

# NCA Community Services and Integrated Care

Joint Health Overview and Scrutiny Committee  
February 2026

# Summary

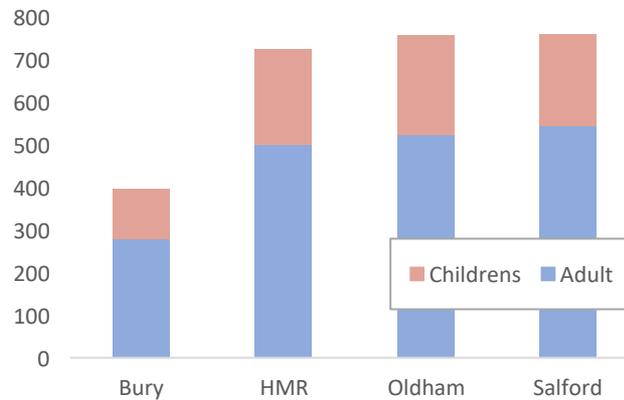
- Overview of NCA Community Services
- Examples of Integrated Care delivering improved performance
- Future NCA Clinical Strategy

# NCA Community Services

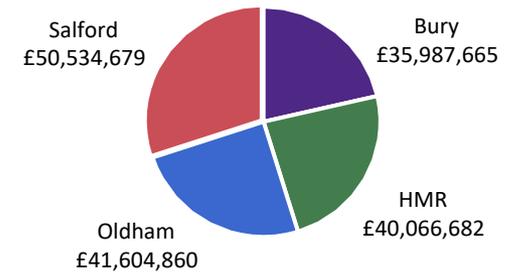
4 localities served, covering a population of 929,600 over 190 square miles



## Workforce of 2636 staff



## £168,194,000 income from ICB localities (25/6)



Services are delivered in different settings, such as:



Our District Nurses provide c **967,000** domiciliary visits per year, or **80,800** per month. Around **25,000** of these per year are urgent call outs, preventing hospital admission or supporting discharge



# Rochdale Operating Model

## Our shared challenge



We need to deliver improvement in the context of **increasing demand and acuity** across all parts of the health and care system

Yet – the health and care system is complex and delivered through **multiple, complex and siloed** organisations with different accountabilities...leading to “failure demand” in A&E and care settings...leading to **increased costs and poor experience**.

And – we know that health and care services are only a fraction of what contributes to individual’s health and wellbeing:

### Deprivation

1 <sup>st</sup> Quintile	47.4%
2 <sup>nd</sup> Quintile	25.0%
3 <sup>rd</sup> Quintile	9.9%
4 <sup>th</sup> Quintile	13.7%
5 <sup>th</sup> Quintile	3.9%

**Building blocks to better health and wellbeing**

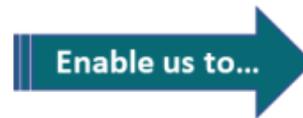
Having good relationships in a decent home	Having sufficient income and meaningful occupation	Good Education/ Learning Opportunity	Healthy culture and social life	Healthy neighbourhood environment
Protection from hazards	Good start/ early years	Having an active life	Improving internal thinking	Having services that meet need

**We understand our challenges and know that we are more likely to deliver improvement if we work together as a whole system**

# Delivering integration – Our Social Operating Model

Describing the features that make our system work is difficult, some are hard to define, and we are still on a journey.

We think our characteristics include, but are not limited to these five things...



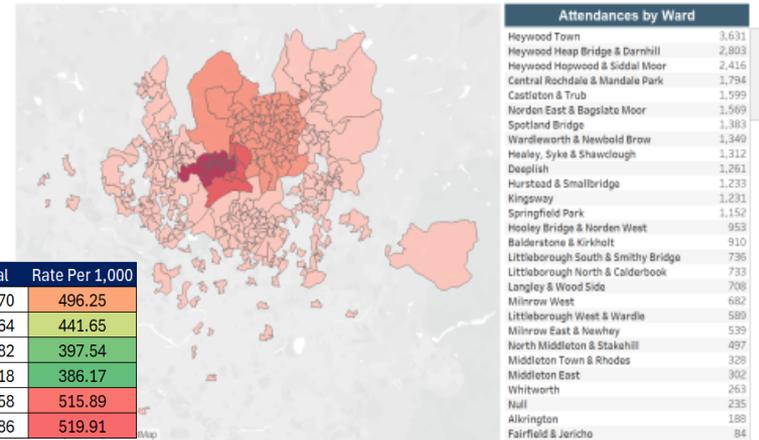
# Integration delivering improved performance



Northern Care Alliance  
NHS Foundation Trust



Map of Attendances by Residence - Fairfield

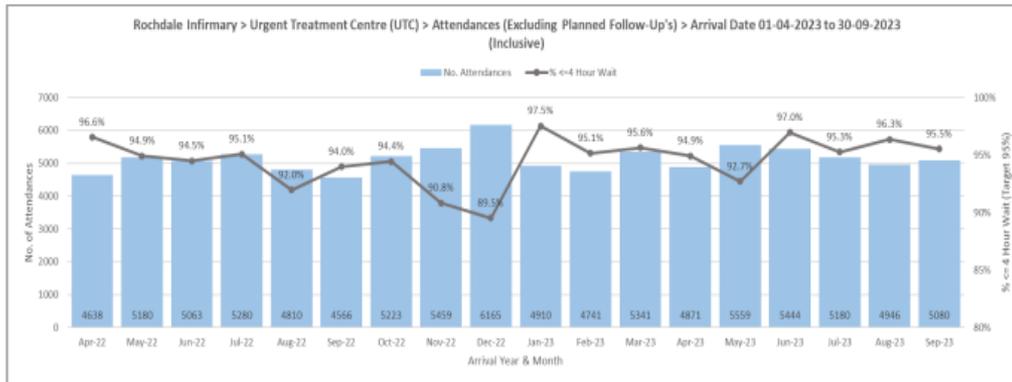


PCN	Type 1 & 2	Type 3 & 4	Total	Rate Per 1,000
Canalside	13,113	11,157	24,270	496.25
Heywood	12,264	3,000	15,264	441.65
Middleton	13,443	4,539	17,982	397.54
Pennines	7,579	6,939	14,518	386.17
Rochdale North	14,700	17,758	32,458	515.89
The Bridge	5,231	6,755	11,986	519.91

All Types Attendances



# Integration and financial sustainability



- Integrated Urgent Care delivery model
- System wide pathways
- Blended roles
- 47% cheaper than DGH model

## Comparison of Emergency Care costs and activity at Rochdale Infirmary and Fairfield Hospital 2022-23

HRG	HRG Description	Fairfield Hospital	Rochdale Hospital
		Average Cost	Average Cost
VB01Z	Emergency Medicine, Any Investigation with Category 5 Treatment	£469	£175
VB02Z	Emergency Medicine, Category 3 Investigation with Category 4 Treatment	£793	£299
VB03Z	Emergency Medicine, Category 3 Investigation with Category 1-3 Treatment	£560	£223
VB04Z	Emergency Medicine, Category 2 Investigation with Category 4 Treatment	£535	£289
VB05Z	Emergency Medicine, Category 2 Investigation with Category 3 Treatment	£309	£222
VB06Z	Emergency Medicine, Category 1 Investigation with Category 3-4 Treatment	£148	£120
VB07Z	Emergency Medicine, Category 2 Investigation with Category 2 Treatment	£283	£197
VB08Z	Emergency Medicine, Category 2 Investigation with Category 1 Treatment	£296	£189
VB09Z	Emergency Medicine, Category 1 Investigation with Category 1-2 Treatment	£145	£118
VB10Z	Emergency Medicine, Dental Care	£73	£69
VB11Z	Emergency Medicine, No Investigation with No Significant Treatment	£135	£86
UZ01Z	Data Invalid for Grouping	£141	£72
<b>Total</b>		<b>£298</b>	<b>£159</b>

# Clinical Strategy – Our Vision for Transforming Care

## OVERARCHING PRINCIPLES

These principles apply to all clinical services across the group. They are the pillars on which our clinical strategy is based.



### Working with partners to deliver cutting edge services

We will collaborate with partners across the health and care system and use innovative technologies and research to improve care.



### Tailoring care to the needs of our population

We will take a population health approach and work to reduce health inequalities in our communities.



### Transforming where and how we provide services

We will deliver care closer to home, reduce waiting lists, and transform pathways through integration and technology.



### Using our resources wisely

We will maximise efficiency and financial sustainability by making effective use of our people, equipment, and facilities.



### Excellent Care informed by evidence

We will deliver evidence-based care aligned with national best practice.

These principles will guide the future direction of our clinical services. Underpinning this is the recognition that healthcare delivery across the NCA footprint needs to radically change to meet our current challenges and the demands of the future.

# Future Delivery Pillars

## Pillars

- Prevention and Population Health**  
 We will strengthen a trust-wide approach to prevention, population health, and health inequalities. This will support earlier intervention to prevent avoidable harm, reduce inequalities, and improve outcomes, embedding prevention and equity across acute pathways as well as through partnership working with neighbourhood and system partners.
- Neighbourhood Led Health**  
 We will deliver neighbourhood led services in the community in partnership that are built around the needs of people, focusing on integrated pathways of care for frailty, long term conditions and end of life care.
- A New Outpatients Model**  
 We will transform our outpatients model so that a hospital setting is no longer the default, through better specialist advice provided earlier in the pathway, digital alternatives at scale and more effective delivery models when patients need to be seen on a hospital site.
- Hospital at Home**  
 We will provide safe, specialist care for medical conditions at home supported by digital, clinical and neighbourhood infrastructure – delivering a full virtual hospital model. We will support people to live independently, and to die in a place of their choice.
- Integrated Urgent and Emergency Care**  
 We will create an urgent and emergency care offer that is a network of services which ensures patients are seen in the right place, at the right time, by the right service – reducing avoidable admissions and ensuring patients return to their home as early as possible following a hospital stay.

NCA Wide Transformation Programme

Delivered consistently at scale



In partnership with our localities



**Our Mission:**  
To create a sustainable health and care model with our partners across our four localities

Underpinned by



People



Digital Strategy



Estates Strategy



Financial Sustainability Plan

# Clinical Leadership Model (CLM) Update

Joint Health Overview and Scrutiny Committee  
26 February 2026

# The Clinical Leadership Model update

- Clinical leadership at the heart of decision-making
- NCA wide services
- Connectivity to Place / Population

# Clinical Leadership Model

## How will CLM feel different?

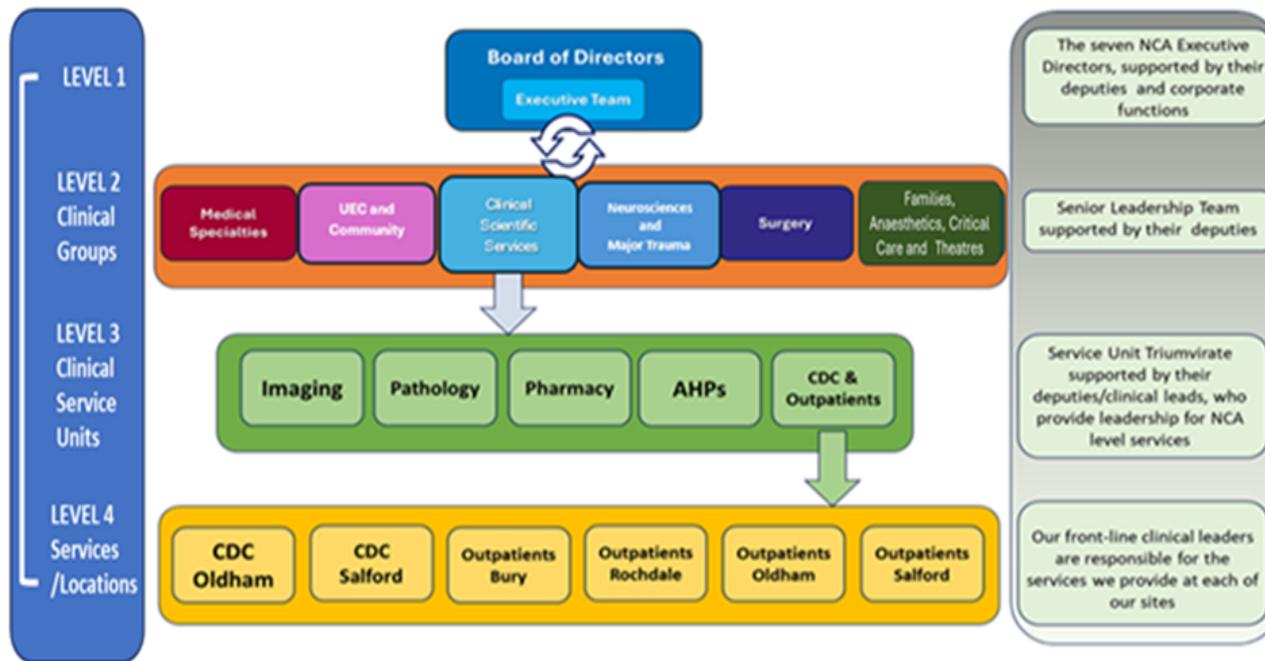
Much more than a structural reset – the structure is just an enabler.

- Stronger clinical leadership at every level
- Clearer accountability in Clinical Service Units and Clinical Groups
- Faster, clinically owned decision-making, closer to patients
- Fewer layers from ward to board
- Trust wide networking in governance, audit and improvement

# Clinical Leadership Model

## CLM operating model v current operating model

The example of Clinical Scientific Services is used to illustrate the leadership levels within the new CLM organisational structure

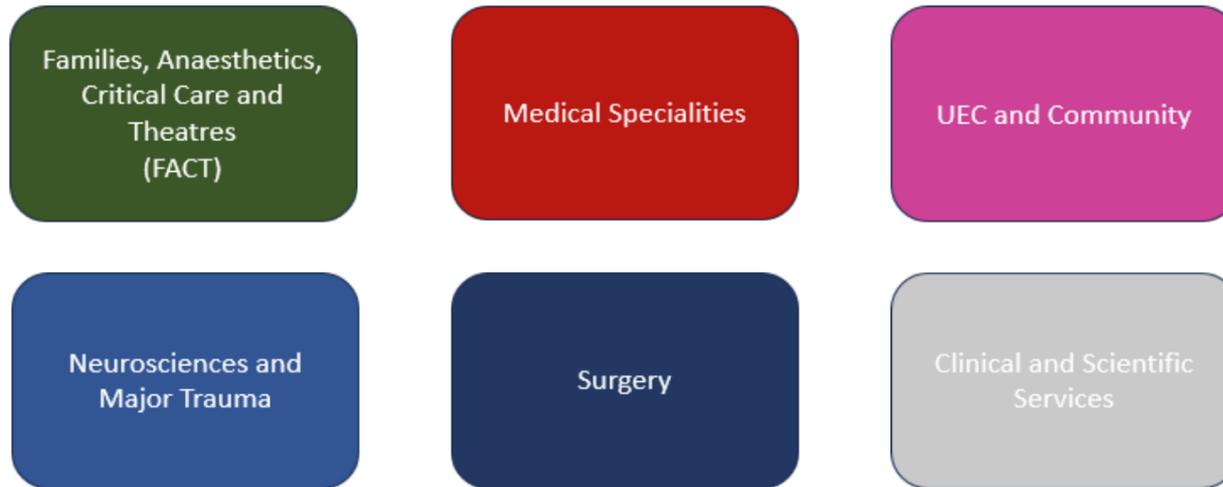


**Current Operating Model:** At present the NCA is structured vertically operating across four localities; Salford, Oldham, Bury and Rochdale. Some services, such as Diagnostics and Pharmacy, centralised corporate teams and parts of Estates and Facilities operate across the four localities. There are currently five leadership levels of the organisation from the Board to the frontline services we deliver to patients.

**The CLM Operating Model:** Introduces a simplified, four-level leadership structure which replaces the previous five levels of leadership. Roles and responsibilities at each level will be standardised wherever feasible. The CLM operating model will remove a leadership level – delivering on the ambition of better connecting our senior leaders with our clinical teams.

# Clinical Leadership Model

## Operating model: Clinical Groups



The Clinical Groups have now been confirmed during the consultation period. They are based on the work from over 200 colleagues who supported design teams to develop the six Clinical Groups.

# Clinical Leadership Model

## Connectivity to Place

1. There are existing Place Executive leads within the NCA who will support strategic Locality priorities and forums.
2. 6 Clinical Groups will exist with Band 9 Ops, Nursing and Medical Directors, all of whom will need to interact with Place in varying degrees.
3. Existing Place based arrangements will need supporting to ensure continued shared ownership of key performance , quality and financial ambitions e.g.
  - ✓ System risks of ED performance
  - ✓ Development of community services alternatives
  - ✓ Deployment of BCF funding
4. Site leadership : Roles for Salford, Oldham and Bury& Rochdale will support system EPRR processes
5. Place based roles hosted through the NCA, commissioned by localities for Place support and service delivery will remain. These roles are currently out of the scope of Consultation, as these roles will form a key component of Place Based Partnership arrangements working in conjunction with the ICB locality team and other local partners

# Clinical Leadership Model

## Next Steps: Mobilisation and Transition timeline

### Clinical Groups Draft Arrangements: By March 2026

Consultation will be completed, and the new leadership teams for clinical groups will be selected. The shape of clinical groups will be defined including how they will work with each other and with Place, as well as how they will align to the new Operating Model and Accountability Framework.

### Delivery of 30-day plan to Clinical Group Go Live in April

### Clinical Group Go Live: By April 1<sup>st</sup> 2026

All key milestones set out in the Critical Path will be met so CLM teams can operate in the new CLM environment safely and effectively, with minimal disruption to services, patients and colleagues, with the required capacity and capability. Clinical group leadership teams and clinical service unit leadership teams will be in place. Clinical Groups and fundamental activities required for 'Go Live' will be transferred from Care Organisations – for example there will be a new Finance Ledger, aligned to the ESR Hierarchy and Active Directory.

### Post April 2026 – Post Transition Implementation Plan (PTIP)

Following the Clinical Groups 'Go Live' in April 2026, work will still be required for the full implementation of CLM and the Clinical Groups, for example longer-term service integration, benefits realisation and any tasks not completed by April 2026. It is likely the roles, responsibilities and governance for place for will continue to evolve, post April 2026, and the implementation will be need to iterative to align with changes to the national, regional and ICB strategic direction of travel.