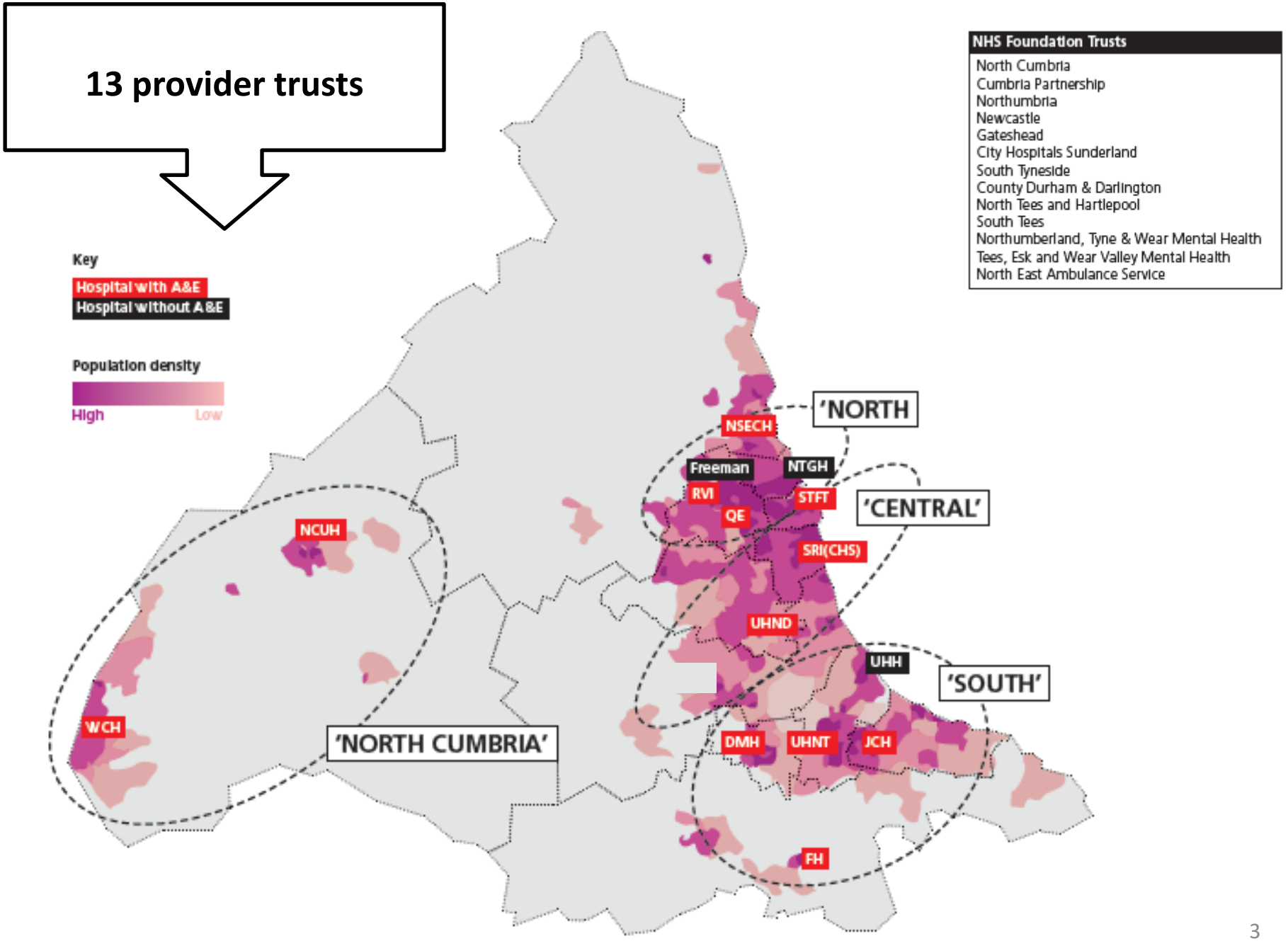
NHS Direction of Travel
An Integrated Care System for the North East and North Cumbria
Update & Next Steps
22 August 2018

Developing Integrated Health and Care Partnerships
North East and North Cumbria

12 Clinical Commissioning Groups

12 unitary local authorities and 2 county councils with districts

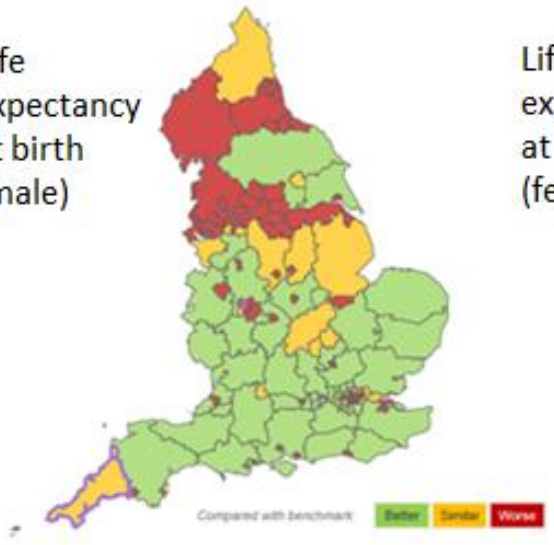
13 provider trusts



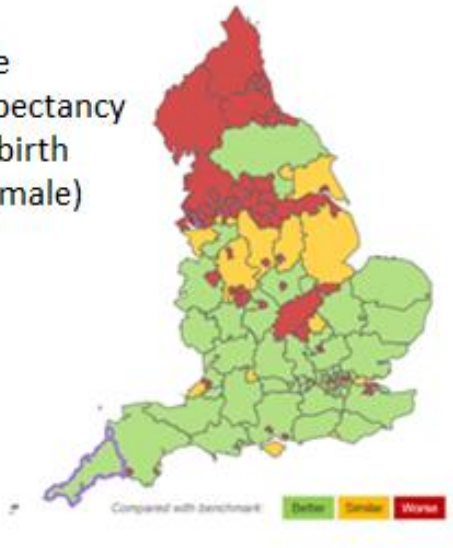
Why do we need to become an Integrated Care System?

The opportunity cost is poorer health outcomes

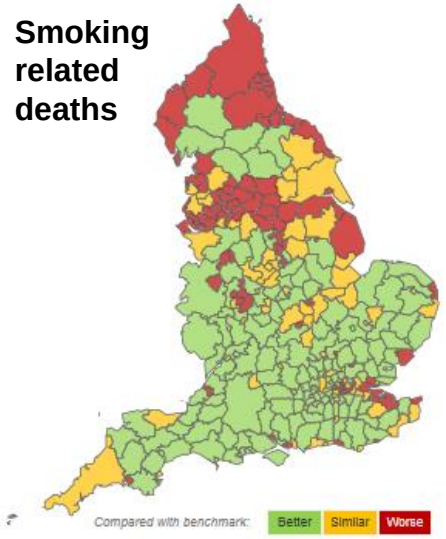
Life expectancy at birth (male)



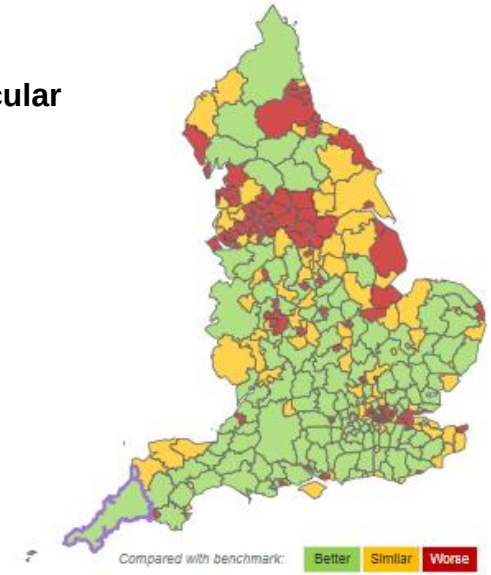
Life expectancy at birth (female)



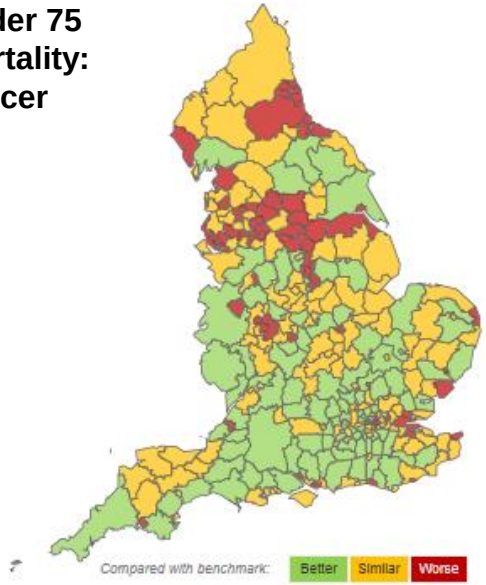
Smoking related deaths



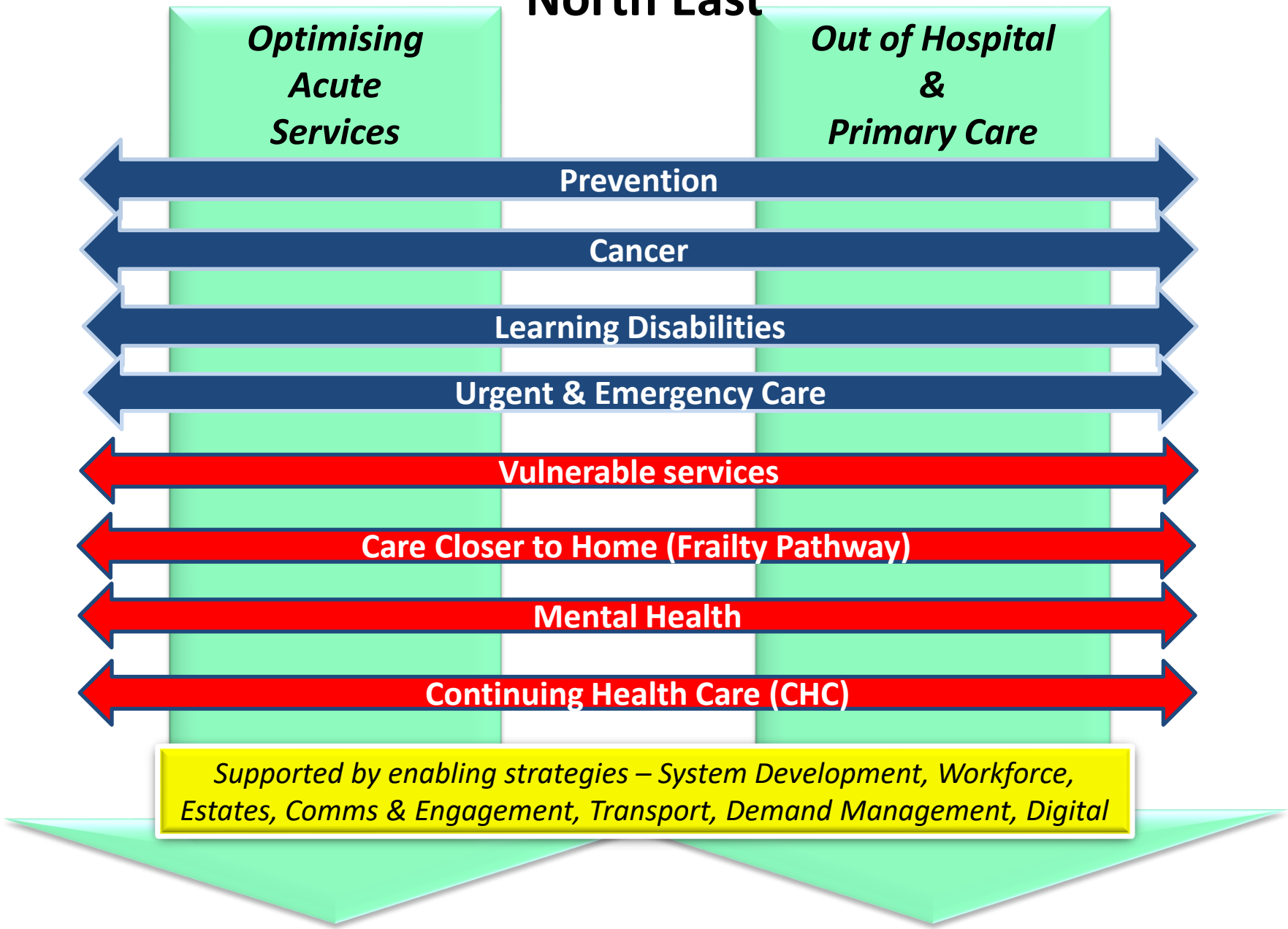
Under 75 mortality: cardiovascular disease



Under 75 mortality: cancer



Why we need an Integrated Care System in Cumbria and the North East



Why we need an Integrated Care System in Cumbria and the North East

Context

- A long-established geography, with highly interdependent clinical services
- Vast majority of patient flows stay within the patch.
- Strong history of joint working, with a unanimous commitment to go further as an ICS
- High performing patch, with a track record of delivery

Challenges

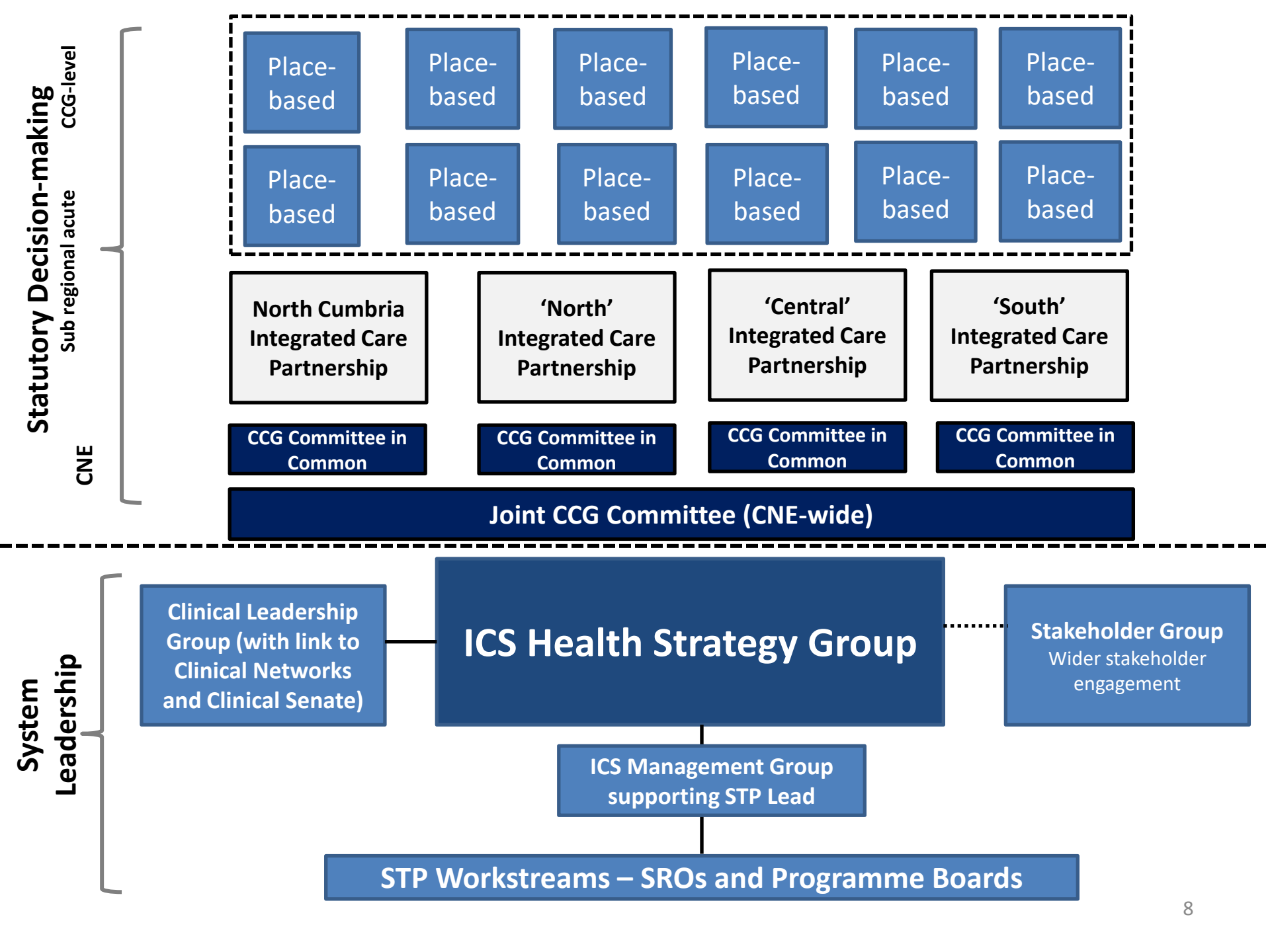
- Fragmentation following the 2012 Act has made system-wide decision-making difficult
- Significant financial gaps , service sustainability issues and poor health outcomes
- Maximising our collective impact to delivering best patient outcomes whilst reducing duplication and overheads.

Our ICS will:

- Create a single leadership, decision-making and self-governing assurance framework for CNE
- Coordinate the integration of 4 Integrated Care Partnerships – building on the learning from North Cumbria
- Establish joint financial management arrangements
- Aspire to devolved control of key financial and staffing resources
- Set the overall clinical strategy and enabling workstreams to reduce variation
- Coordinate 'at scale' shared improvement initiatives – including prevention and pathway standardisation
- Arbitrate where required and hold the ICPs to account for the delivery of FYFV outcomes

Our ICPs will be commissioned to

- Deliver integrated primary, community and acute care (aligned to the overall ICS strategy).
- Ensure critical mass to sustain vulnerable acute services within their geography


Statutory Decision-making
CCG-level
Sub regional acute
CNE
Place-based
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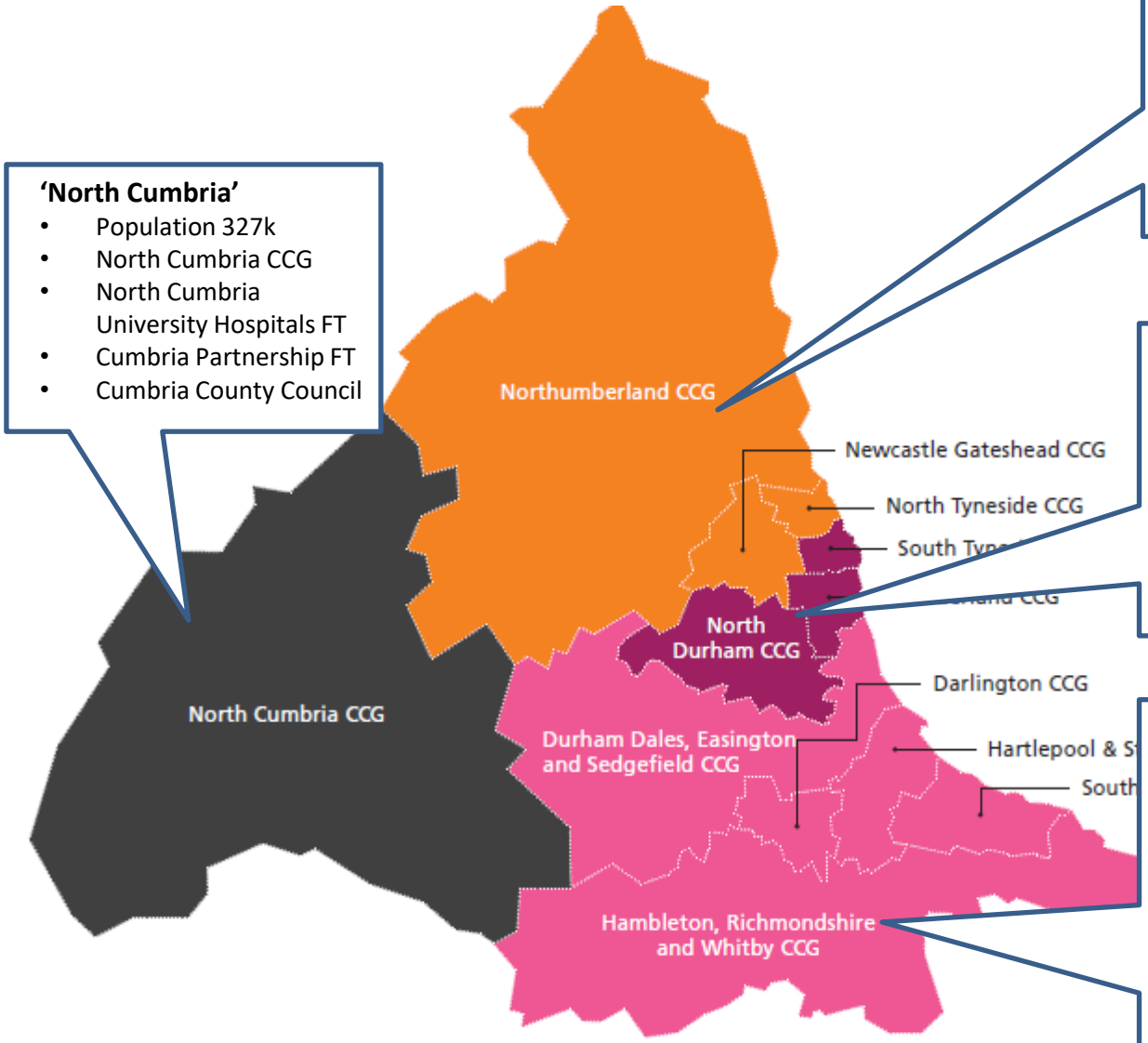
Place-based
North Cumbria Integrated Care Partnership
'North' Integrated Care Partnership
'Central' Integrated Care Partnership
'South' Integrated Care Partnership
CCG Committee in Common
CCG Committee in Common
CCG Committee in Common
CCG Committee in Common
Joint CCG Committee (CNE-wide)
System Leadership
Clinical Leadership Group (with link to Clinical Networks and Clinical Senate)
ICS Health Strategy Group
Stakeholder Group
Wider stakeholder engagement
ICS Management Group supporting STP Lead
STP Workstreams – SROs and Programme Boards

Four Integrated Care Partnerships

'North'
- Population 1.025M
- 3 CCGs: Northumberland, North Tyneside, Newcastle Gateshead
- 3 FTs: Northumbria, Newcastle, Gateshead
- 4 Councils: Northumberland, North Tyneside, Newcastle, Gateshead

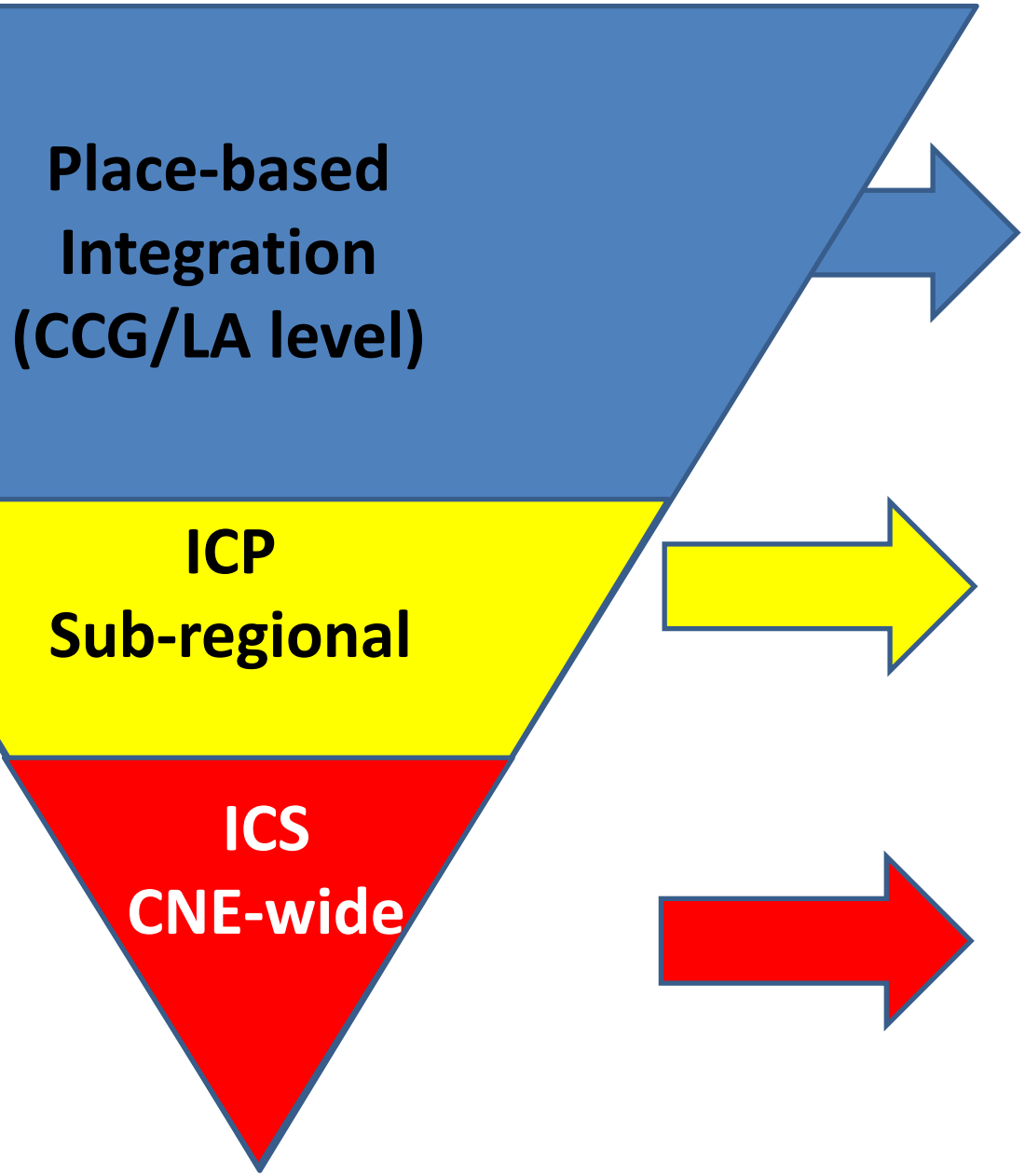
'North Cumbria'
- Population 327k
- North Cumbria CCG
- North Cumbria University Hospitals FT
- Cumbria Partnership FT
- Cumbria County Council



'Central'
- Population 675k
- 3 CCG areas: South Tyneside, Sunderland, Durham
- 3 FTs: Sunderland-South Tyneside, CDDFT
- 3 Councils: South Tyneside, Sunderland, County Durham

'South'
- Population 1.1M
- 5: CCG areas: Durham, HAST, Darlington, South Tees, HRW
- 3 FTs: CDDFT, North Tees, South Tees
- 7 Councils: County Durham, Darlington Hartlepool, Stockton, Middlesbrough, Redcar & Cleveland, North Yorkshire

What gets done at ICS, ICP, and place-based levels



- Public & political engagement and consultation
  - Health and Wellbeing Boards
  - Overview and Scrutiny committees
  - GP Councils of Practices
- Relationship with local public and third sector
- Commissioning of
  - GP services
  - Community Services
  - Health and Social Care integration
  - Local pharmacy services
- Local workforce development
- Safeguarding children and adults

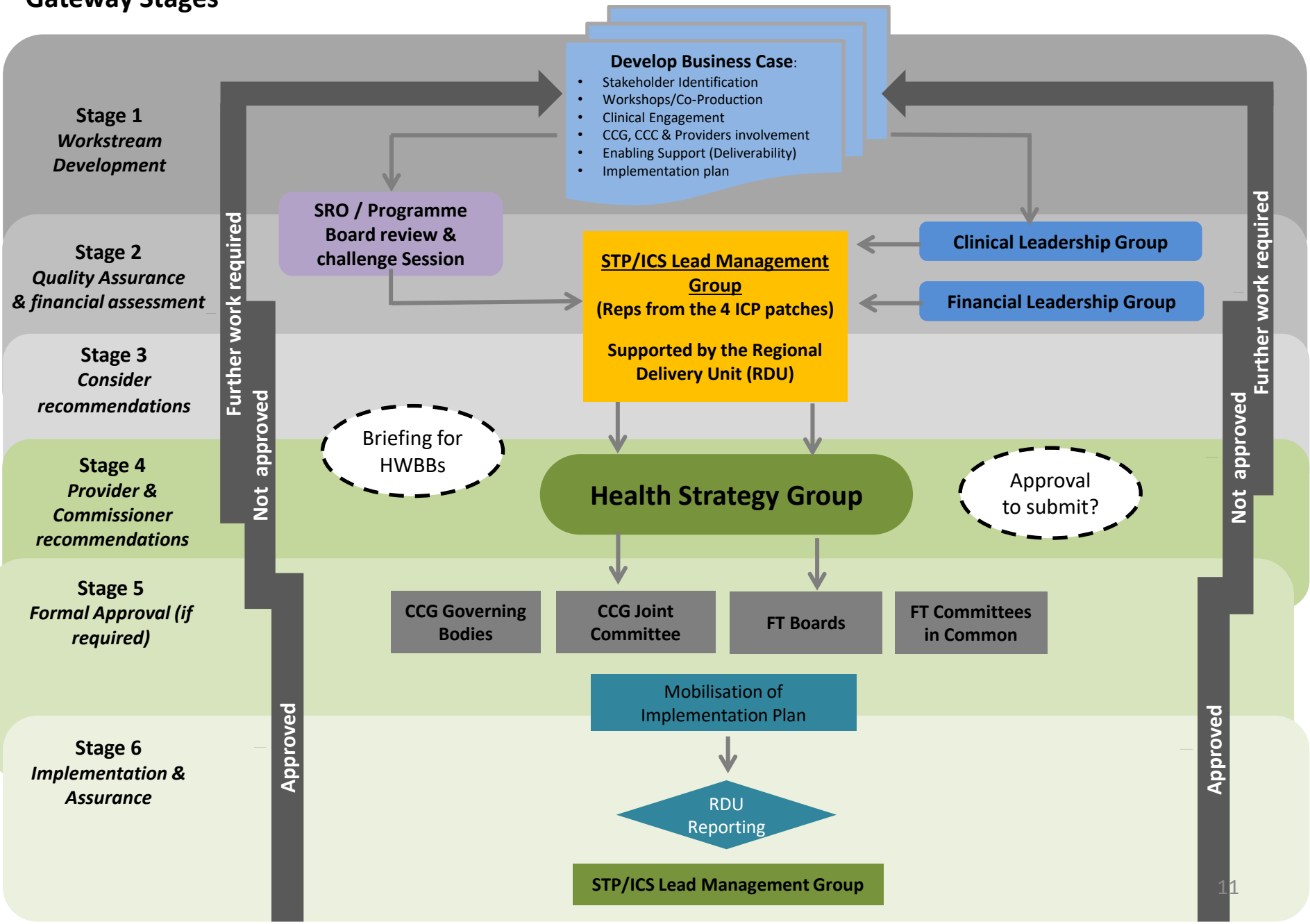
- Commissioning, contracting and performance management of acute hospital services
- Acute services reconfiguration and improvement (e.g. BHP, P2E, Success Regime)
- **Risk sharing …**

Strategic Commissioning
- Population Health Management
- Joint financial planning
- Commissioning of specialised acute services
- 111 and ambulance
- Shared policies and pathway redesign (VBC/IFRs) - TBC

System-wide coordination
- Transformation programmes
- Urgent & Emergency Care
- Primary prevention, Public Health and Comms
- ICT, data management and digital care
- Workforce planning, e.g. recruitment and harmonised training

Governance Process

Gateway Stages



Re-Prioritised Workstreams

- *Need to focus on key priorities – our "must do's"*
- *Utilise available, limited resources where most needed*
- *SIMPLIFY a complex system…*
- *Learn from best practice*
- *Respect local priorities/decisions but be aware of how these impact the region*
- *Be clear about approach, responsibilities and governance, e.g.*
  - *Work programmes, enabling work streams*, established programmes
  - *SROs, Programme leads/project support*
  - *STP lead, Portfolio Director, regional delivery unit*
  - *NHS England, CCGs, Trusts, Local Authorities, Health & Wellbeing Boards*
  - *Health Strategy Group, STP Oversight Board, Clinical Reference Group, Financial Leadership Group, CCG Joint Committee, Committees in Common, Trust Boards*
- *Need to work together for the benefit of all, not one alone - System Development sessions*

Update

- Reviewed all 14 work programmes current status to determine priority areas/distinguish between established programmes and gaps
- Established NCNE Acute Programme Board to oversee delivery
- People Framework opportunities – limited success
- Joint North OSC on ICS programmes, public narrative and public engagement working with Healthwatch and partners
- Process of developing critical pathway to become an aspirant / shadow ICS by October 2018

The NHS Funding Settlement

- £20.5bn in real terms by the end of 2024
- 3.4 per cent a year real-terms increase in funding over the next 5 years

NHS England Allocation						
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
New nominal budget (£bn)	114.6	120.55	126.91	133.15	139.83	147.76
Real growth (£bn)		4.1	4.2	3.8	4.0	4.4
Cumulative real growth (£bn)		4.1	8.3	12.1	16.1	20.5
Real growth (%)		3.60%	3.60%	3.10%	3.10%	3.40%

The NHS Funding Settlement (2)

Part of a developing 10-year plan in which priorities will include:

- getting back on the path to delivering agreed performance standards
- move towards the very best European outcomes in cancer care
- mental health services – achieving the government's commitment to parity of esteem
- better integration of health and social care, so that care does not suffer when patients are moved between systems

The NHS Funding Settlement (3)

The government will also……

- come forward with proposals to reform social care later this year
- ensure that adult social care doesn't impose additional pressure on the NHS
- consider any proposals from the NHS for legislative changes that will help it to improve patient care and productivity
- consider proposals from the NHS for a multi-year capital plan to support transformation and a multi-year funding plan for clinical training places
- ensure that public health helps people live longer, healthier lives

The NHS Funding Settlement (4)

5 key financial tests:

- improving productivity and efficiency
- eliminating provider deficits
- reducing unwarranted variation
- managing demand effectively
- better use of capital investments

Questions

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