Northamptonshire’s Sustainability and Transformation Plan
2016-2021
How We Will Support Local People To Flourish
Welcome

I am delighted to introduce Northamptonshire’s Sustainability and Transformation Plan (STP), setting out how health and social care locally will develop over the next five years.

This plan sits alongside the county’s Health & Wellbeing Strategy, Supporting Northamptonshire to Flourish, and builds upon previous work to shape services in a joined up way. It describes how health and social care can be improved to bring real benefits to individuals and communities.

We have developed our plan through an unprecedented level of commitment between local partners across health and social care and the voluntary sector. Members of the public have also been involved.

When we succeed in delivering our plan, we will see people staying in good health for longer, with better care and more of it provided closer to home. This is an exciting opportunity. We want the people of Northamptonshire to help us get it right.

John Wardell,
Senior Responsible Officer,
Northamptonshire STP Programme
1. What is this plan?

Every part of England is working on a local Sustainability and Transformation Plan (STP), setting out how health and social care will evolve over the next five years.

This is a summary of the STP for Northamptonshire. It is very much work in progress and a lot more detail will follow in the months and years to come. But it is being published now so that local people can know what is planned for our area.

The vision of our county’s Health and Wellbeing Strategy, Supporting Northamptonshire to Flourish, is to:

“Improve the health and wellbeing of all people in Northamptonshire and reduce health inequalities by enabling people to help themselves”

We also want to provide more choice for people by increasing their options in the community support they can get closer to home.

In doing these things, we will address at a local level the three top priorities facing the NHS across the country:

1. Health and wellbeing: By promoting healthier lifestyles, we can improve people’s quality of life and reduce the pressure on our health and social care services.

2. Care and quality: We want to ensure that needs are met by services of consistently high quality.

3. Funding and efficiency: Efficient use of our limited resources is essential if our services are to remain effective, affordable and able to provide up-to-date treatments.

This plan has been developed with a range of professionals from health and social care, including doctors, nurses and social care workers. Many frontline clinicians have been helping over a period of years to shape plans and get us to the point we’re at now. There will be more opportunities to contribute as proposals for specific areas of care take shape.
2. Why do we need this plan?

Every day, thousands of people across Northamptonshire receive high quality care from skilled and dedicated professionals. But we know we can do better.

This plan is about ensuring that services can meet the needs of local people in the future. To achieve this, there needs to be change.

**Without change, we will not be able to deal with the significant challenges we are now facing:**

- **Population change.** Northamptonshire’s population is growing and getting older. More people have complex needs and the demand for care services is increasing.

- **Health and wellbeing.** Many of our citizens could be healthier. There are also big inequalities in health within the county, including differences in cancer rates and how long people can expect to live. We need to support people to make positive lifestyle choices such as not smoking, having a good diet and exercising.

- **Access.** People can find it hard to see a GP when they want, and sometimes choose to be treated in our Accident and Emergency departments when local services could help them to manage their care differently.

- **Operational pressure.** It is difficult to deal with the sheer number of people requiring health and social care, which is putting a severe strain on services. Some people are in hospital longer than they need to be, which is not good for them or the service.

- **Mental health.** We want to help people to stay well emotionally, while ensuring that those who need support can access the right mental health services in the most appropriate way.

- **Standards.** There are important expectations on national standards, such as waiting time targets and service guidelines. Quality standards are getting more stringent and providers of care will need to work together to meet them adequately.

- **Staff shortages.** It is difficult to recruit enough health and social care professionals. Not having enough staff or the right skills increases cost, creates stress and hampers our ability to provide high quality care.

- **Integration.** Services could be more joined up to create a better experience for people.

- **Money.** Health and social care budgets are challenging to manage. We have to work differently, to be able to meet the future needs of Northamptonshire people within the resources available.

Increasingly, we have a system which relies heavily on people being cared for in a hospital setting, fails to provide the best type of care in some cases, is expensive and is becoming increasingly unsustainable.

By changing how services are delivered, we can improve care, help people live healthier lives AND make better use of our resources. That is what this plan aims to achieve.
Northamptonshire’s NHS is currently running a deficit of £41 million.

If nothing is done to address the challenges listed on the previous page, we estimate the local NHS gap could rise to somewhere in the region of £230 million by 2020/21.

The pressures by numbers

19% of Northamptonshire adults smoke – higher than the national average

2 in 3 people are overweight – higher than the national average

Demand for urgent care (Accident & Emergency) is rising by 4–5% a year

Health and social care in Northamptonshire costs more than £1 billion a year

The NHS funding gap will be £230m by 2021 if nothing is done

Without service change, by 2021 Northamptonshire will:

Need 150 extra GPs to deal with half a million more patient contacts

Need 283 extra hospital beds to take 22,000 more admissions

Get 2,500 more requests for social care
3. What will this plan achieve?

Addressing the challenges we face creates big opportunities to improve. The aim of this plan is to shape health and social care for Northamptonshire which is fit for the 21st century, supports a healthier population, meets all the needs of local people – and becomes affordable.

It will result in a very different way of providing care for our county:

- **A focus on prevention first** – supporting people to stay healthy and live independently.
- **A “whole person” approach** – taking into account all care needs, both physical and mental, where services are focused on the individual, not the organisation providing them.
- **The right care, in the right place and at the right time** – safe care in the most appropriate setting; fast access to services wherever people live.
- **Reduced reliance on hospitals** – high quality specialist services available when needed, supported by a system which enables people to move back home quickly.
- **Integration** – more joined-up services, delivered in the community by GPs and other professionals working in one system; stronger collaboration between specialists in our main hospitals in Northampton and Kettering.
- **Voluntary support** – greater involvement of voluntary and community groups in helping people to stay well.
- **Viable hospitals** – ensuring that our district hospitals can continue to provide high quality acute and specialist services.
- **Sustainability in general practice** – GP practices joining together to provide a wider range of services for their population.
- **Working differently** – staff will be supported to work in new ways and across mixed teams in one Northamptonshire system.

There will also need to be a focus on value for money, to ensure that services are financially sustainable:

- Significant investment will be needed in new technology to create a more streamlined system.
- Providers of services will be helped to work differently – with a major emphasis on operating across organisational boundaries county-wide, to provide consistently high quality care. New community-based organisations will also be created, capable of delivering the full range of out of hospital services.
- A major review will assess how all health and social care buildings are used.
- NHS organisations will be expected to make year-on-year savings and to streamline services. This may involve stopping some services where they don’t significantly improve outcomes for patients, and offering others in different ways.

All these issues will be considered as we develop our plans. We know that change is not easy and we are likely to face some difficult decisions along the way.
4. What will care look like?

We intend to transform four key strands of care:

- Urgent care (such as emergency services)
- Complex care (for people with multiple needs)
- Scheduled care (such as planned operations and outpatient clinics)
- The prevention of ill health

Our plans will improve Northamptonshire’s care system and make it more efficient.

This means providing the right care for people without going to hospital if that isn’t necessary – and also ensuring that our hospitals can provide consistently high-quality specialist services when they are needed.

There are wider groups of people and aspects of health, where we will meet national standards, prevent ill health and provide accessible personalised care:

- Respiratory
- Cardiovascular
- Cancer
- Maternity
- Children and young people
- Mental health
- Learning disabilities

Introducing Madeline

54-year-old Madeline has lung disease, is overweight and also drinks heavily to help her cope. She has been into hospital several times. Madeline recently lost her part-time job and has become withdrawn and socially isolated. We are using her story to illustrate how changes set out in this plan will improve things for patients.
Urgent Care

The aim is to ensure people get the right care, first time – based on services closer to home. This will help to reduce A&E attendance, emergency admissions and the length of time people have to stay in hospital. This should result in greater patient satisfaction and a better quality of life.

For urgent but non-life threatening care needs, highly responsive services will be provided outside hospital or as close to home as possible.

For more serious or life threatening emergency needs, people will be treated in centres with high expertise, delivering the best possible outcomes – enabling as many patients as possible to return safely to their own homes.

Through this plan, there will be:

- **Rapid access** to GPs and community services such as physiotherapy, working together around the clock to provide support on the day people need it, so avoiding hospital care. Care homes will get more support to meet the needs of those they look after.

- **More joined-up community care**, including more services which allow people to leave hospital quickly. This will involve greater use of technology to monitor people at home and access to community support groups (for example, for those with eating disorders or alcohol issues).

- **Co-ordinated urgent response when required**. The joint working of NHS 111, carers and social care will be key to arranging the most appropriate service for their needs – so avoiding unnecessary visits to A&E.

- **Efficient emergency care**, with people streamed in A&E to direct them to the right place. GPs and the ambulance service will have direct access to services to avoid A&E attendance. The flow in hospitals will be managed better, with consistent standards seven days a week. New models of care will be introduced, and some services may be changed so they work better for patients and are more efficient.

What it will be like for Madeline

Madeline has tried to manage her lung condition but it’s got worse and she’s having trouble breathing. The centre co-ordinating her care is automatically alerted and works with the ambulance crew to consider what to do. Options include additional intensive support at home or a short time in a local health bed. This time, Madeline is admitted to the local acute hospital so she can be assessed. When she arrives, hospital staff know all about her as they have access to the information on their computer networks. Just 24 hours later, they liaise with Madeline’s GP and care team to prepare for her discharge. The team have arranged for someone to look after her pet, and will provide a volunteer to take her home and check her house is warm enough, with food to eat. The volunteer will also work alongside the community care team for the first week Madeline is home, to ensure things run smoothly.
Complex Care

An increasing number of people have a range of long-term health conditions, such as a mental illness, diabetes, or heart failure. Their care is complex. Such people are often frail, vulnerable and potentially in need of a lot of support from both health and social care. Complex care can also be needed by some people who have been in an accident.

The aim is to ensure that the care system identifies those considered to be most at risk and has the right services in place to keep them well. This gives people a better quality of life by keeping them independent and avoiding deteriorations in health so they don’t have to be admitted to hospital.

For those identified as at risk, there will be:

- **Proactive care** targeted at those who most need it. Each of these individuals will have a personalised care plan in which they and their families have had a say, and support from integrated teams of health and social care professionals.

- **Intermediate care** for people recovering from an acute hospital stay – either at home or in a local bed. Different professionals working together will provide rehabilitation and other support for up to six weeks, to help patients return to their home (adapted if necessary) or to avoid unnecessary admission to hospital in the first place.

- **Specialist care**, re-designed to meet the needs of people with complex physical and mental health issues. Services will provide adequate access to specialist input with care that is safe, compassionate and person-centred.

What it will be like for Madeline

Madeline has been identified as at risk of becoming increasingly dependent on services. Her GP puts her in touch with her local care team who do a full assessment. She is allocated someone who will make regular visits and help her get the support she needs. Madeline is helped to join the local community clinic, which is run by people with respiratory conditions. It provides social engagement, education and access to professional advice in an informal setting. The group also has its own psychosocial therapist. As the group gives her greater confidence, Madeline also joins the Breathe Easy Choir to exercise her lungs and through it finds new friendship and support. She has monitoring equipment at home which alerts her care team, should any of her readings stray from the norm.
Scheduled Care

Not all care is given in response to an urgent need. While it may require input from a specialist, a lot of care is routine. The aim is to ensure that these services are consistently of high quality, operate efficiently and can be easily accessed by those who need them.

Through this plan, there will be:

■ **Re-designed care** in ten different specialties, to create single streamlined county-wide services operating across organisations, with less duplication.

■ **Closer collaboration** between medical teams at both our main hospitals and in other settings.

■ **More specialist clinics in community settings**, so people don’t always have to travel to hospital for outpatient appointments.

Work is already well advanced in orthopaedics, rheumatology and dermatology, and is also underway in cardiology and pathology. A similar approach is planned for ophthalmology, radiology, ENT (ear, nose and throat), gynaecology and urology.

What it will be like for Madeline

Madeline has had moderate eczema since she was young. She manages the condition with support from her GP, but occasionally it gets worse. When this happens there’s a risk of dehydration and infection, so Madeline is immediately referred by her GP to a dermatology clinic. Such clinics are delivered by a mixed team in a convenient location on a bus route only a few miles from Madeline’s home. This means she can go to appointments cheaply and with minimum disruption to her life. When she attends, Madeline is assessed and seen by a specialist nurse, a GP with a special interest in dermatology or her consultant, so that she gets the most appropriate and consistent care for her condition. If she was eligible, Madeline could be taken to clinic by the Non-Emergency Patient Transport Service. If not, she would be directed to her local Voluntary Car Scheme.
Prevention and Community Engagement

We already have some great working going on in the county to support people to manage their wellbeing. Through our plan, there will be a growing focus on staying well – helping people to make positive lifestyle choices, giving them the confidence to manage their health, and plugging them into the many local community and voluntary support networks which already exist.

The aim is to create a healthier Northamptonshire population, improve the quality of people’s lives and ease the demand for care services.

Through this plan, there will be:

- Prevention of ill health – both county-wide through information campaigns and at a personal level, through direct intervention by health and social care professionals.
- Effective prevention services, such as screening and immunisation programmes and support to make healthier lifestyle choices such as stopping smoking.
- Voluntary organisations with the right capacity to provide care services, building resilient and engaged communities.
- Social prescribing – people being directed to community support to improve population health and wellbeing.
- Individuals or their carers educated and empowered to be proactive in managing their own wellbeing.

What it will be like for Madeline

Through social prescribing Madeline can access six counselling sessions to help avoid depression or anxiety. She will also have three sessions with the local Citizens’ Advice Bureau to deal with debt which has grown since she lost her job. Addressing the debt worries will allow Madeline to attend a prescribed six-week support group with the local community drug and alcohol support centre, to deal with her increasing dependency on alcohol as a coping mechanism. Then she will have contact with a local volunteer centre to start some supported volunteering, to increase her skills and help her get back into work.
5. What happens next?

This is a long term plan for health and social care in Northamptonshire, alongside our Health and Wellbeing Strategy Supporting Northamptonshire to Flourish. It sets out key principles and the direction of travel, but much of the detail is still being finalised. The plan will evolve over time and there is a clear determination to deliver real change during the next five years – starting now.

Health and social care will continue to work with local people, doctors and other professionals to develop individual service changes in detail. You will see a different approach in how we:

- Engage with and support you to live well and stay healthy
- Use services differently so that you can manage your own health where you can, and access the right care when you need to
- Support you to remain at home for as long as possible when you are ill
- Use and share information better to support your care

This is truly a “one Northamptonshire plan”. As it moves forward, a wide range of partnerships will grow to make it a reality – with health and social care staff, local councils, communities and groups. There will be opportunities for people to contribute and comment as this work progresses. It is important to stress that any major changes to services will have to go through formal consultation before they could happen.

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