Agenda item 10

Northumberland, Tyne and Wear NHS Foundation Trust
Council of Governors

Meeting Date: 6 March 2018

Title and Author of Paper: STP paper for NHS Boards

Key points to note: To update on

- STP leadership arrangements in CNE
- STP priority areas for joint working
- The expectation that the STP in Cumbria and the North East develops into an overarching integrated health partnership.

Outcome Required / Recommendations: Consider the proposed system leadership arrangements and direction of travel.

Joint STP Arrangements in Cumbria and the North East

Background

In 2014 NHS England published the Five Year Forward View (5YFV) – a national plan that set out a vision for a better NHS and the steps needed to deliver that vision by 2020-21

To accelerate delivery of the vision every health and social care system in the country has come together in geographic areas to create their own ambitious blueprint to rapidly implement the 5YFV.

These blueprints - Sustainability and Transformation Partnerships (STPs) - aim to set out a clear approach to how the challenges in the 5YFV will be delivered locally by 2020-21.

These challenges are grouped into the following categories:

- Improving the health and well-being of the population
- Improving the quality of care people receive
- Ensuring local services are efficient.

STPs will be delivered by local health and care organisations working together in a geographic footprint to ensure the transformation and sustainability of local services.

In recent months clinicians, from across our region, have come together to develop a mandate that supports organisations to work together, free from geographical constraints or organisational boundaries and focussed on the optimisation of acute hospital services. Governed by an Oversight Board, set up to develop and coordinate the region's Sustainable and Transformation Partnership, clinical staff have created a mandate which is detailed within this paper and are now seeking support and agreement from all NHS Boards, both NHS providers and commissioners, to allow this work move forward.

Report Outline

- Strategic context: national policy and the challenges faced in Cumbria and the North East (CNE)
- The progress made to date by NHS organisations in CNE working together through STPs (Sustainability and Transformation Partnerships) and current areas of shared focus
- How the governance of the STP has developed to date, and a proposed mandate for the recently appointed STP Lead
- The national expectation that the STP in CNE will become an 'Accountable Care System' by March 2019, what that means for us and the next steps in that process.

Strategic Context

1. Our health and care system in the North East is hugely interconnected, with effective healthcare at the local level dependent on strong relationships between GPs, community nurses and social care workers, and, at a regional level, patients flowing into our hospitals across CCG and local authority boundaries. Against this background, the demand for health and social care services is increasing, and can be difficult to manage within the traditional models of health and social care that we currently fund, coordinate and deliver. As the *NHS Five Year Forward View* describes:

"The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient."

2. One key challenge for us in the North East is how we manage the increasing number of frail elderly people in our population, often with multiple cognitive and medical issues, and complex social needs. This group present a challenge to both social care and health, which manifests as increased and often unmet need in the community with repeated and often prolonged episodes of hospitalisation that may not always be appropriate. We need to get much better at sustaining health and well-being among older people and if they do become unwell, ensuring that we can optimise their recovery and transfer their care to community services in a safe and timely way.

3. However, we still offer broadly the same reactive services, centred upon hospitals, as we have done since the NHS was founded in 1948. In order to further improve health and wellbeing and thereby reduce demand on our services, we need to scale up our offering in prevention, addressing those issues such as obesity and smoking that contribute to our poor health outcomes as a region. In addition, we need to develop strategies that support people in or close to their homes, providing care locally and in an environment that improves wellbeing.

4. We could make more rapid and effective progress in preventing both physical and mental ill health if all the parts of the 'health and care system' – GPs, hospitals, social care, and the voluntary sector – worked more closely together, better understood each other, and shared the same goals. There is also more we can do with other parts of the public sector – such as housing, education and leisure services – and with local private sector employers to promote good health.

5. The NHS and social care system also faces major challenges with shortages of key staff, which is exacerbated by the fragility of the independent social care market and the gaps in its workforce. This results in an increased dependency upon agency or temporary staff with the associated risks of escalating costs, variation and loss of continuity of care.

6. Recruitment and training of new staff takes time, and with national guidelines on safe-staffing levels, we will have to make some hard choices that balance the need to maintain certain clinical services (particularly those that are most reliant on scarce specialist clinicians), whilst maintaining accessibility for all our communities.

Sustainability and Transformation Plans - and Partnerships

7. Sustainability and transformation plans (STPs) were announced in NHS planning guidance published in December 2015. NHS organisations and local authorities across England were invited to come together to develop 'place-based plans' for the future of health and care services in their area.

8. STPs are five-year plans covering all aspects of NHS spending in England. Forty-four areas were identified as the 'footprints' on which the plans are based with an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million). Initial

guidance from NHS England and other national NHS bodies set out key issues for local leaders to address: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services to deliver financial balance for the NHS. The plans needed to cover all aspects of NHS spending, as well as focusing on better integration with social care and other local authority services; they also needed to be long term, covering October 2016 to March 2021.

9. A named individual has led the development of each STP, and most STP leaders come from clinical commissioning groups (CCGs) or NHS foundation trusts. There were initially three STPs in CNE: Northumberland, Tyne and Wear and North Durham (NTWD) led by Mark Adams (Chief Officer of NHS Newcastle Gateshead and NHS North Tyneside CCGs); Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby (DDTHRW), led by Alan Foster (Chief Executive of North Tees and Hartlepool NHS Foundation Trust); and West, North and East Cumbria (WNEC) led by Stephen Eames (Chief Executive of North Cumbria University Hospitals NHS Foundation Trust).

10. Draft plans were produced by June 2016 and 'final' plans were submitted in October for assessment. Since that time national guidance has changed and the ‘P’ in STP came to stand for partnership, rather than plan, as the focus shifted from planning to implementation across local health systems. Early in this process, system leaders and STP leads in CNE recognised the important interdependencies across the health system in our region, and identified the following fourteen workstreams common to our three STP plans.

    - Increasing the impact of public health interventions and preventative services
    - Strengthening health and social care services in communities and neighbourhoods
    - Managing demand for high cost treatments
    - How we will deliver acute hospital services in the future
    - Improving the diagnosis and treatment of cancer
    - Coordinating urgent and emergency care
    - Sustaining good mental health
    - Better outcomes for patients with learning disabilities

11. These workstreams will be enabled through more streamlined and effective:
    - Workforce development and transformation
    - Digital care
    - Pathology services and diagnostics
    - Estates management
    - Communications
    - System development

12. This joint working strengthened the case for a combined STP approach across the whole of CNE (which has a population of 3.2 million), and this led to a proposal to NHS England that our three existing footprints unite into a single STP.

A stable, cohesive and strongly performing health system

13. The physical boundaries that define the geography of the North East and North Cumbria, and the population flows and service links within it, have helped create a self-contained healthcare system, with a stable staff-base and consistent leadership across our NHS organisations.

14. The vast majority (over 95%) of primary, community, secondary and tertiary care for the local population is delivered by providers based in the patch with generally only patients requiring very specialised services seeking treatment out-of-area (e.g. Great Ormond Street); we also have providers in CNE whose clinical specialisms attract patients from the rest of the country, and overseas, and this brings wider benefit to the whole system. This geographical area is also coterminous with the North England Clinical Networks, Cancer Alliance, Clinical Senate, Academic Health Science Network, Specialised Commissioning Hub, Local Workforce Action Board, Social Partnership Forum and the local offices of the NHS Improvement and NHS England.

15. Working as individual organisations, and as a system, we have already made tangible progress towards delivering Next Steps on the Five Year Forward View, and, by working together through our Urgent & Emergency Care Network Vanguard, the Cancer Alliance, and the STP Mental Health workstream CCGs and providers within our patch have a strong history of delivering constitutional standards in A&E, Cancer 62 Days, and access to Mental Health services. This has continued in 2017/18 comparing favourably to North of England and national levels, and against the other sub-regional NHS England patches in the North. This strong performance led to the three original STPs within our patch to be identified as either "Outstanding" (DDTHRW STP) or "Advanced" (NTW STP and WNE Cumbria STP) when the first national STP Dashboard was published by NHS England.

16. The integration of primary care, social care and hospital care will be vital to the delivery of effective and high quality services. Within our patch health and social care partners are developing a range of new models to do this, including the Primary and Acute System vanguard (and planned ACS) in Northumberland, the Care Homes vanguard in Gateshead, a Multi-Speciality Community Provider vanguard in Sunderland, and South Tyneside's 'Health Pathways' partnership with Canterbury Health Board (New Zealand) connecting primary, community and acute care. We also host one of the national Building Health Partnerships Programmes funded jointly by NHSE and the Big Lottery fund, developing Asset Based Commissioning/Social Prescribing and one of the national Primary Care Home Rapid Test Sites (in North Tyneside).

17. Nevertheless, all of these models still require overarching system-level coordination to be successful, especially in terms of digital, workforce, and urgent care coordination. Alongside service reform, we need to do more to leverage the potential of technology and innovation. As a patch we have worked hard to develop a single Great North Care Record, and CNE is home to the highest concentration of digital exemplar organisations in the country, supporting patient-centred, digitally enabled health and care services.

18. It is clear that CNE needs to build on this joined-up IT infrastructure, through population health management analytics, to better understand health needs and where we should target our resources. This will require a step change in how we apply actuarial analysis, predictive modelling, and cost accounting to the patient data we hold to achieve the triple aims of improving the health and wellbeing of local communities, providing a better experience of care for patients, and delivering lower per capita cost for the taxpayer.

Sustaining care through networked services

19. Health care systems and their commissioners, in partnership with providers and the public, have to consider the most appropriate future configuration of hospital services to ensure that their clinical functions are adequately supported by other specialties and that they remain sustainable, accessible and deliver the highest possible quality of care.

20. The historic focus on hospitals as autonomous entities, largely independent of the health systems in which they operate, has led to some challenges in coordinating workforce resources. For example, the sustainability of on-call rotas in many specialities is increasingly dependent upon non training-grade doctors, short term appointments and locum staff. This has led to uncertainty and clinical variations (in practice and quality) which in turn results in significant pressures on staff in substantive posts, and the increased frequency of on-call duties, reducing the capacity for clinical staff to engage in leadership, governance and wider professional responsibilities (as well as issues of stress and staff turnover). This is further compounded by the increasing specialisation of medicine making it is now unrealistic to expect substantive doctors to work across multiple specialties. A focus on acute care has also meant we have been unable to make as much progress as we need to on investing in those preventative services that help to keep our population healthier and independent for longer, or to shift the focus of our workforce away from reacting to the consequences of ill health, to pro-actively working with our communities to build up their health and independence.

21. As Cumbria and the North East works through the aspirations of our combined STP (building on the previous Better Health Programme in the southern part of CNE) it is important that early consideration is given to how vulnerable services should be configured to maximise quality and safety, whilst supporting the clinical workforce. In particular, there needs to be plans in place for those services that are known to be vulnerable and for which there are unlikely to be any immediate or short-term resolution to their workforce pressures. Therefore an acute services workstream is being developed to identify such services at risk of collapse, safely manage down excessive running costs and ensure performance issues do not adversely affect quality, safety, and patient experience.

Jointly managing our resources

22. Historically, CNE has been one of the most financially stable health economies in England. However, a growing number of our organisations face significant financial pressures, and, with minimal growth levels, growing demand and rising costs, our estimates are that the financial gap is set to widen considerably to £1.2bn over the five years to 20/21.

23. Local leaders are committed to ensuring that both the system and its constituent organisations remain financially sustainable, and that we maintain high clinical standards and equitable access to services. We also know that transactional relationships and payment systems are no longer supporting system financial stability, but where local patches are forging new ways of working between commissioners and providers to find joint solutions to our financial challenges, we can evidence real progress.

24. A clear ambition of our STP partners is for this genuine partnership approach to become the norm, and for local patches within our health system to deliver our shared objectives within the resources available. Difficult decisions will need to be made and the STP will provide a mechanism for managing financial risk and a forum to help us deliver a shared control total. The table below sets out CCG and provider performance against control totals for 2016/17, the final actual surplus/deficit including system risk reserve (CCGs) - excluding STF core and incentive funding (providers). In the short term, our focus will be on stabilising these positions in 2018/19 and developing credible plans to deliver financial balance across the whole system.

Organisation	Performance against Control Total			Actual surplus/(deficit)	System risk reserve /STF	Final Surplus/(Deficit) net of SRR/STF
	Plan £m	Actual £m	Variance £m	£m	£m	£m
CCG sector	**20.0**	**-23.2**	**-43.2**	**-23.2**	**38.30**	**15.1**
Acute	-0.2	18.8	19.0	18.8	-95.7	-76.9
MH/LD, Ambulance	10.6	31.8	21.2	31.8	-20.7	11.1
Provider Total	**10.4**	**50.6**	**40.2**	**50.6**	**-116.4**	**-65.8**
System performance	**30.4**	**27.4**	**-3.0**	**27.4**	**-78.1**	**-50.7**

Strengthening system leadership

25. Our STP arrangements do not supersede the local clinical leadership and statutory responsibility of CCGs to plan and commission services for their local population, or the independence of NHS Foundation Trusts and their accountability for the quality and efficiency of the services they provide. STPs can, however, provide a vehicle for collective working, and through empowering an STP Lead, will ensure that the STP has a clear focus on transformation and innovation and acts as a forum for the effective exchange of ideas and good practice. Following soundings from system leaders across CNE and after discussion with NHS England and NHS Improvement, Alan Foster took up this position in autumn 2017.

26. Attached as an appendix is the mandate approved by NHS England and NHS Improvement for our STP Lead. This mandate includes the following specific objectives for delivery in the forthcoming year:

- Oversee the development and successful delivery of a shared STP plan, focused on those issues that cut across geographical and organisational boundaries, removing obstacles to effective collaboration and taking a lead in gaining chief officers and chief executives sign up to working together as system leaders.

- Develop a transparent system of collective governance, supported by all stakeholders, that respects organisational autonomy and statutory responsibilities whilst ensuring that the health system in CNE can make the shared decisions needed to make rapid progress on delivering the STP.
- Facilitate financial sustainability and enable organisations to achieve greater efficiencies by working together, ensuring that the North East and North Cumbria manages within the funding available for our populations as defined by shared system control totals across commissioners and NHS providers (although this will not supplant the financial accountabilities of constituent organisations).

- Support CCGs to strengthen and streamline strategic commissioning (at both CNE and sub-regional level) whilst preserving CCGs' local health leadership and their key relationships with primary care, local authorities and the voluntary sector.

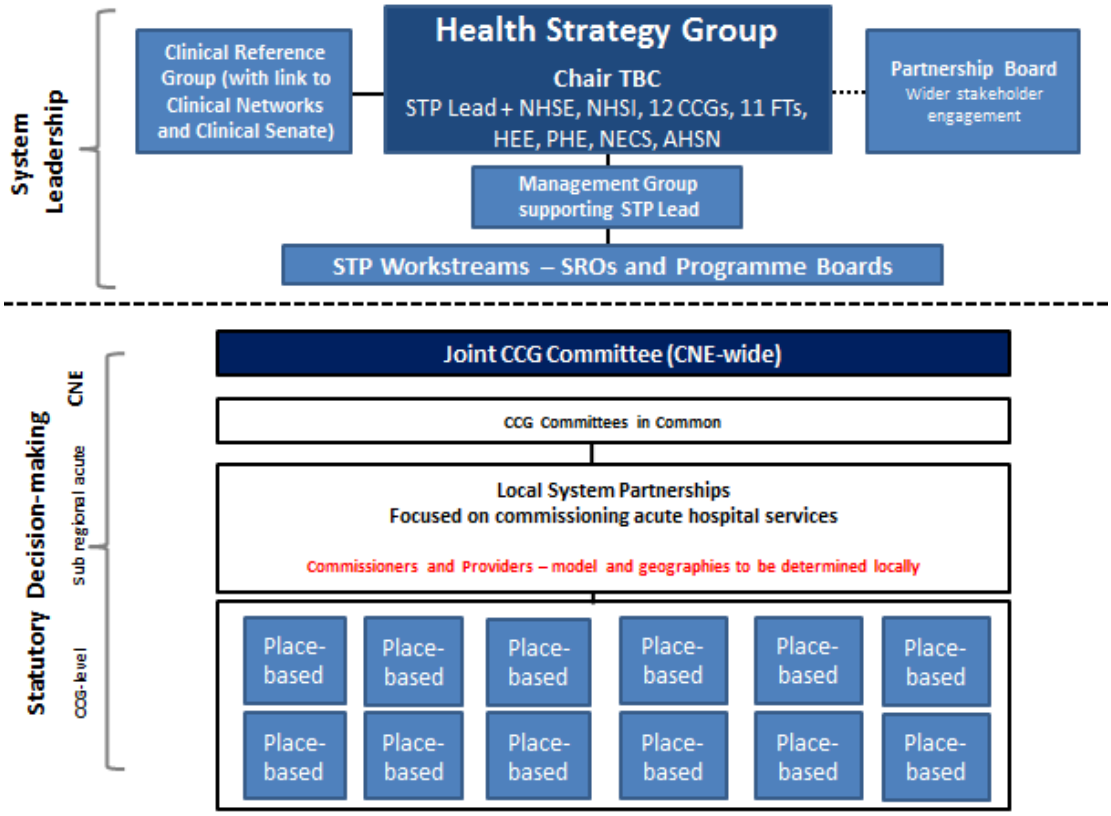
- Support Trusts and clinicians to work together to manage service change as they implement the recommendations emerging from the STP workstreams, especially the review of vulnerable acute services (including Pathology), the Cancer Alliance, and the Urgent and Emergency Care Network.

- Ensure the STP has the necessary programme management and implementation capacity and capability, drawing resources from constituent organisations and from NHS England and NHS Improvement where appropriate.

- Lead the Lead the development of an ACS model for Cumbria and North East supported by an Expression of Interest by Spring 2018 in order that NHS organisations (commissioners and providers), in partnership with local authorities, can take on collective responsibility for population health and devolved NHS resources. Given satisfactory progress, the leadership of the ACS would then be subject to open competition in order to prepare for shadow status from April 2019.

- Establish positive and supportive working relationships with the two emerging ACS in CNE (North Cumbria and Northumberland) in order to ensure clear accountabilities within the context of the CNE STP. Support the sharing of learning from both systems in order to inform the development of both additional local ACSs and the CNE wide ACS model including the effective dovetailing of governance and decision making between the constituent bodies.

27. These current system leadership arrangements, are linked to but separate from statutory decision-making, as shown in the following chart.



28. Alan Foster now chairs a single Health Strategy Group, comprising Chief Officers from all twelve CCGs in Cumbria and the North East, Chief Executives from all eleven Foundation Trusts, and representatives from NHS England, NHS Improvement, Health Education England, Public Health England, North East Commissioning Support and the Academic Health Sciences Network.

29. The Strategy Group is focused on the delivery of the STP workstreams, and overcoming any barriers to progress at a whole systems-level. Each of these workstreams is led by a Senior Responsible Officer (SRO) and programme board, developing detailed recommendations and delivery plans for approval by statutory decision-makers and trust boards.

30. The Strategy Group is supported by a Clinical Reference Group consisting of the Medical Directors and Directors of Nursing from all local providers, and the clinical leads from CCGs and the Northern England Clinical Networks, who will review any clinical models before change proposals are initiated.

31. Alongside this we are now commencing a recruitment process for a system-level chair (distinct from the STP lead). Both Alan and the chair will be supported by a Regional Delivery Unit, which will be resourced via secondments from NHS organisations across CNE.

32. NHS 'healthy board' principles highlight the value of bringing independent external perspectives, skills, and challenge to NHS decision-making, holding the executive to account through purposeful, constructive scrutiny and challenge. This will be vital in our STP governance arrangements, and will help to bring assurance to the governing bodies or boards of their institution. Although the Joint CCG Committee for CNE already now includes lay three lay members (including a lay-chair), the STP Lead will work with NHS stakeholders to strengthen the engagement of CCG lay members more widely and foundation trust non-executive directors to influence, shape and assure the development of our shared plan. This will include the potential to establish

    - A Chairs Group comprising the chairs of CCGs and Trust Boards
    - Networking opportunities with lay members and non-executives at STP area level.
    - Relationships with a wider group of stakeholders, including local HealthWatch, Foundation Trust Governors, the voluntary, community and social enterprise sector (VCSE) and local authority scrutiny representatives to ensure that the voice of service-users and the local population is heard

33. The STP Lead welcomes the ongoing engagement and support of governing bodies and trust boards in developing the most appropriate arrangements.

Statutory Decision-making

34. Whilst CCGs have a statutory duty to make impartial decisions on funding local services, as well as holding providers to account for their performance on behalf of local people, commissioners in CNE believe that some commissioning processes can be streamlined, so that we can redirect our efforts onto improving services.

35. Therefore the twelve CCGs in the region have established a statutory Joint CCG Committee to enable streamlined collective decision-making on key strategic issues emerging from these STP workstreams – whilst at the same time preserving the local autonomy and accountability of CCGs and their vital relationships with local partners, including local authorities, and the wider public and voluntary sectors, and with their local communities themselves.

36. We have mature relationships with our local government partners, and we recognise that much of what needs to be delivered will rely on strong local relationships, as shown through how we have delivered the Better Care Fund, and managed sensitive service change proposals. Therefore after extensive consultation with local government colleagues, it has been concluded that, at

this stage, local authorities prefer to engage with the STP at locality level, through existing Health and Wellbeing Board arrangements, with CCGs being responsible for representing local priorities and concerns into the overarching NHS governance of our STP.

Next steps for CNE

37. NHS England are supporting and encouraging interested STP areas to become more self-governing, with NHS commissioners and providers, often in partnership with local authorities, taking on clear collective accountability for the health and well-being of their population – as well as their own organisational performance – in return for greater local control and freedom over the total resources and operations of the health and care system in their area, with the aim to keep people healthier for longer, out of hospital and with improved health outcomes. Until recently these arrangements were being described as 'Accountable Care Systems' (ACS), but nationally the terminology is shifting to 'integrated care partnerships'.

38. A recent NHS England Board paper[1] described how those parts of the country covered by 'vanguards' and new care models – joining up GP, community and hospital care – are seeing much slower per capita emergency hospitalisation growth, of between one third and two thirds less than the rest of the country, as well as a reduction in the number of elective GP referrals to hospital. Building on this progress, the paper describes how

    > 'eight new accountable care systems have been identified, who are leading the transition to population health funding and integrated care delivery … So in deciding on a fund allocation mechanism for the additional Budget cash in 2018/19 we will seek to ensure that we support and accelerate this care redesign, through ACS and STPs, rather than reverting to traditional organisational silos and funding pipelines.'

39. These integrated health partnerships can vary but they are typically based upon STP areas, and involve a radical reduction of contractual purchaser/provider negotiations, as well as the creation of collective decision making and governance structures. The South Yorkshire and Bassetlaw STP has now become one of England's first ACS areas, and they have described the 'key ingredients' of their system:

    - Increased population health management capability
    - Shared determination of health and care outcomes
    - Single commissioner, or a commissioner alliance
    - Single provider, or a provider alliance

40. Given our track record as a stable and high performing patch with a strong track record of innovation the expectation from NHS England is that CNE starts preparing to become an integrated care partnership by April 2019. This will also reinforce the expectation on all of the stakeholders that we will be accountable for our performance as a system, as much as individual organisations, with the national backing to carry out collective decisions, and with the resources to execute on priorities at scale and pace.

41. In summary, and pending further discussions with a range of stakeholders, establishing an integrated health partnership in CNE could lead to:

[1] 'NHS planning for 2018/19', NHS England Board, 30th November 2017.

- Combining the expertise, resource and capacity of our local health and care systems across the North East and Cumbria – under a joined up system of governance and NHS leadership – to deliver the highest levels of health and well-being to the population.
- Agreeing a shared vision for integrated care and a greater emphasis on new models of care to address the wider determinants of health and wellbeing of the local population and optimise resources and reduce variation
- Ensuring greater clinical input into our strategic decision-making and giving us greater control over our priority setting so that all our efforts are focused on improving health
- Giving NHS organisations in CNE the regulatory headroom to collectively manage our performance and resources, and supporting regulators to develop assurance arrangements that assess the system as much as the impact of individual organisations
- Taking greater system-level responsibility for the coordination of a range of key financial and staffing resources:
  - NHS England's area team and our twelve CCGs (circa £5bn)
  - Health Education North East
  - NHS Property Services (and their assets)
  - National transformation schemes, including digital
  - Research, innovation and service improvement (e.g. academic health science networks)

Local and sub-regional working

42. The development of overarching system leadership arrangements in CNE will only focus on a limited number of cross-cutting issues. This will not prevent areas within this CNE framework from developing their own joint working arrangements on a local and/or sub-regional basis. For example North Cumbria - having emerged from the Success Regime process – has now brought health and social care organisations together to develop solutions to long-standing service sustainability issues across a dispersed rural population. Agreement has been reached on long term approaches for the delivery of integrated care, maternity, paediatric, hyper-acute stroke, acute and emergency medicine and emergency surgery, and the steps towards becoming an ACS in its own right (further signalled by the joint appointment of Stephen Eames as CEO across both acute and community and mental health providers in North Cumbria). The lessons from the Success Regime and the emerging North Cumbria ACS will provide invaluable learning to across the patch as we transition our own STP into a 'strategic' ACS one that can still accommodate a range of delivery models at local level – for example NHS and local authority partners in Northumberland are developing their own Wave 2 application for ACS status.

43. Defining our shared priorities for joint working and large scale transformation provides us with a framework to clarify and differentiate between this 'at scale' work, and what is better planned and delivered at sub-regional and local level.

44. The current commissioning architecture has brought with it opportunities and challenges in terms of dealing with some of our key priorities. For example, the strong connections between CCGs and Local Authorities, GP practices and the third sector have meant a much stronger connection with local communities which has helped better support some areas of work. It was felt to be important to preserve these wherever possible in any new ways of system working. Equally, there have been challenges in some aspects of commissioning which require more 'at scale' working arrangements. Some of these have either remained unchanged from established PCT practice, e.g. specialised services, or ambulance commissioning, while others have developed within the new system, e.g. digital care. There is also a recognition that the way

acute hospital services are commissioned could be streamlined through collaborative working between CCGs on sub-regional footprints that reflect patient flows into our hospitals.

Conclusion

45. The NHS in Cumbria and the North East has made good progress on meeting its shared challenges through effective joint working. The next stage on our journey will require further and deeper partnership working. Delivering our ambitions will be a complex task, and we need to ensure that we bring together managerial and clinical leadership to ensure that the case for change is fully evidenced, effectively communicated and efficiently implemented.

Recommendations

46. Governing bodies and Trust Boards are invited to endorse the direction of travel outlined in the report and consider
    - How the system-wide working described in this paper can support the sustainability of high-quality local health services
    - The principles that should guide discussion with national NHS bodies and our partners as these arrangements develop further
    - The proposed STP leadership and governance arrangements, and how they could be further strengthened and/or clarified.

APPENDIX

Developing a Sustainability and Transformation Partnership for the North East and North Cumbria

STP Lead - core job description

1. The role

From 1 April 2017, all NHS organisations will be expected to be part of a Sustainability and Transformation Partnership (STP). These partnerships will lead the development and delivery of agreed plans to improve health outcomes for local populations (including both prevention and addressing inequalities), the quality of health and social care provision whilst managing within a shared financial control total. These plans need to be underpinned by effective and meaningful local engagement with all partner organisations including patients, communities and NHS staff. They should also reflect the key national milestones set out in *Next Steps on the NHS Five Year Forward View* (2017) including those relating to primary care, urgent and emergency care, mental health and cancer services.

STP leaders will be at the heart of the NHS's transition towards a place based system based on collaboration, with commissioners, providers and local government working together to improve the health and well-being for local communities. They will ensure that the STP provides a focus for transformation and innovation and a forum for the effective exchange of ideas and good practice.

STP leaders will be responsible for convening these systems, developing the governance required to make effective decisions, directing STP resources and driving the rapid implementation of key service improvements.

2. Key Responsibilities

a) National expectations.

- Convene a Sustainability and Transformation Partnership composed of local NHS organisations (including primary care), local government and other public services. STP leaders will normally chair the STP (except where an independent chair is in place) with an STP Board from constituent organisations and including appropriate non-executive participation.

- Provide overall strategic leadership for the STP to improve health outcomes, quality of services and managing the available share of the NHS budget.

- Update the initial STP proposals (reflecting the 2017/18 – 2018/19 contracting and operational planning round) and translating these plans into local implementation plans. These will need to be developed fully with local partners - setting out clear and ambitious milestones and accountabilities for delivering local priorities and the

objectives described in *Next Steps on the NHS Five Year Forward View* – and ready for wider engagement in the Spring of 2018.

- Oversee improvements in priority services as set out in *Next Steps on the NHS Five Year Forward View*, with a particular focus on:
  - Improving A&E performance and upgrading the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authorities.
  - Strengthening access to high quality GP services and primary care, which are the largest point of interaction that patients have with the NHS each year.
  - Improvements in cancer and mental health - common conditions which between them will affect most people over the course of their lives.

- Managing and engaging the network of wider organisations that contributes to the delivery of NHS services, including the academic sector, voluntary / charitable / social enterprise sector and independent sector.

- Working with national ALBs to facilitate improvement, becoming a key point of contact for the national bodies (particularly NHS Improvement and NHS England, which will exercise their powers in consultation with STP leads), and exploring with them how the existing regulatory framework can evolve to support more effective system working.

b) Agreed STP Lead Mandate from the CNE Health System Leaders

Specific objectives for delivery in the forthcoming year to include:

- Oversee the development and successful delivery of a shared STP plan, focused on those issues that cut across geographical and organisational boundaries, removing obstacles to effective collaboration and taking a lead in gaining chief officers and chief executives sign up to working together as system leaders.

- Develop a transparent system of collective governance, supported by all stakeholders, that respects organisational autonomy and statutory responsibilities whilst ensuring that the health system in CNE can make the shared decisions needed to make rapid progress on delivering the STP.

- Facilitate financial sustainability and enable organisations to achieve greater efficiencies by working together, ensuring that the North East and North Cumbria manages within the funding available for our populations as defined by shared system control totals across commissioners and NHS providers (although this will not supplant the financial accountabilities of constituent organisations).

- Support CCGs to strengthen and streamline strategic commissioning (at both CNE and sub-regional level) whilst preserving CCGs' local health leadership and their key relationships with primary care, local authorities and the voluntary sector.

- Support Trusts and clinicians to work together to manage service change as they implement the recommendations emerging from the STP workstreams, especially the review of vulnerable acute services (including Pathology), the Cancer Alliance, and the Urgent and Emergency Care Network.

- Ensure the STP has the necessary programme management and implementation capacity and capability, drawing resources from constituent organisations and from NHS England and NHS Improvement where appropriate.

- Lead the Lead the development of an ACS model for Cumbria and North East supported by an Expression of Interest by Spring 2018 in order that NHS organisations (commissioners and providers), in partnership with local authorities, can take on collective responsibility for population health and devolved NHS resources. Given satisfactory progress, the leadership of the ACS would then be subject to open competition in order to prepare for shadow status from April 2019.

- Establish positive and supportive working relationships with the two emerging ACS in CNE i.e. WNE Cumbria and Northumberland in order to ensure clear accountabilities within the context of the CNE STP. Support the sharing of learning from both systems in order to inform the development of both additional local ACSs and the CNE wide ACS model including the effective dovetailing of governance and decision making between the constituent bodies.

- Review of progress regarding delivery of the above objectives to be undertaken with North Region NHS England / NHS Improvement Regional Directors in September 2018.

3. Personal qualities of the STP Lead:

- A very senior figure with a track record of leading a major organisation.
- Deep knowledge and strong relationships in the NHS and local government.
- Committed to 'system working', partnering across organisations to deliver on key national priorities as set out in *Next Steps on the NHS Five Year Forward View* and managing within the total resources available to the system to make these improvements.
- Expert facilitation and leadership skills; able to work through and with others to achieve tangible and lasting improvements to services.
- Experience of leading change in an open and inclusive way, with a natural ability to communicate with patients, communities and staff as well as to manage complex political environments.
- Values driven, with an optimistic outlook and a strong commitment to maintaining a high-quality NHS.

NHS England / NHS Improvement