost in this pathway.

**Impact**

- Improved patient outcomes through education programmes and care in the community and in primary care.
- Better value for money achieved through a redesigned pathway and better performance monitoring.
- Short term savings achieved from effective medicine management.
- Long term savings achieved through prevention measures ensuring patients remain stable and in control of their condition.

**Initiatives**

**Initiative 5: Care Pathway redesign and Implementation**

The diabetes care pathway will be developed by April 2010 to incorporate the various components of care.
**Rationale:** The significantly high use of acute care, high spending and poor outcomes for diabetes warrants a full review. A stronger focus on primary care with shared data to identify those at risk will be undertaken.

There are other initiatives, identified in the Primary Care Strategy (NHSN 2009) which relate to the development of closer integration between primary and community services. Examples of these include personalised care plans, economies of scale and different ways of working within a clear evidence-based approach, and ability to implement change county-wide. Where there are overlaps and synergies with initiatives being conducted on other long-term conditions we will identify shared benefits.

**Impact:** We will have clarity on the issues contributing to poorer outcomes and increased costs addressing them through redesigning pathways based on evidence, information, clinical and patients and implementing these new pathways including:

- Better patient monitoring to prevent patient health complications associated with diabetes. We will achieve HbA1c <7% in 85% of all patients by year 3 contributing to better outcomes for the patient and reduced costs.
- We will ensure a high percentage of compliance and fewer variations through quality and performance monitoring and contract compliance. An example of this is that adherence to the National Institute for health and Clinical Excellence (NICE) guidelines for insulin prescribing could save £800k per annum.
- Ensuring that by year 2011 3.95% of all patients have a personalised care plan.

Initiative 6: Education Programme

We require all patients to be offered access to the Expert Patient Programme alongside the promotion of self-management in 2010.

**Rationale:** Patient education and health promotion have an evidence-base which shows improved outcomes in dealing with specific conditions. For diabetes this service should help with information which will enable patients to be more independent and to access services when required.

**Impact:** With all patients having been offered a course on the Expert Patient Programme there should be:

- Less reliance on healthcare provision
- An increase in patients’ quality of life
- Reduced admission to secondary care by 10% per year would save at least £158k.
- Reduced re-admission rates to 10% per year. (The cost benefits are included in the figures above).
2) Chronic Obstructive Pulmonary Disease (COPD)

Rationale

Chronic Obstructive Pulmonary Disease (COPD) is a collective term for chronic bronchitis and emphysema; it is a progressive, treatable and largely preventable disease, and is the fourth leading cause of death worldwide with further increases in mortality and prevalence forecast. Smoking is the biggest contributing factor associated with COPD with 50% of all smokers affected.

In Northamptonshire, prevalence is 1.4% and lower than the national average of 1.5%. Mortality is high with Corby having the highest rate and also has the highest prevalence estimated to be 3.9%. Nationally COPD is under diagnosed by 40% and this is likely to be the case in Northamptonshire.

Total costs for COPD are as a minimum thought to be £11m per annum. Figure 16 shows elective and emergency hospital admissions which highlight an excessive level of emergency admissions:

Of these emergency admissions 43% were attributed to Very High Impact Users (VHIU) at a cost, in 2008/09, of over £1m. The top VHIU had 18 admissions during 2008/09.

In addition to these costs, NHSN currently spends £1.2m on oxygen services. A proportion of the spend on COPD falls within the block contract for community services, further currency and pricing work is being undertaken and will be completed by April 2010. Market analysis showed low performance and links to the strategic priorities of chronic disease and smoking.

The Market Analysis work has identified initiatives to reduce this spend and will be focusing on the demand side through patient education, self care and more care in the community. On the supply side we have held an Open Forum with a view to
reducing existing barriers and promote new entrants to the market place which will lead to increased competitiveness. This should have a positive impact on productivity and efficiency. Appendix 9 depicts the market diagnostic summary for the current COPD pathway. The table below (figure 17) provides a detailed breakdown of market analysis findings.

### Diagnostic Summary for COPD

<table>
<thead>
<tr>
<th>Quality Dimension</th>
<th>Outcome</th>
<th>Rationale</th>
<th>Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness</strong></td>
<td>Reduce hospital admissions</td>
<td>Data showed that there were 1,322 non elective COPD admissions 2008/09 and 8,616 for respiratory conditions. The implementation of remote patient monitoring will reduce the admission rate for COPD. High Impact Users will be targeted as a priority group.</td>
<td>Reducing COPD non elective and elective admissions by 40% would lead to an estimated saving of £1.2m. If methodology was applied to reduce respiratory non elective admissions by 20% this would give an additional saving of £3.2m.</td>
</tr>
<tr>
<td></td>
<td>Reduce Readmissions</td>
<td>Current readmission rate for COPD 25.3 % (D39) and 21.2% (D40) (Source: Dr. Foster). The reduction of this rate will be targeted as a priority by examining the root cause and ensuring plans are implemented. The implementation of remote patient monitoring will reduce the readmission rate for COPD.</td>
<td>Reduce readmission rate to 10%. A reduction in readmissions will assist with the cost savings identified for reducing hospital admissions.</td>
</tr>
<tr>
<td></td>
<td>Reduce A&amp;E Attendances</td>
<td>The current spend attributed to COPD amounts to £1.9m. It is estimated that the implementation of remote patient monitoring will reduce the attendance costs by 15-20%.</td>
<td>Reducing the attendance costs by 15-20% will realise £285k-£380k savings.</td>
</tr>
<tr>
<td></td>
<td>Reduce Outpatient Follow Ups</td>
<td>Outpatient follow-ups amounted to £361k for 2008/09. This figure is thought to be underestimated due to the fact that some respiratory clinics may be coded under General Medicine. The implementation of remote patient monitoring will reduce the outpatient follow up rate for COPD.</td>
<td>Clinics need to be more specifically coded to COPD, asthma etc. If follow up appointments are reduced by 20% this would lead to a cost saving of £72k.</td>
</tr>
<tr>
<td></td>
<td>Improve Patient Activation Measurement (PAM) Scores</td>
<td>PAM scores for Northamptonshire fall below the England score which shows that patients want to have more involvement in their care. This reinforces the importance of the self-management strategy.</td>
<td>Improve scores to be above the England score within one year and to be within the top 10% within 3 years.</td>
</tr>
<tr>
<td><strong>NHS Northamptonshire Community Services Strategy</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Implementation of remote patient monitoring will improve PAM scores.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase Number of Diagnosed Patients</td>
<td>Prevalence currently 1.4% (9338 people with COPD). It is estimated that this figure is grossly underestimated therefore it is key that all high risk groups are assessed for COPD.</td>
<td>Target high risk groups for early diagnosis. It is estimated that there are at least 4,000 people undiagnosed with COPD. This figure will be set as the target for diagnosis over the next 3 years.</td>
<td></td>
</tr>
<tr>
<td>Establish a Register for High Risk Patients</td>
<td>A register of high risk patients would assist with targeting specific groups and ensuring early diagnosis.</td>
<td>A register of high risk patients will be set up within first year. This group can then be tested for COPD and if diagnosed a plan of how to remain healthy can be recommended.</td>
<td></td>
</tr>
<tr>
<td>Increase Number of Patients with Personalised Care Plans</td>
<td>The number of patients with a Long Term Condition with a Personalised Care Plan is 19%.</td>
<td>Increase number of patients with a care plan to 50% by end of Year 1, 80% by end of Year 2 and 95% by end of Year 3.</td>
<td></td>
</tr>
<tr>
<td>Reduce Standard Mortality Rates (SMR)</td>
<td>SMR for Northamptonshire is 93.9 (100 for England as a whole). SMR is significantly higher in Corby and significantly lower in Daventry. These figures highlight inequities across the county that need to be addressed particularly in Corby.</td>
<td>Reduce Standard Mortality Rates to below England average. Target areas with high mortality rates i.e. Corby. Reducing inequities of service will contribute to reducing mortality inequities.</td>
<td></td>
</tr>
<tr>
<td>Meet patients needs/wants</td>
<td>A report prepared by the Picker Institute entitled, “Experience of Patients with Long Term Conditions”, highlighted less positive responses from under 45 year olds and those suffering with anxiety/depression (Picker Report). We need to address responsiveness.</td>
<td>Set up process to measure whether patients needs and wants are being met and ensure that the reasons why are captured so that plans can be put into place to address patients needs/wants.</td>
<td></td>
</tr>
<tr>
<td>Ensure that time to travel for treatment fits within the following criteria: 20 minutes for community 45 minutes for acute 60 minutes for specialist</td>
<td>Northamptonshire meets the criteria for accessibility. However, at a local level ease of car parking and bus route availability are key priorities for patients and carers.</td>
<td>Ensure that redesign plans continue to meet criteria for accessibility.</td>
<td></td>
</tr>
<tr>
<td>Equity of Service Provision</td>
<td>There is currently inequity of service across Community Outreach Services, District Nursing, Pulmonary Rehabilitation, Psychology Services and level of clinical</td>
<td>Prioritise areas which have the highest inequities i.e. Corby.</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>Optimise Use of Available Resource</td>
<td>Inefficiencies along current pathway, inconsistencies between staffing ratios and planned activity, communication inefficiencies. These issues will be addressed within the redesigned pathway and the implementation of remote patient monitoring. Research has shown that remote patient monitoring has reduced home visits by 80% resulting in reduced travelling costs and allowing staff to prioritise workload.</td>
<td>Ensure contracts are consistent and targets are SMART. Regular contract reviews and tighter contract management will ensure optimal use of available resource. Staff will have the capacity to manage larger caseloads due to reduced travelling requirements. This additional capacity will be critical as more people are diagnosed.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Reduce Average Length of Stay</td>
<td>Average L.O.S is 9.8 days (D39) and 5.5 days (D40) compared to 9.1 and 5.4 respectively national average (Source: HES 2008/9). Length of stay will be reduced following implementation of the redesigned pathway. Excess bed days for 08/09 amounted to £220k (£1.2m for respiratory conditions).</td>
<td>Reduce excess bed days for COPD and respiratory by 25% Year 1 (cost saving £55k) and 25% Year 2 (cost saving £110k in total).</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Reduce Average Cost per Admission</td>
<td>Average cost per non elective admission for NHSN is £2,000 compared to £1,400 - £1,600 for Leeds PCT. Further analysis need to be conducted to review why the costs differ.</td>
<td>It is estimated that £300k can be saved by addressing the cost differentials (based on 60% of the non elective admissions).</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Efficient Oxygen Assessment Service</td>
<td>Current spend on oxygen is £1.3m for 2008/09. Inefficiencies in the oxygen prescribing and assessment service are leading to increased costs.</td>
<td>It is estimated that cost savings of up to £200k could be realised by improving efficiencies across oxygen services.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Improved Management Information from Providers</td>
<td>Granular activity and outcome data from providers can facilitate; - Assessment of correct level of service provision and expenditure - Patient level costing and spending forecasts - Tracking of pathway activity and outcomes - Feedback to other service providers involved in pathway care provision</td>
<td>Improved activity and outcome data will facilitate further service improvements and more accurate data capture.</td>
</tr>
</tbody>
</table>

Figure 17 - Market diagnostic results for COPD
Each of these areas have been researched using primary and secondary data sources. Further information can be found in the supporting Market Development Strategy report (NHSN, 2009).

In conclusion, the market diagnostic summary highlights significant improvement opportunities. We have identified levers that will improve quality, choice and rivalry. These will in turn have a positive impact on concentration and switching. We will use levers to create a change in market structure and drive improvements in quality.

**Strategic objective**

Our objectives are to improve the diagnosis of COPD and to reduce the number of emergency admissions through personalised care plans and case management with a more rapid roll-out of the Pro-active Care (PAC) model (see initiative 25) beyond the High Impact Users (HIUs). In addition we will increase education programmes dealing with effects of lifestyle on health.

**Impact**

- Improved health outcomes
- More patients diagnosed at an earlier stage and managed for longer in the community.
- Savings in A&E attendances, acute admissions and acute re-admissions.

**Initiatives**

**Initiative 7: Care Pathway redesign and Implementation**

The redesigned COPD care pathway will be commissioned by April 2010.

*Rationale*: The significantly high use of acute care and poor outcomes for COPD warrants a full review. A stronger focus on primary care with shared data to identify those at risk will be undertaken.

Other initiatives include those in Primary Care which relate to the development of closer integration between primary and community services. Examples of these include personalised care plans, economies of scale and different ways of working within a clear evidence-based approach, and ability to implement change county-wide. Where there are overlaps and synergies with initiatives being conducted on other long-term conditions we will identify shared benefits.

*Impact*: We will have clarity on the issues contributing to poorer outcomes and will address them through redesigning pathways based on evidence, information, clinical input and patient input before implementing these new pathways. We will ensure a high percentage of compliance and fewer variations through quality and performance monitoring and contract compliance. We will achieve a Patient Activation Score above the England score in one year and be in the top 10%
within 3 years. In redesigning the pathway we will also address costs per non elective patient in comparison to other areas of the country realising an estimated £300k savings per annum.

Initiative 8: Links with Primary Care

**We will initially target the locality (Corby) where the biggest outcomes are to be achieved.**

**Rationale:** Corby has the highest rate of emergency admissions alongside highest key risk factors for COPD. In order to make a difference and to maximise resources we will, therefore, focus our work on Corby in the first instance with the funding released able to provide subsequently a more equitable service across the county.

We will work with multi-disciplinary teams including community nurses and GPs to increase diagnosis rates in the localities. The programme plan will start in 2010-11 and be monitored throughout the year.

Included in this initiative will be a review of oxygen assessment to ensure that patient’s needs are met and efficiencies are optimised.

**Impact:** We will:

- Improve lifestyles and increased health outcomes
- Improve quality of care by increasing the number of patients with personalised care plans to 60% in 2010/11 and 90% in 2011/12.
- Ensure that patients have appropriate oxygen provision when they need it. Greater efficiency will save £200k in costs per annum.

Initiative 9: Self-monitoring and remote support

**We will make greater use of remote patient monitoring in 2010 for patients with long term conditions e.g. COPD and diabetes.**

**Rationale:** We will invest in telehealth and telecare to provide alternative packages of care. Remote patient monitoring units have an evidence-base on their effect in reducing hospital admissions. These units will be linked to a chronic disease management team who will review variance and support the patients throughout their disease pathway. This would be from low level health care advice through to signposting them to the right service.

**Impact:**

- Reduce the number of non elective admissions by 40% leading to an estimated £1.2m saving. (Using the same methodology across all respiratory conditions non elective would be reduced by 30% saving £3.2m.)
Re-admissions rate will be reduced to 10% (contributing to the above cost savings). 
Telemedicine will give patients greater control over their condition and alert district nurses and GPs to patients health issues sooner
Reduce numbers of patients at A&E and acute in-patient care
Reduce numbers of patients directly accessing A&E services
Reduce spend on acute in-patient care
Chronic Disease Management model will enable self management and provide clear navigation of the COPD pathway.

Currently COPD accounts for £1.9m of A&E costs. Patient self monitoring potentially reduces this attendance by 15-20% saving £285-380k.

**Initiative 10: Smoking Cessation**

We will specifically target smoking cessation advice to patients with, or at risk of developing COPD.

**Rationale:** Smoking is the biggest contributory factor to COPD with smokers 12.7 times more likely to die of COPD than non smokers. However, it has been estimated that exposure to gases, dusts, vapours and fumes at work can account for 15% of cases.

**Impact:**

- Our population will be aware of the impact of smoking on their respiratory health.
- The overall target for smoking cessation within Northamptonshire is that 21% of adults will be smoking in 2010. (Down from 26% in 2002).
- The stop smoking campaign will reduce acute admission costs by £240k over the next 5 years.

**4.3.3 Out of Acute Hospital - Intermediate care**

To support our strategy for community services and achieve our vision of delivering ‘Personalised, Accessible, High Quality and Affordable Care’, an intermediate care strategy and implementation plan has been produced.

Intermediate Care services enable people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community and residential settings. We will commission a range of integrated services with partners to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living. It also encompasses anticipatory care planning for those with long term conditions, through to ensuring that people in institutional settings are able to be cared for in familiar surroundings (where it is in their best interests) when they are acutely ill or at the end of their life.
The intermediate care implementation plan has been included in this document as Appendix 6.

Rationale

The year on year increase in the numbers of emergency admissions to our two acute hospitals is unsustainable and unaffordable. Acute hospital admissions can be reduced and discharges made earlier through appropriate and effective use of primary and community services.

All partners in the health community need to recognise the role they must play in keeping people safe in the community. GPs supported by integrated care, together with step-up facilities in the community, will provide effective care and reduce reliance on acute hospital care.

Strategic objective

Our objective is to provide quality care in the right place, at the right time through an integrated service giving value for money and patient satisfaction, as well as quality and outcomes.

Impact

- In partnership provide care at home/closer to home, with an increase in localised and community based care
- Reduce the number of avoidable emergency admissions to acute hospitals
- Reduce the delay in transfers of care from acute and community in patient facilities, to bring the county performance incrementally up from a lower quartile regional performance, (Dr.Foster 2008/9 data)
- Reduce duplication of patient assessments, shortening the current completion of assessment process time for non complex assessments to a maximum 3 days
- Timely and clinically appropriate management of patient discharge from care provision to reduce current excess bed days by around 8,000 per annum, saving approximately £1.8m
- Maximise patient independence by demonstrating a reduced reliance on long term institutional care and avoidance of unnecessary hospital admission
- Reduce reliance upon long term institutional care by delivering a year on year 10% reduction in older people being admitted to residential and nursing homes
- Reduce admissions to acute hospitals from nursing homes to support the aims of the end of life care programme

Initiatives

Initiative 11: Co-ordinated case management (in partnership with health and social care)
In partnership we will commission 24/7 efficient, high quality intermediate packages of care according to patient need.

**Rationale:** Government policy has increasingly stated that health and social care organisations work together to deliver seamless services. The value of effective partnership working both strategically and operationally is well recognised. Partnership working is essential to deliver seamless services to ensure the most efficient and effective use of resources and improve outcomes for our population. This will include identification of opportunities to use the voluntary sector.

It is impossible to offer a true alternative to hospital care unless there is 24/7 provision within the community. By commissioning a county wide night sitting service the impact of rapid response and intermediate care team services will increase.

In Northamptonshire, Age Concern, SERVE and Shaw Homes all have bed-based provision which is aimed to prevent acute admission (step-up) and facilitate discharge (step-down). Care co-ordinators will arrange effective packages of care which can be set up quickly to prevent delays in care. Impact on outcomes for those with long term conditions e.g. very high impact users (VHIUs) who have COPD will be achieved more readily. We have recently been successful in gaining pilot status for the implementation of individual health budgets.

Community Hospitals and specialist care centres across Northamptonshire provide a range of step-up and step-down facilities, and an assessment of how these beds are currently utilised will take place. Our work in piloting new ways of working, arising from the three months’ closure of Hazelwood ward (Isebrook Hospital) will be assessed and initialising implemented where shown to be effective. Early findings suggest the requirement for a community based 72hour step up assessment facility and the identification of the most appropriate settings for continuing healthcare assessment.

We will undertake a review of our rehabilitation beds with the aim of enhancing quality, patient experience and value for money.

We will define a pathway for the delivery of rehabilitation identifying generic elements and disease specific variant pathways. Our aim will be to support as many people as possible to return to independent lives and reduce the number of patients who transfer to “institutional care”.

We will balance the health and cost benefit of developing new services against the tariff cost for hospital admissions

**Impact:**

- Patients will receive the most appropriate care in the correct setting
- Tailored packages of care will be provided thus avoiding unnecessary hospital admission and re-admission
- Spend on VHIUs in 2008-09 was over £1m. We aim to reduce this spending by 30% in 2010-11
Emergency admissions to acute beds will be reduced by 10% from 2010/11.

Initiative 12: Reduce institutional use of health and social care

**We will reduce admissions to in-patient care, and facilitate timely discharge and entry into long-term residential and nursing home care through a single integrated service**

**Rationale:** An increase in admissions to in-patient care, excess bed days and long term use of institutional care requires new approaches to current ways of working in health and social care. A fully integrated service (including 24 hour home support) will enable patients to receive a seamless service, reduce any potential duplication and increase quicker access to home care and other placements through agreed joint plans. We will develop a consistent skill level across disciplines to support care in the community and home. This will include medical assessment and input including community hospital and specialist care centres. Specialist in-reach to residential and nursing homes will enable people to be cared for in their place of permanent residence.

Partnership working will be effective only if formal structures are established. In 2010/11 we will achieve a single service which will focus on a more rapid step-up in Pro-active Care and better utilisation of both impatient and nursing residential care. Case management will be transformed into case co-ordination, working with integrated teams and linking into the GP federation model.

**Impact:**

- Staff will demonstrate a transformation in the way care is delivered and in their understanding of the roles they perform
- Collaborative working will ensure appropriate skill-mix, increase productivity and provide better quality of care
- Staff will plan better for patient discharge.

To measure impact we will have Key Performance Indicators (KPI’s) in place by 2010/11. These will:

- Ensure that patients have an estimated date of discharge within 48 hours of admission to a community bed.
- Measure the increase in avoided hospital admissions facilitated by providing highlighted levels of home based and community support through skills developed within intermediate care teams.
- Measure the lengths of stay in community beds. These will be significantly reduced. We will achieve a maximum stay of 30 days identifying disease specific pathways. (Currently stay lengths can be 65 days).
- Ensure that greater patient throughput in community beds is achieved enabling access for a larger group of patients.
- By 2012 we will have county wide extended specialist medical input and assessment in the community to prevent admissions and re-admissions into the acute setting.
4.3.4 Rehabilitation

Rationale

Rehabilitation services are provided to a number of different patient groups the largest being Stroke patients and a small number but high cost patients with Acquired Brain Injury.

Stroke is the third largest cause of death in England, and caused 125 premature deaths in Northamptonshire in 2006. This is comparable with the rest of the UK. The prevalence of stroke in Northamptonshire is relatively low at 1.5% compared to the national average of 1.6% although there is thought to be an under diagnosis rate in General Practice of 16%. There is also significant variation between different parts of the county 1.8% in Northampton and 2.5% in Corby. Prevalence is likely to increase as the population ages and increases.

Provision is inconsistent across the county; in the north of the county rehabilitation for stroke patients is provided in 2 Community Hospitals largely accessed by patients discharged from Kettering District hospital and in the south within Northampton General Hospital. A review has identified unmet need in the Community.¹

The total amount spent on Rehabilitation services is difficult to identify however some of the costs are clear. £4.5m is spent on acute neurology and we know that the Continuing Health Care budget expenditure, accounts for approximately £4m in the private sector for patients with Acquired Brain Injury. Other service costs are embedded in the Community service Block contract.

Strategic Objective

Our objective is to provide a local person-centred rehabilitation service, based on a clear strategy and implemented by multi-disciplinary and inter-agency teams who deliver the best possible outcome for patients and value for money.

Impact

- Increased productivity
- Improved access to services across the county
- Improved user experience.
- Better value for money by April 2010.

Initiatives

Initiative13: Care Pathway Redesign and Re-Commissioning Services

¹ United Health Health - Health Needs Assessment Report May 2009
We will develop a multi-agency community based care pathway to provide consistent high quality care across the county by April 2010.

**Rationale:** In order that patients are offered more choice and receive a service that is responsive to need, rehabilitation specialists working in multi disciplinary teams will provide an enhanced service across the county. Care will be provided 7 days a week. Partnerships between primary care, social services and community services will be developed to deliver services in a new way, offering opportunities for staff to learn new skills. This will be embodied in a new care pathway by April 2010.

**Impact:** Services will be transformed and patient experience will be significantly improved. Services currently provided in acute settings will be recommissioned and provided in community settings. Currency and prices will be determined so that effective and more productive services will be contracted in 2011. Costs will be reduced by 15%.

We will drive down length of stay in all inpatient facilities to achieve an average of 21 days so that patients may return home safely as soon as possible wherever that is possible.

**Initiative 14: Commissioning Acquired Brain Injury Service**

We will commission a new integrated service for patients with acquired brain injury which will make more effective use of resources.

**Rationale:** Acquired Brain Injury (ABI) services are currently accessed for patients on an individual basis, provided out of area or by the private sector in county. The intention is to commission a county-wide Integrated Brain Injury Neurobehavioral community service. We are currently piloting this approach for 18 months. Depending on the outcome we will offer this to all patients in 2011/12.

**Impact:** Patient choice will be greater, services more local and cost effective and will reduce the CHC budget by £800k.

**Initiative 15: Stroke Rehabilitation Pilot**

We will pilot an Early Supported Discharge Team within the county to facilitate the earliest possible discharge from an acute stroke unit to a specialist multi-disciplinary stroke team to be cared for in the most appropriate community setting.

**Rationale:** There is a recognised unmet need for stroke specific community rehabilitation in Northamptonshire. A comprehensive stroke specific service providing equity of access across the county is required to address this need. The NHS Stroke Improvement Programme (SIP) was established to provide national
support for local improvement of stroke and Transient Ischaemic Attack (TIA) services and the implementation of the National Stroke Strategy. Following a recently successful local bid, county commissioners and providers will develop a pilot for a high quality equitable community stroke specialist rehabilitation service to meet the needs of stroke survivors in the county.

We will receive support from the SIP National Team and East Midlands Cardiac and Stroke Network to assess current service, identify things that would benefit patients and staff, implement improvement changes and then monitor their effectiveness.

This will meet the National Stroke Strategy Quality Marker 10 – people who have had strokes access high-quality rehabilitation and, with their carer, receive support from stroke-skilled services as soon as possible after they have a stroke, available in hospital, immediately after transfer from hospital and for as long as they need it.

**Impact:**

- Reduced length of stay for eligible patients who can be discharged home supported by the multi-disciplinary team
- Reduced numbers of readmissions and re-referrals
- Integrated working across primary, secondary care and social care which is critical in delivering measurable and achievable health and service improvements
- Prioritisation of community resources
- Potential reduction in long-term mortality
- Reduction in cost of acute care

**Initiative 16: Awareness Campaign**

We will launch an Awareness Campaign which will achieve increased recognition and identification of the main symptoms of stroke and Transient Ischaemic Attack (TIA).

**Rationale:** To achieve National Stroke Strategy Quality Marker One - Members of the public and health and care staff are able to recognise and identify the main symptoms of stroke and know it needs to be treated as an emergency.

The campaign, successfully implemented, will increase the number of members of the public and health and social care staff who can recognise the main symptoms of stroke and know that it needs to be treated as a medical emergency. This will reduce the number of deaths and long-term disability from stroke.

This campaign will link with and support the East Midlands Cardiac and Stroke Network planned educational days for primary and community care staff.

**Impact:**

- Promote healthy living, and management of specific risk factors
• Responsive healthcare services appropriate to need
• Optimal use of healthcare services
• Improved emotional health and well being
• Promote equity
• Potential reduction in mortality and long-term dependence
• Increased referral activity for TIA
• Prompt recognition of stroke and TIA symptoms within primary and community services
• Reduced long-term dependence on health services through stroke support

4.3.5 Children and Young People

Rationale

Northamptonshire has a history of joint commissioning of children’s services and the Children’s Trust arrangements in the county are delivered through a Children and Young People’s Partnership Board (CYPPB) with an agreed Children’s Plan.

The transformation programme for children and families includes:

• The Healthy Child Programme (HCP) focuses on reducing inequalities and improving health outcomes for children. It is largely provided by the health visiting service and families can access through GP practice, any Children’s Centres (located within walking distance of home) and some Surestart Centres.

• Community services for children with complex health needs. While these children access universal services additional support is provided in specific child and family centre packages to promote resilience and build their own capabilities.

In partnership with the Local Authority we have produced a local Joint strategic Needs Assessment (JSNA) and Children’s Plan based on a detailed analysis of the needs of children and young people. We will together, develop integrated services that may include developing shared accommodation and joint management teams in order to address the key issues identified such as childhood obesity.

We will set out with the Local Authority a future investment for community services in line with Transforming Community Services; Ambition, Action, Achievement transforming Services for Children, Young People and their families (DH 2009).

Strategic Objectives

Our objectives are to work with our partners to develop integrated local services around the child and family. Children’s Centres currently have a commissioning role and we will explore opportunities to support them in this role to ensure more efficient use of resources and increased value for money.
Impact

By transforming services which are jointly commissioned we will achieve benefits in:

- Reduce expenditure on out-of-area and specialist services for children
- Improved safeguarding arrangements
- Reduce hospital admissions
- Reduce childhood obesity at reception age
- Increase breast feeding rates at 6-8 weeks
- Reduce inequalities in provision and access to services

Initiatives

Initiative 17: Developing Integrated Services

We will ensure that our community children’s services are fully integrated and resources are maximised.

Rationale: To maximise resources and to ensure fully integrated easily accessible services the Local Authority and NHSN will work together to review services and develop joint objectives, shared accommodation and joint management teams. We will enable shared workforce development opportunities and identify areas where there are opportunities for commissioning joint provision of services and future transfer of responsibility for delivering services through the section 75 agreement.

Health services will be provided in easily accessible local settings such as children’s centres and extended school settings rather than traditional health service settings.

Working with Northamptonshire County Council (NCC), we will undertake a joint review of family support services and agree a county wide model. Savings will be released for both organisations if opportunities for shared accommodation and management are realised. A joint review of estate is in progress to enable the integrated approach and identify cost efficiencies.

Impact: Integration of services for children will result in:

- Improved access for children
- Improved safeguarding arrangements
- A reduced need for high cost longer term interventions
- More efficient use of public funds
Initiative 18: Services for looked after children

**Working with the Local Authority we will review and re-commission services for looked after children.**

**Rationale:** Children who are looked after are recognised as being among the most vulnerable in society and often have increased health needs including, safeguarding, mental health problems and unplanned pregnancy.

A joint review of services for looked after children is in progress and a county wide model for health services will be developed and commissioned. This includes a review of the Designated Doctor and Nurse role for Looked After Children, medical assessments and access to universal services.

**Impact:** This initiative is unlikely to make short term cost savings, but will:

- Improve quality and safeguarding
- Realise longer term savings from a reduction in unplanned pregnancies
- Improve mental health in this group resulting from improved quality of service.

Initiative 19: Children and Young People’s Therapy Services

**We will review and recommission therapy services for children and young people.**

**Rationale:** The local development of our Aiming High Strategy has highlighted the need to improve therapy services for children with a disability, addressing inequalities in provision across the county, reducing waiting times and improving integration and local access. According to the schools census data for all Northamptonshire schools (2008) there are a total of 348 children and young people within Northamptonshire with a Statement of Special Educational Needs (SEN) primarily due to Physical Disability and 72 children with profound and multiple disabilities. These children will have a high level of physical needs requiring equipment and adaptations.

Children’s physiotherapy services are currently provided by two providers in the county – NHS Provider Services and NGH Children’s block. These 2 providers were in existence prior to the reconfiguration of the 3 PCTs in the county, in 2006. Occupational Therapy and Speech and Language Therapy are provided by the PCT Provider Arm.

We will review children’s therapy services, developing our detailed understanding of local need and develop a county-wide model and service specification.

Market analysis work recently undertaken highlights the need to address specific areas. Appendix 10 shows the market diagnostic charts of children’s therapy services. In summary, these charts show that having conducted an analysis of the Children’s Occupational Therapy, Children’s Physiotherapy and Children’s Speech
and Language markets a number of key drivers were identified. The quality of all 3 service areas has been viewed as relatively low, with patient choice practically non-existent. Manual data recording does not lend itself to evidencing quality. Accessibility issues are present in all three service areas, with waiting times presenting particular challenges for some users. The planned review will allow the range of service issues to be quantified, and, if necessary, contracts to be varied or services re-commissioned.

**Impact:**

- Improved quality through more efficient use of service
- Targeted services bringing savings in the long term by reducing the need for long term specialist support.

**Initiative 20: Community Paediatrics**

**We will develop an equitable model for Community Paediatric Services.**

**Rationale:** Community Paediatric Services are provided by the NGH acute consultant team (£930k), and the other managed as a part of the PCT Provider Services (£725k). Funding is embedded in block contracts, not through activity based tariff.

This service will be reviewed and a countywide model service specification developed by 2010. An analysis of this market has confirmed that, although quality is at a reasonable level, services could be improved through a smarter use of resource. Some specialisms are only available in either the north or south of the county, leading to potential inequality. We will put in place a robust service specification across the county, and may need to consider the benefits realisation that could be achieved by reconfiguring the two services – reducing duplication and enhancing specialism.

This specification will draw together key drivers from Safeguarding, and the requirements of inter related services within Disability, CAMHS, Ill Child, and Healthy Child CRG activities. See appendix 11 for market diagnostic chart.

**Impact:**

- Increased early intervention to improve outcomes
- Reduced long term health problems and the need for specialist support
- Delivery of the paediatric input to the Sexual Assault Referral Centre (SARC) from April 2010.
Initiative 21: Children’s Community Nursing Services

We will develop an equitable county wide model for community nursing services.

Rationale: There is no county-wide model of service provision. Therefore, the service will be reviewed and a fully costed county-wide model will be commissioned in 2010.

Impact:
- Address existing inequalities between north and south
- Reduce hospital admissions for children with complex needs.

Initiative 22: Child Health Records

We will develop a single child health record system across the county.

Rationale: The two existing child health record systems (north and south) carry significantly different costs. The child health record system will be reviewed and recommissioned in 2010. This will require unbundling of costs from one acute unit provider. It is likely that re-commissioning will produce significant savings although this is dependent on the roll out of System1.

Impact:
- Improved continuity of service.
- Improved information sharing.

Initiative 23: Healthy Child Programme

We will review and develop the universal Healthy Child Programme.

Rationale: The Healthy Child Programme includes services that are currently provided by the NHS and Local Authority. This includes breast feeding advice and support, stop smoking advice in pregnancy, family support and specific advice and support to teenage parents.

Analysis of this market has identified that service quality is not as good as it could be. Staffing levels within the service have historically been lower than recommended, and an inequitable service has developed as a result. Clarity of countywide specification has helped to improve the position, but there is still more to do. The service has started to embrace the integrated provider agenda with the
Local Authority. A focus on the nationally defined Healthy Child Programme will enable a range of local issues to be addressed, including a ‘duplicate payment’ for the delivery of childhood immunisations. (See appendix 12 for market diagnostic chart).

An approach based on the “team around the family” will identify financial savings from shared management, shared accommodation and reducing duplication. We will change the way in which immunisations and vaccinations for children are delivered in-conjunction with primary care commissioners.

GPs currently receive payment for childhood immunisation and vaccination; however it is delivered mainly by health visitors.

**Impact:**

- Savings of approximately £300k currently invested in health visiting if GP’s are required to deliver this service within their existing contracts.

**4.3.6 Repatriation of Continuing HealthCare (CHC) and Registered Nursing Care Contribution (RNCC) Team**

**Rationale**

The CHC/RNCC team within the Provider Arm assesses patient’s eligibility for Continuing HealthCare (CHC) or Registered Nursing Care Contribution (RNCC) funding, and for CHC arranges care and manages contractual relationships with service providers. The total budget for this service in 2009/10 is circa £21m.

The CHC functions of assessment, determination of eligibility, commissioning, case management and budget management are clearly functions of a commissioning organisation. In addition, market development and ensuring contestability within the CHC provider market cannot be undertaken by a single provider on behalf of the PCT.

Commissioning of CHC for children and for people with mental health needs or needs associated with learning disability is already undertaken by teams within NHSN.

Therefore the CHC/RNCC function for adults in the Provider Arm will be repatriated to NHSN as part of a major programme of re-design to improve CHC business processes and to reduce spend through the commissioning of alternative care pathways.

The table below (figure 18) shows PCT Provider Arm Continuing Healthcare and RNCC expenditure for the financial year 2008/09.
### Table: Client Category Total Cost FYr 2008/09 £'s

<table>
<thead>
<tr>
<th>Client Category</th>
<th>Total Cost FYr 2008/09 £'s</th>
<th>No. Patients on the CHC Books as at the end of March '09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Disability</td>
<td>£4,072,405</td>
<td>241</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>£2,316,296</td>
<td>100</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>£8,361,705</td>
<td>58</td>
</tr>
<tr>
<td>RNCC</td>
<td>£6,000,000</td>
<td></td>
</tr>
<tr>
<td><strong>PCT Provider sub-total</strong></td>
<td><strong>£20,750,406</strong></td>
<td></td>
</tr>
</tbody>
</table>

Figure 18 - Costs of Continuing Healthcare 2008/2009.
*Source: NHS Northamptonshire Continuing Healthcare/ Individual Package of Care Review – NHSN August 2009*

Analysis of expenditure trends between 2007/08 and 2008/09 reveals:

- Acquired brain injury costs have increased by 12%.
- Physical disability costs increased by 29%.
- Mental health/learning disability increased by 23%.

Similar upward pressure on CHC expenditure was seen in previous financial years and in PCTs regionally and nationally as a result of:

- Demographic pressures
- Increased awareness of general public and local authorities.
- Introduction of new national eligibility and decision making framework.

When CHC expenditure on mental health, learning disabilities and children is taken into account approximately £34m was spent in 2008/09 on CHC/RNCC in NHS Northamptonshire to the benefit of an estimated 1,556 patients.

The expenditure in question represents roughly 4.7% of the PCT’s total budget in 2009/10. CHC is therefore a major area of activity for the PCT and a high risk in terms of financial risk. Year on year increases like those seen in recent years will simply not be affordable in the future.

### Strategic objective

Our objective is to ensure that CHC is established as an integrated function within the commissioning PCT supported by robust business processes and effective commissioning arrangements in order to secure high quality care for eligible patients and most efficient use of resources for the PCT.

### Impact

The CHC function will be fully integrated within NHSN by April 2010 and will achieve savings through:

- Improved assessment and review of individual cases.
- Strengthened decision making panels to ensure rigorous and consistent application of eligibility criteria.
• Development of robust contract framework and pricing mechanism with service providers.
• Improved information and finance processes.

An internal review of Continuing Healthcare/ Individual Package of Care (IPC) arrangements was undertaken in August 2009 and concluded that there is an estimated £3.56m in savings to be realised as a consequence of concerted action across the CHC/IPC function. Such action requires effective strategic and operational management to be in place in order to lead and manage the CHC/IPC teams. A summary of potential savings identified in recent reviews of CHC/IPC and RNCC functions is included in the following table:

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Estimated Saving (£m's)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service re-modelling (2% of total CHC/IPC costs)</td>
<td>0.77</td>
</tr>
<tr>
<td>Application of fair pricing tool on retrospective cases</td>
<td>2.40</td>
</tr>
<tr>
<td>Abolition of PWP</td>
<td>0.04</td>
</tr>
<tr>
<td>Application of 'Primary Healthcare Need' test on retrospective cases</td>
<td>0.35</td>
</tr>
<tr>
<td>(assumes 25% of cases fail the test)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.56</td>
</tr>
</tbody>
</table>

Figure 19 – Estimated saving opportunities across CHC/IPC functions

4.3.7 Review of pathways and services

Rationale

We will commission more responsive community services, promoting greater choice, contestability and value for money. We will work to achieve these aims with our current providers, but will not hesitate to open up markets to new competition and bring in new providers where this is necessary to achieve our aims.

Providers will be strongly encouraged to work collaboratively on pathways of care to deliver evidence based model of care, which will improve productivity and cost.

We have already identified a range of services which will be market tested during the next 12 months, prioritised either because we believe quality can be improved or savings made.

By the end of 2013-14 all community services will have undergone a rigorous process of analysis to understand which market interventions will deliver required service outcomes. Figure 20 shows services currently provided by our community provider services and the value of the services as they are reviewed. It illustrates the intention to address priority areas early with a programme of change from 2009-2014.
Further work during 2010/11 will identify sub-acute services currently provided by other trusts in Northamptonshire. These services will be subject to the same rigorous process.

All market activity will be assessed to ensure compliance against the Principles and Rules for Co-operation and Competition (DH, 2007)

**Strategic objective**

We will ensure that all services commissioned by NHSN undergo a rigorous review process in order that the best outcomes in performance, quality and value for money terms will be achieved for the local population.

**Impact**

- Innovative services based on international and national best practice
- Productivity will be increased and 3% cash per annum will be saved over the next 5 years
- Increased quality through agreed metrics.

**Initiatives**

**Initiative 24: Market Testing Services**

We will begin the process of market testing some services in 2010.
Dental Access Services – These services are similar in scope to those that can be provided by providers in the General Dental Services (GDS) market. The current service is expensive without any apparent quality enhancement. We will therefore go to market for these services and re-commission by October 2010.

GP services – the PCT Provider Arm provides GP services from two surgeries in Northampton. These practices offer relatively poor value for money when compared to other practices and they do not perform as highly as many other practices as demonstrated on the balanced scorecard (our quality indicator set). We will therefore recommission these services by October 2010.

In addition, we have identified a number of service lines where further analysis is required to fully define our future approach. This will be completed by June 2010 so that market testing can be complete for 2011 contracts.

- Community Hospitals
- Long Term Conditions – specialist nursing
- Long Term Conditions – community nursing
- Short term care
- Community equipment (logistics).

Initiative 25: Improving Case Management

We will ensure that the most effective model of case management is in place by April 2010.

Rationale: We believe that effective case management is a critical part of our future plans to personalise care, with case managers orchestrating care via provider organisations. This is a commissioning function and should not be provided via the current provider, the PCT Provider Arm.

However, our Integrated Care Organisation (ICO) pilot provides us with an opportunity to test an integrated approach to care delivery.

Therefore, we will not transfer these staff at this time, but will instead review as part of our evaluation of the ICO/Pro-active care effectiveness taking a view in April 2010.

The Pro-active care model is active in 65 practices across Northamptonshire covering a population of 615,000. To date, emphasis has been focused on set up and delivering the roll-out. The shift in emphasis now has to be on delivery.

Impact: Pro-active care will:

- Integrate all elements of care across:
  - Social care
  - 3rd sector
  - Primary and community care
Secondary and emergency/urgent services

- Improve outcomes for patients
- Improve patients ability to function and their quality of life
- Enable patients to remain in their homes and communities, avoiding unnecessary admissions to hospital saving £1.6m per annum as a result
- Increase choice for patients and carers and help patients and their carers plan for the future
- Improve end of life care
- Reduce length of stay in hospitals and saving a further £250k per annum.

The Pro-active care model is anticipated to deliver savings through avoided admissions and reduced length of stay for a group of patients with a long term condition diagnosis or at the end of life stage of their disease. It will deliver quality outcomes for patients and carers.

We believe that Pro-active care has significant future potential, but only if the model adapts and can use information from primary as well as secondary care to improve case funding and the delivery of a personalised approach to care delivery.

### 4.3.8 Improving Contracting

**Rationale**

To cope with reduced future funding, NHSN needs to ensure that every pound spent delivers the best return possible for patients and taxpayers.

Our approach to contracting will reflect this requirement and will be underpinned by quality, innovation, productivity, prevention and savings (QIPPS), demonstrating clinical and cost-effectiveness.

The existing standard contract for community services will be reviewed and will be made much more explicit with regard to the quality standards required, the pathways to be followed and the price we expect to pay, moving away from block contracts towards more competitive contract pricing structures.

We will implement Transforming Community Services: *Currency and Pricing Options for Community Services* (DH, Nov 2008), with the guidelines on quality enabling our contracts to have more clarity in activity, costing and outcomes.

Year on year cash releasing efficiency requirements will be required of all providers.

**Strategic Objective**

Our objective is to underpin the transformational changes we plan for care services and pathways with a rigorous approach to contracting which ensures delivery and the payment of a fair price for delivery of a specified, high quality service.
Impact

- From 2010/11, 70% of our community services contracts will move from block to cost and volume. By 2012 we will be contracting on the basis of local tariffs and/or Payment by Results (PbR).

- Quality metrics will be in place and Commissioning for Quality and Innovation (CQUIN) (DH 2009) payments will reflect the transformation and personalisation of services needed to drive quality and gain in efficiency which is essential.

- We will drive up productivity in all services to release cash savings of at least 3% per annum.

Initiatives

Initiative 26: Information and Knowledge

We will build on pilot work to move towards productivity and evidence based contracts from 2010/11.

Rationale: Work is being undertaken in 2009/10 on 4 pathways of care (Healthy Child, Diabetes, End of life and Musculoskeletal (MSK)) to enable testing of future currency and pricing models for community services.

We will, as a minimum, expect providers to have delivered the high impact changes published in Ambition, Action, Achievement (DH 2009).

As the range of services in the community continues to expand, data definitions become increasingly important. Historic, implicit understandings are no longer sufficient and good quality data is crucial to deliver transformational change.

We need to derive better value from better information knowledge, and work with the rollout of System 1 which will reduce duplication of effort, produce individual risk scores, provide foundation for currency and pricing, and help to inform further market analysis.

With such accuracy we will show improved outcomes through increased choice, improved value for money and higher productivity.

Impact:

- Where possible 20% productivity savings from all services as they are contested.
- Services that are as good as the best.
- Monitor how, where and what we spend on community services enabling monitoring and evaluation to be more accurate.
Initiative 27: Incentives

We will develop incentives to achieve quality targets.

**Rationale:** Along with our CQUIN payments, we will use incentives which will help NHSN to achieve a reduction in admissions and provide care closer to home. Conversely, we will introduce penalties for those areas where missed targets affect the agreed quality outcomes. We will also work with GPs on opportunities they have identified in the *Primary Care Strategy* (NHSN 2009).

**Impact:** We will see an increase in quality outcomes as incentives drive transformation and personalisation.

Initiative 28: Improved Performance Management

We will specify activity and cost within the service contract for 2010/11 and will develop local currencies and prices for transformational services.

**Rationale:** As our understanding of care pathways, quality and cost improves we will be in a position to clarify patient activity and specify that in our contract for services 2010/11. From April 2010 we will not pay for services which have not been commissioned and specified in the contract for community services. There will be transparency around prices and activity.

**Impact:**

- The right services at the right price, volume, quantity and place for our population.

4.3.9 Organisational Form

**Rationale**

Originally the DH set out a timeline that required PCT boards to reach a decision on organisational form by October 2009. For a variety of reasons relating to policy, practicality and the current financial position the DH has acknowledged that the majority of health systems need more time to evaluate their options and choose an appropriate workable solution. This has now provided us with an opportunity to explore innovative and transformational options giving us the opportunity to make the right decision appropriate to our population need.

In the current economic climate there is no appetite to create another organisation with additional management costs. There are however a number of organisational and managerial options available to the PCT. When considering organisational form for community provider services a variety of options have been considered.
A set of criteria and/or desirable characteristics to evaluate the relative strength of each alternative form has been developed (see appendix 13). Early assessment, aligned with informal consultation, together with the view of key partners, favours an Integrated Care Organisation (ICO) model of provider delivery.

We have concluded that an ICO represents the most advantageous strategic and operational fit for community services. The main driver of that decision is that we commission services to deliver the vision outlined within this strategy. The core objective clearly outlines the future of such services. The secondary, and equally pressing driver, is the need to drive up value and productivity to create a more efficient provider environment.

Real transformation is urgently required for community services in Northamptonshire. We acknowledge that quality, service integration, value for money and seamless care are all directly correlated to the degree of collaboration and genuine partnership resulting in an ICO as the most logical model and the one most likely to deliver against the strategic vision held by the health economy across Northamptonshire. We will use the experience gained from the DH ICO pilot in Northamptonshire to build a future integrated care model.

**Strategic Objective**

Our ambition is to create a comprehensive integrated care model capable of delivery care closer to home. The most important characteristic of the model is that it is first and foremost a way of working rather than a pure organisational form. The organisational form will be the central co-ordinating body yet to be agreed. It is envisaged that the ICO will embrace community, primary, acute and social service providers. The more engaged partners are then the more effective the model, the greater the access to expertise, innovation, market and clinical leverage to extract value and manage change. In the context of the NHSN’s overall strategic approach the ICO will play a pivotal and revolutionary role in transforming care across Northamptonshire. It will accelerate work to redesign current pathways of care and methods of delivery and will pursue defined service improvement and savings targets.

**Shift to Non-Acute Care: - A Cycle of Improvement**

The ICO Strategic Partnership will lay significant responsibility for delivery and change on its constituent provider partners. It will provide an enormous opportunity to extract value, savings, access to new markets, procurement capacity and all the other benefits that should come with genuine, structured collaboration.

Benefits will be realised in redesigning community based care both at a service and organisational level. As commissioners we will lay significant responsibility for delivery and change on the constituent partners of the ICO.

Community focused providers and partners in health and social care have a number of clear objectives that mirror those of NHSN:

- Deliver on the vision outlined in TCS
• Redesign services fit for the task and meeting patients needs and expectations
• Generate savings and efficiency.

Ensure that service change and improvement has a direct impact on reducing acute expenditure releasing further resources for the non-acute or preventative, health promotion imperative.

NHSN believe that this model of delivery will be the vehicle for releasing and re-investing resources in non acute care. Figure 21 shows the drivers for redesigning community services in favour of integrated care.

![Diagram](image)

**Figure 21 – Drivers for Organisational Form**

**How powerful should the model be?**

The reality is that although the quality of community services is the central organising principle, it is the demonstrable shift of resources and care from acute to community settings enabling patients to be cared for at home through integrated services that will be:

- A critical and indeed essential objective in terms of releasing resources for reinvestment.
- A very clear, tangible indicator of the overall success of the strategy.

**Creating a sustainable non acute system**

Once the ICO is established it will work to specific goals. Given the significant current expenditure levels, the scenario below (figure 22) is not unrealistic.
### SCENARIO 2

<table>
<thead>
<tr>
<th></th>
<th>Current Community Spend (£ Millions)</th>
<th>Total Budget (£ Millions)</th>
<th>GROUP A SAVINGS 10%</th>
<th>GROUP B SAVINGS 5% Sector Saving (£ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>60</td>
<td>70</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Northants Social Services</td>
<td>100</td>
<td>150</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Acute Trust</td>
<td>10</td>
<td>270</td>
<td>1</td>
<td>13.5</td>
</tr>
<tr>
<td>Mental Health Trusts</td>
<td>20</td>
<td>100</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Out Of County Providers</td>
<td>30</td>
<td>50</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Estates Rationalisation *</td>
<td>300</td>
<td>0</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>520</strong></td>
<td><strong>640</strong></td>
<td><strong>52.1</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

NSS Savings accrue to that organisation

**Figure 22 – Organisational form scenarios**

**Group A Savings** = Savings the integration process will generate **WITHIN** Provider current budgets

**Group B Savings** = Savings the health system/Commissioner will make on reduced secondary care expenditure.

**Early Priorities: Redesigning Care**

The real strength of the partnership will be in examining the current models of care and investments. Early work would focus on Children’s Services, Intermediate Care, Proactive Care, End of Life, Long Term Conditions, rationalisation of capacity and capability, estates appraisal, repatriation of Out Of County Services and the potential to extending the partnership model to Milton Keynes.

**Other Organisational Options**

Other options (Community Foundation Trust (CFT)), mergers, social enterprise, hosting arrangements, dispersal of the current portfolio and the status quo) have been considered. It has been determined that these options are either less able or highly unlikely to deliver the broader strategic, transformational and quality agenda, compared to an integrated care model.

Broad options for organisational form are depicted as described below in figure 23 and expanded further in Appendix 14.
In assessing the options for the future we have concluded that a more urgent issue is the transformation of community services via an ICO strategic partnership and believe that will provide a more robust platform for the development and independence of the current APO.

**Strategic Initiatives**

- By January 2010 the integrated care provider will have been explored, strategic partnership agreement secured and an agreed implementation plan in place.
- In 2010-11 the implementation plan will be delivered with service and operational changes occurring in parallel with the establishment of the new managerial/organisational form.

**Impact**

- Coherent integrated non acute care across Northamptonshire
- Increased quality and continuity of care
- Improved system efficiency
- Appropriate combination of care at home/in the community that meets the needs of the patient and their carers.
Section 5 Estates

Introduction

The Department of Health have set out guidance through the *Art of the Possible* (2009) and *Commissioning investment asset management strategy CIAMS* (2009) to assist with this work. The developing Estate and Infrastructure strategy will:

- Ensure that clear priorities are set and aligned with this strategy, the Intermediate care and Primary care strategies. It will ensure a strategic fit with QIPPS and the innovation agenda. In addition, we will strive towards levels of understanding in all care pathways.
- Drive the WCC agenda ensuring all infrastructure/estates provision supports, where appropriate pathway and service review.
- Ensure that existing estate and infrastructure is reviewed against current and future healthcare needs.
- Ensure that clear priorities are set for future investment.
- In accordance with TCS guidance the acknowledgement that commissioners retail ownership and responsibility for the NHSN estate.

One key theme from ‘Facing the Future’ (2008) was to “localise where possible, concentrate where necessary” health care, this will underpin the Community Estate and Infrastructure Strategy to be completed by April 2010.

In commissioning the estates strategy NHSN will have:

- Aligned estates requirements with commissioning plans
- Improve commissioning ability to obtain desired outcomes from providers
- Created a level playing field for existing healthcare providers and potential new ones

Strategic Context

Northamptonshire is one of the fastest growing counties in England. Planned housing growth over the next two decades provides both challenges and opportunities for the future provision of health services.

Meeting the health and social challenges in Northamptonshire requires us to respond on several fronts:

- Promoting a robust prevention agenda as outlined in the Wanless Report (2007) is the best way to secure an affordable health and social care system. This will involve addressing the broader determinants of health such as poverty, educational attainment, employment, environment and the “lifestyle choices” that are often made as a result of a person’s wider social and economic environment.
Empowering patients and their carers to self-care improves satisfaction and outcomes for patients and reduces health care resource use.

Improving efficiency and cost effectiveness, working with partners to assist the delivery of care pathways to drive savings.

Proactive engagement with partners will ensure that new communities and growth extensions to existing communities can be positively planned, ensuring access to local services. In addition, new settlements take into consideration spatial planning with health and wellbeing at its core. The strategy will be underpinned by a joint public health approach with our Local Authorities.

**Service Developments**

Our Community Estate and Infrastructure strategy will seek to;

- Provide clarification on allocation of core estate critical to the delivery of key services
- Review short/medium term requirements for the estate. This will highlight potential surplus properties that are provided:
  - Not in the right place
  - No longer fit for purpose after pathway redesign
  - Which can be replaced with a suitable value for money alternative
  - To work in partnership with other stakeholders e.g. local authority, voluntary sector to review opportunities for co-location of services.
- Provide clarity of medium term support of the estate in line with DH guidance in the *Art of the Possible* (2009).
- Determine longer term provision of estates for NHSN services and discuss the use of Operating Companies (OPCO), Property Companies (PROPCO) or Strategic Enterprise Partnerships (SEP) *Art of the Possible* (2009).
- Discuss the medium to long term vision of procuring estate investment using Express Lift to support the vision for innovative, world class patient environments.

**Affordability**

The vision for NHSN is to provide care closer to home, increase productivity, ensuring efficient value for money patient services in Northamptonshire. The estates strategy will act as an enabler to ensure that NHSN achieve capital/revenue savings and efficiencies where possible. We will achieve this by:

- Short/medium disposal of assets
- Quality assurance/market contestability
- Work to achieve the targets set out in the Sustainable Development Unit national NHS ‘carbon reduction strategy’ (2008).

The strategy needs to demonstrate how we intend to work with our providers to make progress in meeting our priorities, set out in the Strategic Plan (2009 – 2014). This includes the PCT provided community services and our primary care contractors.
Through the initial working of our Estate and Infrastructure strategy some cross cutting themes have already appeared, these include:-

- Potential for maximising the use of major assets between organisations
- Opportunities created by facilities that are no longer fit for purpose
- Development of Local Community and Primary Care facilities
- Limited availability of capital
- The need to minimise our ‘carbon footprint’

As the estate review progresses, future pathway developments will impact on the estate and care environments, these include such issues as:

- Promotion of self care and self managements systems (e.g. social care)
- Wider range of disease prevention
- Substantial care pathway redesign in order to be able to deliver interventions earlier (care closer to home, outpatients in non-acute settings), in order to minimise costs
- Increase patient choice
- Integrate delivery models to a whole systems approach in line with the Next Stage Review, to ensure that care is responsive to the local population’s needs

This list is not exhaustive. The Community Estate and Infrastructure strategy will seek to outline specific schemes and a timescale for implementation of the priority schemes.
Appendices
Appendix 1: **Population demographics and socio-economics**

Northamptonshire has a population of 695,000 people, with over 85% living in towns and urban areas.

Minority ethnic groups constitute less than 5% of the population of Northamptonshire. Over the past five years there has been a significant increase of migrants from eastern European countries giving rise to a change in the demographic profile for specific areas of the county which impacts on health needs and service provision.

Northamptonshire is part of the Milton Keynes South Midlands development region, a designated government area for major housing expansion, which along with increasing life expectancy and birth rates, will be a significant driver of population growth. The population is forecast to increase by 23% over the next fifteen years, with 7.5% growth occurring over the next five years. The largest forecast growth will take place in urban areas whilst rural areas are forecast to have growth rates below 1%. In some parts of the county growth will be faster than in others, with Corby for example experiencing a 17% growth in population by 2014.

![Projected Population by Age Band 2009-2014](image)

**Figure 1 - Projected population by age band 2009-2014**

*Source: NHSN Public Health Dept*
Whilst the demographic change projections were accurate when produced in 2008 there are signs that there is a slowing down of the actual growth in population due to the impact of economic recession.

As a County, Northamptonshire has relatively low deprivation, rating 116th out of 152 PCTs in England. Some 97% of the rural population and 50% of urban dwellers belong to the least deprived or second least deprived quintiles in the country. Overall 12% of Northamptonshire’s population fall within the most deprived quintile nationally. These figures, however, hide pockets of high deprivation which tend to concentrate predominately in urban areas.

Research undertaken in highly deprived areas indicates health related information may not be available or appropriate resulting in poor access to health care and poorer health outcomes which is evident in mortality rates and high emergency admissions from deprived areas within Northamptonshire. As such, reducing health inequalities is still a priority for the PCT and within a County-focus close attention will be given to addressing locality needs.
Appendix 2: National Policy for Community Services

The Northamptonshire strategic plan was informed by the NHS Next Stage Review, *High Quality Care for All*, which set out the strategic direction for driving improvements in the quality of care across the health service. It envisions “an NHS that gives patients and the public more information and choice, works with accredited partners and has quality of care at its heart”. In delivering the vision the NHS must tackle variations in the quality of care head on, enabling patients to have more information and choice. The Department of Health publication *Our vision for primary and community care (DH July 2008)* drew together the main conclusions of the Next Stage Review for community-based NHS services and set out a strategy based around four areas:

- Shaping services around people’s needs and views.
- Promoting healthy lives and tackling health inequalities.
- Continuously improving quality.
- Ensuring that change is led locally.

Health improvement, and in particular reducing health inequalities, has always been a significant component of both NHS policy and our local strategy. Key principles include:

- Informed choice – supporting people to make informed decisions that impact on their health, by providing credible and trustworthy information.
- Personalisation – tailoring support to the needs of individuals, ensuring services are patient-centred.
- Working together – effective partnerships across communities, including local Government, the NHS, business, the voluntary sector, faith organisations and many others.

*The NHS Operating Framework 2008-09* reinforced the necessity for separation of the provider arm from PCTs. This separation enabled a focus on commissioning responsibility, and ensures adherence to World Class Commissioning and *Principles and Rules for Co-operation and Competition* (DH, 2007)

Supporting guidance issued by the DH sets out the framework within which community services will operate:

- *Enabling new patterns of provision* (2009) describes the range of organisational forms for PCT provider arms.
- *Currency and pricing options* outlines the process for moving away from block funding to contracts based on performance and quality.
- The *Resource Pack for Commissioners of Community Services* sets out basic principles for commissioning effective and responsive community services.
- The *Quality Framework* introduces outcome-based measures of performance.
- The 6 Transformational Guides share best practice through high impact changes

We will apply this framework in a way which is responsive to the needs of our population, as set out in this document.
Appendix 3: **Potential Shift of Care**

The tables below show the top ten emergency conditions and the top fifteen outpatient specialties identified by the NHSI Opportunity Locator.

### Emergency Admissions

<table>
<thead>
<tr>
<th>Condition</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes complications</td>
<td>866</td>
</tr>
<tr>
<td>Ear, nose and throat infections</td>
<td>541</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>422</td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
<td>416</td>
</tr>
<tr>
<td>Convulsions and epilepsy</td>
<td>291</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>264</td>
</tr>
<tr>
<td>P06 Minor Infections (including Immune Disorders)</td>
<td>234</td>
</tr>
<tr>
<td>P26 Infectious and Non-Infectious Gastroenteritis</td>
<td>231</td>
</tr>
<tr>
<td>F47 General Abdominal Disorders &lt;70 w/o cc</td>
<td>211</td>
</tr>
<tr>
<td>P15 Accidental Injury without Brain Injury</td>
<td>91</td>
</tr>
<tr>
<td>Others</td>
<td>397</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,964</strong></td>
</tr>
</tbody>
</table>

### New Outpatients

<table>
<thead>
<tr>
<th>Specialty</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>811</td>
</tr>
<tr>
<td>Cardiology</td>
<td>787</td>
</tr>
<tr>
<td>Neurology</td>
<td>565</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>462</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>442</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>431</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>429</td>
</tr>
<tr>
<td>Clinical Haematology</td>
<td>398</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>342</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>280</td>
</tr>
<tr>
<td>General Surgery</td>
<td>268</td>
</tr>
<tr>
<td>Pain Management</td>
<td>203</td>
</tr>
<tr>
<td>Midwife Episode</td>
<td>181</td>
</tr>
<tr>
<td>Diabetic Medicine</td>
<td>153</td>
</tr>
<tr>
<td>Dermatology</td>
<td>132</td>
</tr>
<tr>
<td>Others</td>
<td>1,277</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,161</strong></td>
</tr>
</tbody>
</table>
**Outpatient Follow-Up**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>836</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>785</td>
</tr>
<tr>
<td>Pain Management</td>
<td>784</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>613</td>
</tr>
<tr>
<td>General Surgery</td>
<td>586</td>
</tr>
<tr>
<td>Urology</td>
<td>502</td>
</tr>
<tr>
<td>Cardiology</td>
<td>399</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>393</td>
</tr>
<tr>
<td>ENT</td>
<td>284</td>
</tr>
<tr>
<td>Clinical Oncology (previously Radiotherapy)</td>
<td>242</td>
</tr>
<tr>
<td>Maxillo-Facial Surgery</td>
<td>219</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>211</td>
</tr>
<tr>
<td>Transplantation Surgery</td>
<td>161</td>
</tr>
<tr>
<td>Haemophilia</td>
<td>157</td>
</tr>
<tr>
<td>Clinical Haematology</td>
<td>145</td>
</tr>
<tr>
<td>Others</td>
<td>1,259</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>7,576</strong></td>
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</tbody>
</table>
Appendix 4: **Community Services Spend**

Figure 1 below shows indicates the breakdown of spend against community services commissioned in Northamptonshire.

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost £m’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Hospital</td>
<td>6.6</td>
</tr>
<tr>
<td>Long Term Conditions Specialist Nursing</td>
<td>2.4</td>
</tr>
<tr>
<td>Long Term Conditions Therapies</td>
<td>2.0</td>
</tr>
<tr>
<td>Long Term Conditions Community Nursing</td>
<td>10.6</td>
</tr>
<tr>
<td>Short Term care</td>
<td>4.8</td>
</tr>
<tr>
<td>Universal Children</td>
<td>8.6</td>
</tr>
<tr>
<td>Specialist Children</td>
<td>4.6</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>3.4</td>
</tr>
<tr>
<td>Community Dental</td>
<td>2.3</td>
</tr>
<tr>
<td>Palliative care</td>
<td>4.1</td>
</tr>
<tr>
<td>Health Improvement</td>
<td>3.5</td>
</tr>
<tr>
<td>Prison Services</td>
<td>1.0</td>
</tr>
<tr>
<td>Primary care</td>
<td>1.1</td>
</tr>
<tr>
<td>Community equipment</td>
<td>2.2</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>21.5</td>
</tr>
<tr>
<td>Podiatry</td>
<td>2.4</td>
</tr>
<tr>
<td>Support services</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Figure 1 – Northamptonshire Community Spend (2008)

Figure 2 below shows indicates the breakdown of spend against community services commissioned in Oxfordshire.

<table>
<thead>
<tr>
<th>Service</th>
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<td>Out of Hours / Urgent Primary Care</td>
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Table 1: Community Services Spend Commissioned in NHS Oxfordshire (2008)

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<th>Service</th>
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<td>Radiology Services</td>
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<td>Speech Therapy Services (Adults)</td>
<td>19,477</td>
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</table>

Figure 2 - Community Services spend commissioned in NHS Oxfordshire (2008)

Figure 3 below shows the breakdown of spend against community services commissioned in Peterborough.

Table 2: Community Services Spend Commissioned in NHS Peterborough (2008)

<table>
<thead>
<tr>
<th>Service</th>
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Figure 3 - Community Services spend commissioned in NHS Peterborough (2008)
### NHS Northamptonshire Community Services

#### Phase 1 Priorities for Contestability

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Appendix 6: Intermediate care Strategy Implementation Plan

Vision

Northamptonshire will provide integrated health and social care intermediate care services. With 24/7 access, delivery through co-located staff working on a locality basis in joint teams, care will be provided across the county through a 3 tier model – acute, step up/step down beds and home based support.

Introduction

The Intermediate Care - Integrated Commissioning Strategy has been produced collaboratively by NHS Northamptonshire, Northamptonshire County Council and Nene Commissioning Limited. The development of this strategy was informed by a wide ranging stakeholder2 consultation in 2007 and feedback from stakeholders between October and December 2008. With our stakeholders we have developed our vision for Intermediate Care.

This implementation plan seeks to turn our strategy into action, to start the delivery of our vision for really effective out of hospital care. It is our intention that in future patients will receive the right care, in the most appropriate place, provided by organisations working together in partnership.

Strategic Context

Our strategy and this implementation plan will help deliver the requirements of the 2006 White Paper ‘Our Health, Our Care, Our Say’ which set out a new direction for the health and social care system, and will support the delivery of the ‘Putting People First’ (Department Health, 2007) agenda. The health and social care initiatives within our strategy and plan are designed to enhance independence and reduce reliance on institutional care.

The Local Area Agreement (LAA 2008-11) process identified the need to increase and develop domiciliary care, community matrons; community based urgent care initiatives, further integration of Intermediate Care, equipment services and the development of assistive technology. It also highlighted the significant budget pressures which will be experienced as the population grows with no expectation of significant increases in health and social care budgets. The challenge given the expected pressures on public spending will be to deliver change through innovation and maximise the use of resources to realise the benefits for the population of Northamptonshire.

2 Including statutory and voluntary organisations and patient groups.
This Intermediate Care Strategy is integral to the development of services set out in the NHS Northamptonshire 5 year Strategic Plan. It also relates to and complements other developments including:

- The Transforming Community Services agenda and the developing Community Care Strategy. (due November 2009)
- Primary Care Strategy. (due November 2009)
- End of Life Care
- Long Term Conditions
- National Dementia Strategy

Delivering our vision in total will take several years; our priorities have been identified through and analysis of:

- Need
- Stakeholder consultation/feedback
- Review of current capacity and service provision
- Examination of local and national best practice
- Impact on performance

## Delivery

### Outcomes

Our strategy describes the direction for development and delivery of Intermediate Care in Northamptonshire. This plan seeks to deliver the following outcomes:

- Provide care closer to home, with an increase in localised and community based care
- Reduce the number of avoidable emergency admissions to acute hospitals.
- Reduce the delay in transfers of care from acute and community in patient facilities, to bring the county performance incrementally up from a lower quartile regional performance, (Dr.Foster 2008/9 data).
- Reduce duplication of patient assessments, shortening the current completion of assessment process time for non complex assessments to a maximum 3 days.
- Timely and clinically appropriate management of patient discharge from care provision, with an aim to reduce current excess bed days by around 8000 per annum.
- Maximise patient independence by demonstrating a reduced reliance on long term institutional care and avoidance of unnecessary hospital admission
- Reduce reliance upon long term institutional care by delivering a year on year 10% reduction in older people being admitted to residential and nursing homes.
This is a key driver for and will predominantly impact upon the social care provider NCC.

- Reduce admissions to acute hospitals from nursing homes to support End of Life care aims.

**Strategic Themes**

Five key strategic themes have been identified and are listed below:

1. Working in **partnership** to deliver seamless services, to use finite resources more efficiently and effectively and achieve better outcomes for our clients.

2. People with long term conditions are ‘known’ throughout the system and have their care actively managed to **avoid unnecessary admission** to hospital or institutional care.

3. Ensure people who are acutely unwell or are at the end of life can be treated in familiar surroundings where at all possible, **care closer to home**.

4. The **right beds in the right place at the right time** with clinical need being the determinant of admission to hospital and length of stay.

5. Equality of access and extended choice and control for individuals.

The relationship between our vision, strategic themes and priorities is shown in Fig 1 below.
Prioritisation of Initiatives

Each of the initiatives set out in the strategy\(^3\) has been tested against 2 criteria. Firstly the impact that the change would have of increasing quality, or improving efficiency. Secondly, the feasibility and ease of implementation for each proposed change. The results of the analysis are shown in fig 2:

---

**Figure 2 – Feasibility and Impact Assessment of Intermediate Care Initiatives**

**Intermediate Care Programme**

The immediate focus is to deliver the most important initiatives but to ensure future delivery through the establishment of an Intermediate Care Programme supported by NHSN and NCC.

Clear dependencies exist with other areas of work and hence close co-ordination will be required with the, the End of Life Care, Long Term Conditions and Urgent Care programmes and the implementation of the National Dementia, Primary Care and Community Services Strategies. Furthermore, it cannot be assumed that any additional resources will be made available to support change and therefore the delivery of our initiatives will have to be funded at best through invest to save

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schemes and from the decommissioning of services which are recognised by commissioners as no longer meeting current needs or offering best value.

Immediate Actions – by November 2009

There is an urgent need to consolidate and formally take forward a range of initiatives to improve patient flow that have improved the delivery of the 4 hour A&E transit time targets. The urgency for immediate action is heightened by the impending winter surge in activity compounded by a national additional intensity in demand anticipated due to pandemic flu.

Our intention is to move quickly to communicate our strategy and implementation plan and then deliver initiatives to improve patient management across the whole of the county. The following immediate actions are required:

1. **Evaluate effectiveness of Pilot work undertaken during Hazelwood ward closure and confirm models for re-opening and continuation** – September/October 2009. Identification of high impact changes to inform prioritisation and planning of initiatives and commissioning intentions for future contractual arrangements.

2. **Communication and adoption of the strategy** – October 2009. Direction of travel and implementation plan to be confirmed by all stakeholders.

3. **Establishment of integrated multi-agency assessment teams** - at acute hospitals with county wide model that is actively managed and co-ordinated by the end of November 2009. This will impact by reducing times for patient assessment completion at acute hospitals through a co-ordinated, multi-agency approach that reduces duplication. This will build on initial work that has commenced with multi agency stakeholders where commitment to this approach has been agreed. Co-ordinated management will enable the evidenced delivery of efficiency gains.

4. **Establish Rapid Response Team** - Commission to begin by early November 2009. Reduction in wait times for patients to access home support care at point of readiness for discharge from acute hospital. Reduce delayed discharges from acute and community inpatient care. Mitigate the risk that reduced assessment wait times could extend the wait times for home support services. More rapid patient flow will release acute hospital capacity to meet anticipated seasonal surge demand.

5. **Realign current Intermediate Care Teams** in north and south of county, to establish a single high skill level county model of provision, to be in place by the end of November 2009. Delivery of a seven day week service, flexible across the county. Supported by the rapid response team, a high skill Intermediate care team can work at an appropriate level of seniority supporting patients of a higher intensity to be discharged earlier from hospital and to remain in their own home avoiding need for unplanned emergency admission.

Next Steps

Following our immediate actions we will deliver the following initiatives in 3 tranches of activity within our proposed intermediate care programme.
Tranche 1

1. Define a pathway for the delivery of rehabilitation to identify generic elements that will also support disease specific specialist variant pathways.
2. Complete workforce analysis for community provision including medical input.
3. Agree model for implementation of step up provision at Community In-patient facilities. Implement pilot 72 hour step up facility.
4. Confirm solution for information sharing across organisations.
5. Gap analysis of community equipment and technology requirements.
6. Bid for Department of Health Pilot site for Individual Health Budgets.
7. Implement Specialist Pro-active Dementia Service.

Tranche 2

1. Extend Integrated Assessment & Rapid Response Team to provide 24 hour / 7 day a week provision county wide.
2. Expand use of community technology and equipment.
3. Extend Proactive Care provision
4. Commission evidence based county wide rehabilitation service
5. Extended specialist medical input and assessment into community
6. Develop Section 75 agreement where it will enhance partnership working
7. Identify further opportunities for integrated community health and social care teams
8. Evaluate impact of specialist support services into Nursing and Residential homes
9. Extend 72 hour community based step up facilities

Tranche 3

1. Establish Specialist in reach service to nursing and residential homes
2. Further extend specialist medical input and assessment into community
3. Impact assessment of equality of access across the county
4. Prioritised introduction of Individual Health Budgets.

Summary

The delivery of this strategy will improve outcomes for patients, provide more seamless pathways of care and deliver efficiencies particularly realised by current Acute Hospital Providers where the impact of increased demand is particularly apparent and affecting actions required.

To deliver the strategy there will be a requirement for realignment of current budgetary arrangements including decisions relating to a range of decommissioning and re-commissioning actions to enable the achievement of these efficiencies.
Appendix 7: Market Diagnostic Chart’s for End of Life Care

Market Diagnostic Summary – General End of Life Care

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<th>High (H)</th>
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</tr>
<tr>
<td>Choice</td>
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<tr>
<td>Rivalry</td>
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Conclusion: Based on market analysis, to deliver high quality care in a range of settings, supporting access and choice and increasing the number of deaths at home, the quality of general End of Life services need to be improved across six key areas.

Market Diagnostic Summary - Specialist Palliative Care

<table>
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<th>High (H)</th>
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<tr>
<td>Choice</td>
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<tr>
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Conclusion: To deliver high quality care in a range of settings the quality of specialist palliative care services needs to be improved across all of the six key areas.
Appendix 8: Market Diagnostic Chart for Diabetes

Market Diagnostic Summary - Diabetes

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<tr>
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Conclusion: The diagnostic summary indicates a need to improve quality, choice and rivalry. These will in turn affect concentration and switching.
## Appendix 9: Market Diagnostic Chart for COPD

### Market Diagnostic Summary - COPD

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<tr>
<th>Factor</th>
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<tbody>
<tr>
<td>Quality</td>
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<tr>
<td>Choice</td>
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<td>Concentration</td>
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<td>Switching</td>
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<tr>
<td>Rivalry</td>
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</tbody>
</table>

**Conclusion**: The diagnostic summary indicates a need to improve quality, choice and rivalry. These will in turn affect concentration and switching.
Appendix 10: Market Diagnostic Chart’s for Children’s Therapy Services

### Market Diagnostic Summary – Children’s Occupational Therapy

<table>
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<tbody>
<tr>
<td>Quality</td>
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<td>Choice</td>
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<td>Concentration</td>
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<td>Switching</td>
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<tr>
<td>Rivalry</td>
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</table>

**Conclusion:** There has been no change to services even though there are issues regarding quality in terms of accessibility. The accessibility issues may be due to the under resourcing of the service for a number of years or it may be due to the lack of rivalry or opportunity for switching within the market.

### Market Diagnostic Summary – Children’s Physiotherapy Services

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<tbody>
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<td>Quality</td>
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<td>Concentration</td>
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<td>Switching</td>
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<tr>
<td>Rivalry</td>
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</tbody>
</table>

**Conclusion:** There has been no change to services even though there are issues regarding quality in terms of responsiveness, equity and accessibility. This may be due to the lack of rivalry and switching within the market. This is a specialised area of activity and barriers to entry are high.
### Market Diagnostic Summary - Children's Speech and Language Therapy

<table>
<thead>
<tr>
<th>Quality</th>
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<tbody>
<tr>
<td>Choice</td>
<td>L</td>
<td>H</td>
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<td>Concentration</td>
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<tr>
<td>Switching</td>
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<tr>
<td>Rivalry</td>
<td>L</td>
<td>H</td>
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</tbody>
</table>

**Conclusion:** There has been no change to services even though there are issues regarding quality in terms of access to the service with waiting lists in all areas. This may be due to consistent under resourcing or the lack of opportunity for switching within the market.
Appendix 11: Market Diagnostic Chart’s for Children’s Community Paediatrics

Market Diagnostic Summary – Social Paediatrics

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<tbody>
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<td>Quality</td>
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<td>Choice</td>
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<td>Concentration</td>
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<td>Switching</td>
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<tr>
<td>Rivalry</td>
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</table>

**Conclusion**

- Overall quality of care within social paediatrics is good, but could be improved through a smarter use of scarce resource (Consultant time) and by developing specialism by provider.
- Few providers compete in this market with patients selecting local provision, real competition is limited. In fact where the pathway allows for competition, this can only be achieved through provider collaboration.
Appendix 12: Market Diagnostic Chart’s for Children’s Health Visiting Services

Market Diagnostic Summary – Health Visiting Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Low (L)</th>
<th>High (H)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td></td>
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<tr>
<td>Choice</td>
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<tr>
<td>Concentration</td>
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<tr>
<td>Switching</td>
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<tr>
<td>Rivalry</td>
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</table>

Conclusion: Extremely difficult to evidence quality as reporting systems are poor. There is only one current provider but the service is offered in a range of community settings. Choice could be further improved if the service operated from children’s centres. There is no evidence of switching other than that resulting from relocation. Health visitor case loads are generated by GP practice lists and switching would involve also changing GPS. Rivalry currently would only be via other health visiting services. GPs may wish to employ their own health visitors. Acute and Community Trusts could provide the service. Or Local Authorities could provide through Children Centres.
Objective Assessment

As the Provider Service Organisation in Northamptonshire considers future form we are developing a set of criteria or objectives to assess the benefits of various options. These may be viewed as characteristics or qualities we might desire in the potential new arrangements.

One difficulty is that any set of criteria or objectives are prone to subjective judgement. Some may be absolute measures (e.g. Is it a New Organisation or is it large enough?) Many however might require an assessment of “the degree to which the proposed arrangement will have a more positive impact on that goal “(e.g. Will Option A be “more likely” to deliver Integrated care or Maximise Choice than Option B? ) . We will of course seek to develop an approach to assessment that minimizes that subjectivity.

<table>
<thead>
<tr>
<th>National, SHA and PCT Policy Drivers:</th>
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<tbody>
<tr>
<td>1 Demonstrate appropriate degree of separation of the Commissioning Organisation(s) and its functions from those of Service Provision and Operational Management such that the Accountability, Responsibilities and Management arrangements are no different to those of other NHS Providers.</td>
<td>SEPARATE (From Commissioning )</td>
</tr>
<tr>
<td>2 Avoid where possible the creation of additional NHS organisations—specific context increase in Management Costs, politics of new organisations in times of financial difficulty. The goal is particularly no increase in net direct and indirect transactional or infrastructure costs. Public may also have a view of more new organisations.</td>
<td>NO NEW ORGANISATIONS CREATED</td>
</tr>
</tbody>
</table>
| 3 Wider NHS Policy Integration  
   • The Organisational Form and Service provision is consistent with National, SHA and Commissioning Strategy.  
   • It must specifically be consistent with the Commissioning PCT’s stated intentions in their Community Services, Primary Care, and Procurement Strategies  
   • It should not conflict materially from Commissioning Intentions emerging from the market Analysis.  
   • It secures the support of the critical stakeholders within the health system. | CONSISTENT WITH NATIONAL, PCT AND SHA INTENTIONS AND POLICY |
| 4 That the proposed organisation form will satisfy the PRCC and its Competition Panel . Specifically that it demonstrates it is in the patients and taxpayers best interest (Principle 9) | ACCEPTABLE TO THE MARKET IN BEST INTEREST OF PATIENT AND PUBLIC |
**Patient Centred**

Any new Organisational arrangement must demonstrate that it is better placed to advance the service objectives embodied in the TCS Policy and a service driven by Quality, with specific reference to:

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<tr>
<td><strong>5</strong></td>
<td>Delivering the highest degree of integration of care across all health and social care partners and secure and promote models of service delivery that are &quot;seamless&quot; to the patient and their carers. Assumption is that this is more efficient.</td>
</tr>
<tr>
<td><strong>6</strong></td>
<td>To be responsive to patient and community needs demonstrably by providing a greater range of Choice to patients in deciding how they want their services provided and the settings or context in which it is delivered. Assumes more providers but that may not necessarily be the case.</td>
</tr>
<tr>
<td><strong>7</strong></td>
<td>Enhancing the Quality of Care across all service areas such that it deliver direct and demonstrable additional benefits to patients and staff. Essentially that it is best placed to deliver and sustain modern, high quality community services.</td>
</tr>
<tr>
<td><strong>8</strong></td>
<td>An organisation that is best able to motivate, enable and empower frontline staff to innovate and free up time to care for patients and one that is structurally and culturally more likely to empower clinicians to shape the future of community services</td>
</tr>
<tr>
<td><strong>9</strong></td>
<td>An organisation that is best placed within the market to deliver greater Access to a greater Range of services.</td>
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**Business Preparedness, Sustainability and VFM**

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<td><strong>10</strong></td>
<td>The organisation must have the opportunity to develop a robust business Infrastructure, capable of contracting with commissioners and delivering effective business planning, performance management and governance. It must have the management and clinical capacity to meet those high standards. (TCSENPP)</td>
</tr>
<tr>
<td><strong>11</strong></td>
<td>To be sustainable and flexible, capable of evolving to meet increasing challenging environment of Patients and Carers expectations, Commissioners, Regulators, and Competitors (TCSENPP). It must be in a form less likely to be subject to short or medium term organisational uncertainty.</td>
</tr>
<tr>
<td><strong>12</strong></td>
<td>The new organisation must demonstrate represent a Value For Money and a Cost effective Option. (TCSENPP)</td>
</tr>
<tr>
<td><strong>13</strong></td>
<td>In pursuing any Option we must access the balance between Achievability and potential impact on Business Continuity in moving to a new form and the degree of disruption likely leading into and after the formal creation of the new entity. We should be concerned about the set-up costs and the risk of failing to achieve the desired form/outcome.</td>
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**Other Important Issues**

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<tr>
<td><strong>14</strong></td>
<td>The SIZE of the Organisation: is critical to many aspects of the criteria above. This has a huge impact upon: Ability to deliver TCS agenda, Market Strength, Operational and Managerial Capacity, Organisational Resilience, Genuine Autonomy and Freedom. What is that Critical Financial / Operational Mass &gt; £100 Million for a CFT for example?</td>
</tr>
<tr>
<td><strong>15</strong></td>
<td>Innovation, Leading Edge: The healthcare system needs transformational change. A form based on Partnership and Integration is deemed more likely to galvanise support for change. Is the organisational form more or less likely to bring that style to the health system?</td>
</tr>
</tbody>
</table>
### SIZE CRITICAL MASS

The **SIZE** of the Organisation is critical to many aspects of the criteria above. The organisation needs increasingly to have a service and managerial critical mass. This has a huge impact upon: Ability to deliver TCS agenda, Market Strength, Operational and Managerial Capacity, Organisational Resilience, Genuine Autonomy and Freedom.

**What is that Critical Financial/Operational Mass > £100 Million?**

#### Impact If Achieved

- a) The organisation will have the managerial capacity to respond to the market and operational issues.
- b) It will be able to sustain periodic adverse impacts on the volume range of services.
- c) It will have the financial leverage within the market.
- d) It will be politically stronger and more likely to maintain independence and determine its own future.
- e) Likely to attract better managerial and clinical talent if larger entity.
- f) A larger entity will be more attractive to partners and make the organisation more attractive to commissioners.

#### Impact If NOT Achieved

- a) The reverse of all the above.
- b) Specifically a marginally operational size may result in continued uncertainty and challenge from other providers.
- c) A relatively small organisation would not be able to sustain the position if it lost critical services through market mechanisms or important staff talent.
- d) A small organisation is less able to divert energy to innovation, policy response etc.

#### Qualifying Commentary Summary

This will undoubtedly be a critical factor in assessing the viability and sustainability of the organisation in an increasingly competitive environment. It is likely that as the financial environment of the NHS tightens ALL organisations will come under pressure in this context. The accepted benchmark for "viability" will rise and the number of organisations in existence may fall in response.

An organisation could be sustainable at a relatively small / medium scale if its model of delivery or partnership was deeply integrated into other provider partners.

#### Ranking

<table>
<thead>
<tr>
<th><strong>CRITICAL</strong></th>
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<tbody>
<tr>
<td><strong>This is a defining criteria.</strong></td>
</tr>
<tr>
<td>It is to be debated as to what income/turnover range represents a risk to viability and sustainability.</td>
</tr>
<tr>
<td>If a stronger national steer emerges this would directly impact on certain organisational options.</td>
</tr>
</tbody>
</table>

### SEPARATION of Provider APO from Commissioning Organisation(s)

**Demonstrate appropriate degree of separation of the Commissioning Organisation(s) and its functions from those of Service Provision and Operational Management such that the Accountability, Responsibilities and Management arrangements are no different to those of other NHS Providers.**

#### Impact If Achieved

- a) The Commissioning Organisation is able to focus upon Commissioning and the pursuit of World Class competence.
- b) There is no conflict of interest or challenge from the market re openness and fairness in procurement.
- c) The provider Organisation is more likely to develop and mature as an independent entity.
- d) The provider organisations will have a far more rigorous commercial relationship with commissioning.
- e) The provider organisation will have a far more robust business infrastructure.
- f) The provider organisation is more likely to be able to forge strong provider-based partnerships/alliances as an independent entity.

#### Impact If NOT Achieved

- a) The opposite of the majority of the positive benefits outlined above.
- b) The continued accountability relationship with the Commissioning entity and the control it exerts on decision making and development of the provider services is not conducive to the development of a sound strategic or operational base.
- c) That implies a direct impact on delivery of TCS goals and the development of an effective provider service.
- d) If not achieved the problem would not disappear. The level of uncertainty about the future would continue to undermine provider service development and it capability and capability to be an effective player in the healthcare system.

#### Qualifying Commentary Summary

Regardless of the agreed future organisational management form to support community services it is inevitable threat the provider Services in part or whole will continue in APO Status for some time.

#### Ranking Impact on Option Appraisal

<table>
<thead>
<tr>
<th><strong>CRITICAL</strong></th>
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<tbody>
<tr>
<td>Independence from Commissioning function and autonomous management capability is of enormous importance in the context of growth, innovation and strategic change.</td>
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</table>
### Appendix 14: Organisational Form summary of Challenges

<table>
<thead>
<tr>
<th>OPTION</th>
<th>Summary Challenges Of This Form</th>
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<tbody>
<tr>
<td>Status Quo</td>
<td>Would secure few of the objectives and reflect a limited number of the characteristics of a desirable form. Not commercially acceptable. Limited political support beyond the interim transition period, although transition may take several years. Could allow the provider arm to grow its business and reach greater critical mass.</td>
</tr>
<tr>
<td>CFT</td>
<td>It would be a new organisation, high profile with significant establishment costs. The application process is long 2-3 years, the outcome uncertain. It does not necessarily address the issue of critical mass or capability. The benchmark turnover is currently informally set at c£100 million. Current provider too small. Leaves the entity still open to competition. Is it long term viable? A formal institutional model would not be supported by the other providers, concern re costs at this time and management talent spread too thinly. Critically it seems less likely to be a vehicle for integration. Foundation Trusts so far have very individual, growth and income based strategies. If successful the organisation would have strong identity, staff motivated and by definition professional and robust business infrastructure.</td>
</tr>
<tr>
<td>Social Enterprise</td>
<td>In its basic form, related to Right of Expression, not a clear policy for broad-based solution. Not attractive to staff. One ICO solution is a version of SE.</td>
</tr>
<tr>
<td>Mergers or Take Over</td>
<td>No new organisation, tried and tested process, distracts management, no history of success, could promote vertical or horizontal integration, and might reduce overhead. Will it promote integration and partnership? Politically challenged at staff and other levels likely. If it is a merger over large geographic area again provides management challenges. Business continuity would be affected for 2-3 years. If merger/takeover by Acute/Mental health not widely supported but while producing some benefits not system-wide. Reduces competition. FT's not keen or indeed able to absorb organisations if the financial/service infrastructure future is not clear through due diligence process.</td>
</tr>
<tr>
<td>Hosting</td>
<td>Seen as an interim step and therefore potentially delay development and innovation. The next step would be one of the other models. HOWEVER: Hosting may be one of the devices to underpin the ICO management infrastructure and provide formal employment security.</td>
</tr>
<tr>
<td>Dissolution</td>
<td>This would be expedient but is it a strategically positive decision? How will that advance integration and partnership? Is it an opportunity lost?                                                                                                                                                                                                 oundary. Will it promote integration and partnership? Politically challenged at staff and other levels likely. If it is a merger over large geographic area again provides management challenges. Business continuity would be affected for 2-3 years. If merger/takeover by Acute/Mental health not widely supported but while producing some benefits not system-wide. Reduces competition. FT's not keen or indeed able to absorb organisations if the financial/service infrastructure future is not clear through due diligence process.</td>
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</table>
Abbreviations

CAMHS    Child and Adolescent mental Health Services
COPD    Chronic Obstructive Pulmonary Disease
DCSF    Department of Children, Schools and Families
DH    Department of Health
IPC    Individual packages of care
MSK    Musculoskeletal
NHSN    NHS Northamptonshire
NCC    Northamptonshire County Council
PCTs    Primary care Trusts
QOF    Quality Outcomes Framework
WCC    World Class Commissioning

References

*Art of the possible - Capital, Estates, and Infrastructure – Using a Commissioners’ Investment and Asset Management Strategy (CIAMS) to deliver a service-led environment  DH, 2009

*Every Child Matters   DCSF, 2003

*Gold Standard Framework (GSF) for palliative care   Dr Keri Thomas, 2005

* Healthy Lives, Brighter Futures – the strategy for children’s and young people’s health DCSF/DH , 2009

* Liverpool Care Pathway   Marie Curie Palliative Care Institute, 2007

*Next Stage Review (NSR)   High Quality care for all   DH, 2008

Our Vision for Primary and Community Care   DH, 2008

* The NHS Operating Framework 2008-09   DH, 2007

*Northamptonshire’s Facing the Future   NHSN, 2008

*Principles and Rules for Co-operation and Competition   (DH 2007)


*Transforming Community services (TCS): enabling New Patterns of Provision   DH, 2009

*Transforming Community Services Quality framework: Guidance for Community services   (DH 2009)
Glossary

<table>
<thead>
<tr>
<th>Commissioning for Quality and Innovation (CQUIN)</th>
<th>The key aim of the CQUIN framework is to support a shift towards the vision set out in High Quality Care for All of an NHS where quality is the organising principle. The framework helps to make quality part of the commissioner/provider discussion everywhere.</th>
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<tr>
<td>Contestability</td>
<td>Contestability theory was developed in the early 1980s by the American economist Will Baumol, who recognised that monopoly providers do not need to be exposed to actual competition in order act competitively, but only the threat of competition. Contestability is not a synonym for competition but rather refers to a situation where a provider faces a credible threat of competition. The concept is fundamentally different to 'market-testing', as it does not require every individual service to be completed.</td>
</tr>
<tr>
<td>Health Improvement Programmes</td>
<td>An action programme to improve health and healthcare locally and led by the PCT. It will involve NHS trusts and other primary care professionals, working in partnership with the local authority and engaging other local interests.</td>
</tr>
<tr>
<td>JSNA (Joint Strategic Needs Assessment)</td>
<td>Since April 2008, Local Authorities and PCTs have been under a statutory duty to produce a JSNA. JSNA will inform Local Area Agreements and the Sustainable Communities Strategy. The Operating Framework for the NHS in England 2008/2009 refers to the importance of JSNA in informing PCT Operational Plans. JSNA underpins a number of the World Class Commissioning competencies. The process of JSNA will establish the current and future health and wellbeing needs of a population, leading to improved outcomes and reductions in health inequalities. This is a partnership duty which involves a range of statutory and non-statutory partners, informing commissioning and the development of appropriate, sustainable and effective services</td>
</tr>
<tr>
<td>Payments by results</td>
<td>A transparent rules-based system that sets fixed prices (a tariff) for clinical procedures and activity in the NHS, enabling all trusts to be paid the same for equivalent work.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>The initial contact for many people when they develop a health problem is a member of the primary care team. The team covers family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners. NHS Direct and NHS walk-in centres are also primary care services.</td>
</tr>
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</table>
### QIPPS (Quality, Innovation, Productivity, Prevention, Savings)

In a letter to Chief Executives on 10 August 2009 David Nicholson set out how QIPP principles should be used to implement the next stage review with delivering quality as the organising principle in everything that we do. In October 2009 NHSN added an ‘S’ for savings to QIPP in response to the economic environment facing the NHS.

### Strategic Health Authority (SHA)

The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans, and that PCTs are performing well. There are ten SHAs in England, largely co-terminous with Government Offices.

### System 1

SystmOne provides robust clinical recording and data collection as required by the Commissioner. This system is a Connecting for Health (CfH) approved NPfIT solution, with tried and tested functionality, confidentiality, and interoperability, to assist the service to deliver a high quality response to the needs of clients, staff, and Commissioners.

### Telecare

The use of information and communications technology systems to provide diagnosis, advice, treatment and monitoring to patients remotely. It is being used in both primary and secondary care settings.

### World Class Commissioning

See competencies below

Commissioning competencies are described by a series of 11 headlines. These require that commissioners:

1. Are recognised as the local leader of the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the NHS
7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. Secure procurement skills that ensure robust and viable contracts
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11. Make sound financial investments to ensure sustainable development and value for money