Health and Wellbeing Board
25th May 2017

SHROPSHIRE NEIGHBOURHOODS/ OUT OF HOSPITAL WORK

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1. Summary

1.1 This paper serves to summarise the recent work undertaken between Shropshire CCG, Shropshire Community Health NHS Trust and Shropshire Council, to review the structure, governance and content of the Shropshire Neighbourhoods Programme and to request agreement from the Health and Wellbeing Board for the proposed structure.

1.2 In early 2017 the CCG and the Shropshire Council commissioned a review of the Neighbourhoods Work and the resulting report is attached as Appendix A. The report has been a catalyst for agreeing the key areas of work needed to support the planning and transformation needed as part of the STP Neighbourhoods/ out of hospital work.

1.3 A programme board of the Neighbourhoods/ Out of Hospital work is proposing 5 key workstreams;

- Prevention/ Healthy Lives
- Population Health Management
- Primary Care 5 Year Forward View
- Admissions Avoidance
- Community Services Review

Please see the Background section of this report for more details and Appendix B for the organisational structure.

1.4 It is important to note that the workstreams have considerable overlap and will need to work closely together to be successful. It is also important now to ensure that our planning for the HWBB, the Better Care Fund, and the STP Neighbourhoods/ out of hospital work is drawn together and understood by the system as one strategic planning package; each portion making up a part of the whole. The Better Care Fund plan and proposed governance structure also makes reference to the key workstreams as described in the Appendix B below.

2. Recommendations

2.1 For the Board to:

- Consider and discuss the Optimity Review;
- Agree the approach as described in the report below to take the out of hospital work forward and the key workstreams, including agreement regarding the best place for the population health management work;
- Discuss and input into the governance of the Neighbourhoods/ Out of Hospital work.

REPORT

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

3.1 The Health and Wellbeing Board works to reduce inequalities and health inequalities and must make considerations of inequalities with all decision making.

4. Financial Implications

4.1 No direct financial commitment asked for from the Local Authority and partners at this time, however there are significant resource implications for developing out of hospital services and support or people living and using services in Shropshire. As appropriate these details, recommendations and decisions will be brought to the HWBB.

5. Background

5.1 Introduction

5.1.1 This paper serves to summarise the recent work undertaken between Shropshire CCG, Shropshire Community Health NHS Trust and Shropshire Council, to review the structure, governance and content of the Shropshire Neighbourhoods Programme.

5.1.2 The basis of this review was a short diagnostic undertaken by Optimity Advisors, the output report of which is attached (Appendix 1).

5.2 Programme Structure

5.2.1 Following the review we have collectively recognised that the Shropshire Neighbourhoods work should continue, but is only currently covering a small section of the change that is needed to effect a proper population health management plan, namely upstream prevention, focused primarily on primary prevention work. The Neighbourhoods Programme however, needs to be complemented with four other inter-dependent workstreams:

5.2.3 **Shropshire Primary Care Development Workstream and GP5FV**. This work will be led by Shropshire CCG. The managerial lead for this will be Nicky Wilde, who is the Primary Care Director for Shropshire CCG.

5.2.4 **Population Health Management**. This was a specific recommendation from the Optimity report and will be led by Rod Thomson.

5.2.5 **Secondary Health Focused Admissions Avoidance**. This has a prior dependency with Population Health Management and will be led by Michael Whitworth.

5.2.6 **Community Services Review**. This is an existing workstream that forms part of the Shropshire CCG Financial Recovery Plan, reviewing Minor Injury Units, DAARTs and Community beds. This is being led by Julie Davies and reports into the CCG QIPP Delivery Board, but will input into the Shropshire Out of Hospital Programme.

5.3 Shropshire Primary Care Development Work Stream and GP5FV

A MCP positioning paper has been produced by Shropshire CCG (Appendix 2) that sets out the proposed clustering of primary care and directional development. Much of this programme will be driven by NHS England timescales and deadlines, which will be revealed at a Regional conference on 11 May 2017. Julian Povey and Simon Freeman will be attending for Shropshire.

5.4 Population Health Management

A short debate will be held over the next two weeks as to how this work is taken forward. Consideration should be made as to whether this Workstream sits best at the STP level and taken forward jointly with Telford and Wrekin as part of the STP planning footprint.

5.5 Secondary Care Admission Avoidance

This has a prior dependency with Population Health Management and will be co-produced between Shropshire CCG and Shropshire Community Health NHS Trust. Prior work will be re-evaluated under this workstream and prioritised appropriately.

5.6 Shropshire CCG Community Services Review

This review is in train and the terms of reference are attached (Appendix 3).

5.7 Governance

The overall governance for this workstream is being developed by Rod Thomson and Michael Whitworth and the Draft governance diagram can be found in Appendix B, along with the draft Better Care Fund diagram. These are both a work in progress and decision making regarding funding will continue to rest with the Local Authority's cabinet and the CCG's Board.

5.8 Shropshire OOHP and STP

The programme will form a key role in the STP and its development, both plan and content, and is critical to the STP and Future Fit Programme. As a result the programme will have a programme manager allocated by Phil Evans whose role will be one of co-ordination and reporting.

6. Additional Information

N/A

7. Conclusions

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **See appendices**
Cabinet Member (Portfolio Holder) **TBA**
Local Member **N/A**
Appendices **Appendix A – Optimity Review** **Appendix B – Shropshire Neighbourhoods Governance Structure**

Shropshire Health and Care

Shropshire County Council in partnership with Shropshire CCG

3 May 2017
Final

Matrix Knowledge formally joined the global consultancy group Optimity Advisors in September 2014. As its European arm, the newly combined business trades as Optimity Matrix to run the public policy arm of Optimity Advisors' global operations." For more info go to: www.optimitymatrix.com. Optimity Matrix and Matrix Knowledge are trading names of TMKG Limited (registered in England and Wales under registration number 07722300) and its subsidiaries: Matrix Decisions Limited (registered in England and Wales under registration number 07610972); Matrix Insight Limited (registered in England and Wales under registration number 06000446); Matrix Evidence Limited (registered in England and Wales under registration number 07538753); Matrix Observations Limited (registered in England and Wales under registration number 05710927); and Matrix Knowledge Group International Inc. (registered in Maryland, USA under registration number D12395794).

Any enquiries about this project should be directed to enquiries@optimityadvisors.com

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1.Introduction

1.1 The scope of this work

Optimity Advisors were commissioned by Shropshire County Council in partnership with Shropshire CCG to undertake a review of the current initiatives underway across the county to deliver out of hospital care and neighbourhood working. Optimity reviewed a range of documents and existing data analysis to understand the key population health management issues that face the Shropshire health & care system and how these were being prioritised. Our analysis identified areas of agreement and difference of emphasis and this was presented back to a wider group of stakeholders at a working session on 22 March 2017. The purpose of this session was to facilitate a discussion in order to reach consensus on a shared Shropshire system wide objective for out of hospital care and commitment to developing a collective programme of work. This discussion started the process of articulating a collective high-level vision for out of hospital care and neighbourhood working across Shropshire and the important role played by primary care and general practice delivering it.

Our review was underken in the context of the wider work across Shropshire and Telford and Wrekin, where NHS commissioners and providers are working with the Local Authorities on the design and delivery of a Strategic Transformation Plan (STP) designed to improve local care outcomes and system efficiency (operational and financial). The Shropshire and Telford and Wrekin STP seeks to bring together a number of individual and collective workstreams to create and deliver a coherent aligned plan. Neighbourhood working is a key component of this plan.

We recognised that within Shropshire significant time and energy has already been invested by the Shropshire County Council ('the Council'), the Shropshire Community Health NHS Trust ('the Community Trust') and Shropshire Clinical Commissioning Group ('the CCG'), to develop locally relevant prevention and managed care solutions and implementation plans. These pre-existing plans provide a strong foundation for transforming out of hospital care in Shropshire as part of the wider STP. However, the Shropshire stakeholders had already recognised there were important gaps, particularly in relation to the involvement and integration of primary care. This review looked at the prevailing plans in the light of what were understood to be the needs of the Shropshire population, as part of a coherent collective and affordable Commissioning Strategy.

The objective of the review was to arrive at, or start the process of arriving at, a shared understanding of collective purpose, areas of difference, and actions to address these.

The hypothesis underpinning our approach is based on our experience of good practice internationally, evidence of what works to deliver the triple aim through population health management and our experience of similar large-scale complex transformation work in health and care systems. Shared purpose needs to encompass not just what is delivered (vision, goals, financial commitment, etc.), but the manner in which it is delivered (values) and the way of working as a partnership. Shared purpose can then be communicated as a shared narrative to the local health and social care community and embedded within operational plans and working practices. This report is intended to support the partners in that journey forward.

In summary, our scope was to:

- Focus on out of hospital care
- Review documentation detailing current initiatives underway
- Review the existing analysis
- Engage with key stakeholders across the CCG, Council, Community Trust and General Practice
- Undertake an analysis of areas of agreement and difference of emphasis.

For the purposes of this report we have referred to the Council, the Community Trust, the CCG and general practice as stakeholders rather than partners. It is our view that the commitment to the next steps agreed on 22nd March will signal the shift from conversations happening between a group of stakeholders to a working partnership.

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2.Summary of approach

2.1 Review of the data analysis

During the first phase of this review, we reviewed programme documentation and supporting local evidence sent to us by the CCG, the Council and the Community Trust and talked to a number of key stakeholders either one to one or in groups (see Annex 2 for full list).

Optimity reviewed existing evidence which included:

1. Local demographic, health and epidemiological data by localities/ neighbourhoods;
2. Best estimates of current financial picture, if possible by practice/ locality/ neighbourhood and covering prevention, primary care, socal care, and hospital and community health services
3. Descriptions of current initiatives designed or underway to achieve improved integration and/or to otherwise for each of the sponsor organisations and any plans or progress monitoring reports

We received a large quantity of data and information from stakeholders and the sources of the data are set out in Annex 1.

2.2 Engagement with stakeholders

The interviews and group discissions conducted during this phase were aimed at exploring perceptions of local leaders on the problem they were trying to solve and in particular views as to where iniatives were working well, and where there were challenges – all evidenced with examples or case-studies. We focused on making sense

of the wide variety of initiatives across Shropshire in the context of a whole system programme of work.

2.3 Working session to reflect on the findings

Optimity then facilitated a working session on 22nd March attended by a range of participants from across the stakeholders (full list of attendees in Annex 3) aimed at:

- Reflecting back what we reviewed and heard from stakeholders across the system
- Reaching consensus on a shared Shropshire system wide objective for out of hospital care
- Reaching commitment on developing a collective programme of work

2.4 Findings and summary report

This report sets out the overall findings of this review including the outputs of the working session and recommendations for next steps. The next steps are based in part on the outputs of the working session but also on the experience that Optimity has in supporting and evaluating other health and care systems as they design and deliver whole system programmes of work in England and internationally.

3.Our view of the Shropshire health and care system

3.1 Summary of stakeholder engagement

The key themes which emerged across all of the conversations that we had on a one to one basis or in groups included:

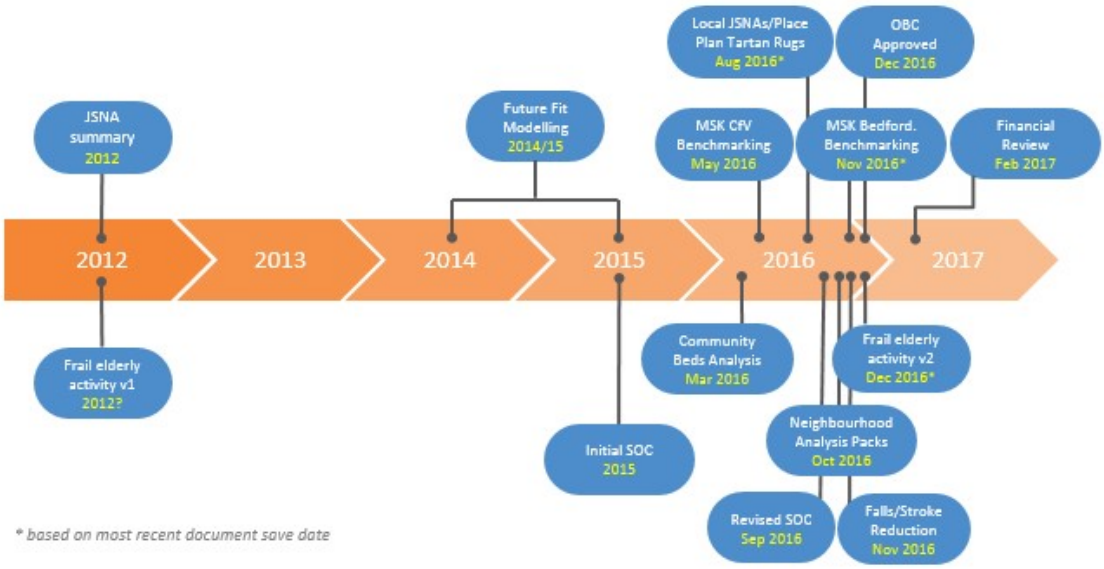
- Each stakeholder organisation has different drivers for change based on different perceived interests;
- A significant amount of work has happened but had largely happened in silos;
- There were differences of emphasis around the problem that needed to be addressed for Shropshire and the initiatives that were being developed. These differences were complementary rather than in conflict;
- There is an absence of a coherent narrative for the transformation of out of hospital care;
- There is evidence of cost and utilisation analysis but it is not clear what the data is telling stakeholders and how it is infoming decision-making;
- It is not clear where population health analysis is currently being conducted other than at neighbourhood level by public health. In order to baseline and measure the impact of any population health management initiatives this needs to be conducted for the whole population and then drilled down into smaller population groups (these can be locality based or risk segmentation or both);
- Prioritisation and sequencing is not possible as there is no shared understanding and ownership of the problem that is being solved;
- There is no evidence of return on investment calculations informing decisionmaking;

- It is inclear where leadership sits for out of hospital care in Shropshire.

3.2 Data analysis and evidence

We reviewed a wide range of data packs from multiple sources, some of which contained the raw data, others only the ouputs of the analytical work. A summary of the data analysis conducted by various stakeholders across the system is presented in figure 1 below and in Annex 1.

Figure 1: Timeline of data analysis sent to Optimity Advisors



Our review of the data sets highlighted that:

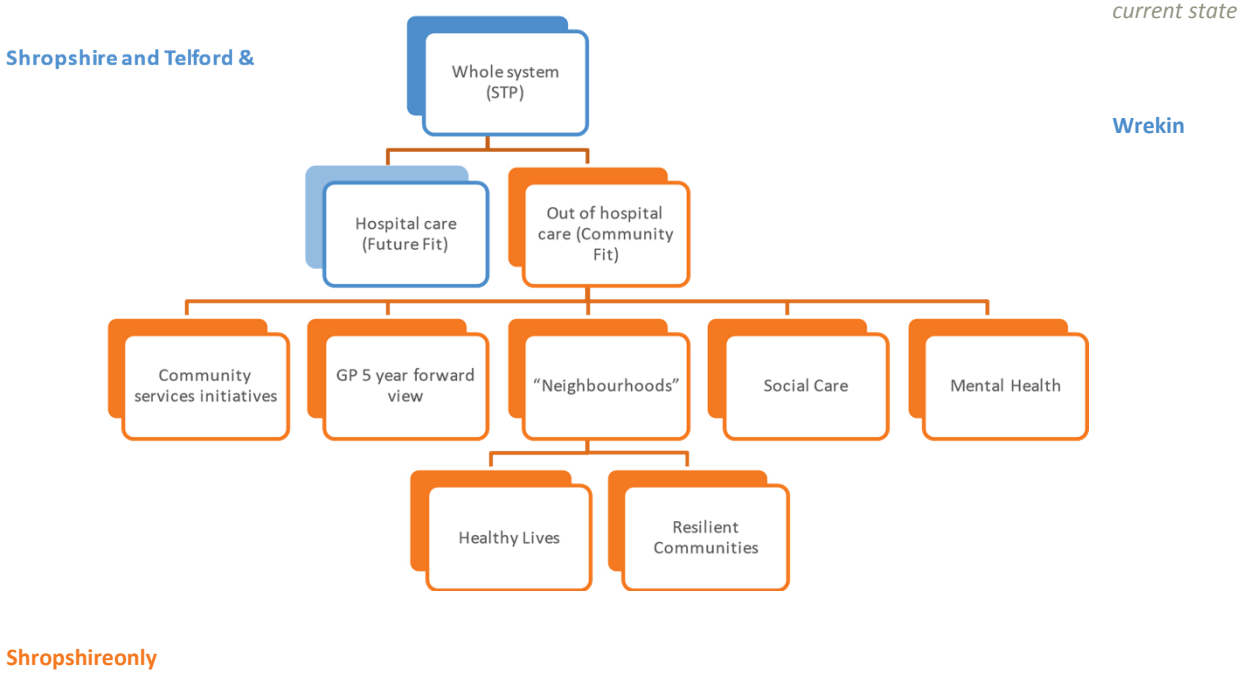
- There is a lack of clarity on the Future Fit Stratgic and Outline Business Case activity shift analysis and we know this work has been a source of friction between stakeholders (as evidenced in our interviews). We have not seen the modelling that was done as part of this work.
- It is not always clear what assumptions are being used in the analyses.
- Where we don't have the raw data, it is not always clear from the output reports what the data inputs and sources were.
- Its is not clear how the outputs were assured and validated as this is not consistently set out in the output reports.
- Based on information shared with Optimity, there is a lack of mental health activity analysis or review of mental health services but this work may have been done elsewhere in the system.
- There is a significant gap in primary care and specificically general practice activity data. Primary care data should be integrated with the linked data, or a separate analysis of primary care data should be conducted to look at current activity and capacity and model the potential impact of increased demand through more community provided care based on new (not necessarily general practice delivered) models of care.
- We have seen no analysis of the overlap between frail elderly activity and MSK opportunity (both have been identified as key focus areas for intervention).

- We have seen some evidence of collaboration and data sharing between stakeholders but not at a wider system level and this is restricting the potential benefits of data analysis.

3.3 Presenting the current state as a programme of work

We used the insight from the data anlysis and interview outputs to map the health and care system in terms of the programmes of work currently underway. We have presented these simply in the visual below. In the next section we explore in more detail the areas of difference and similarity across these.

Figure 2: the current state



Our key message message here is that the significant amout of work already underway forms the firm foundations of a coherent, joined up programme of work and this can and should be the basis for moving forward.

4. Your programme of whole system population health and care

4.1 Why a whole system of population health?

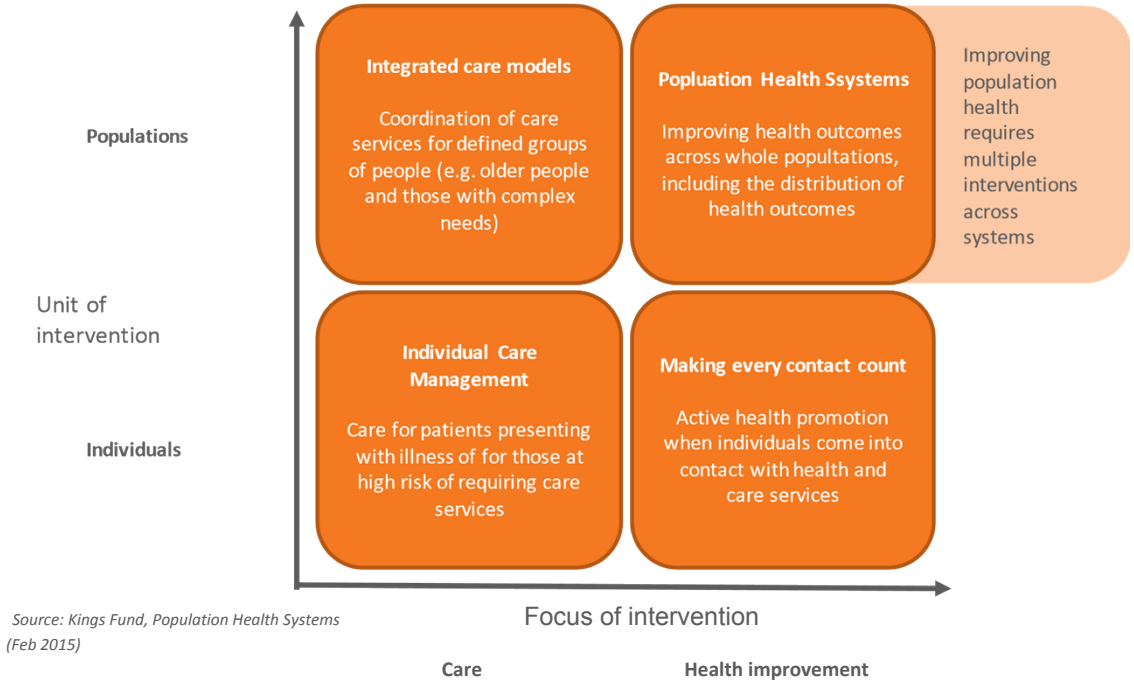
One of the key themes of consensus across all stakeholders was that the current way of delivering services is not sustainable nor sufficiently agile to respond to the rapidly changing needs and demands of the health and care system in Shropshire.

The transformation required is ***not*** a mere shifting of activity from acute providers to other place-based community services including general practice, but is a fundamental shift in thinking and in the ways of working to improve population health by working as a system and not constrained by organisational boundaries. The Council articulated this as a move to a health and wellness service rather than illness service, the CCG articulated a need to deliver clinical and financial sustainability by sharing collective responsibility for health and care outcomes and the community provider stated they want to deliver transformed services within a clear strategic commissioning framework that sets out the commissioners expectations for population health.

Using Figure 3 below as a means of describing population health systems , Shropshire has a number of initiatives that sit within the boxes of Making Every Contact Count (primarily led by the Council) and Individual Care Management (primarily led by the Community Trust). There are relatively fewer Integrated Care Models in evidence although the Oswestry work is an early stage example of this work. There are no examples that we have seen of population health system intiatives.

Based on the conversations we have had with stakeholders and confirmed during the working session on 22nd March, we believe that Shropshire stakeholders have a shared ambition to move to becoming a population health system. We have therefore used this terminology to describe the programme of work that could emerge from this review.

Figure 3: : Population Health Systems



Source: Kings Fund, Population Health Systems (Feb 2015)

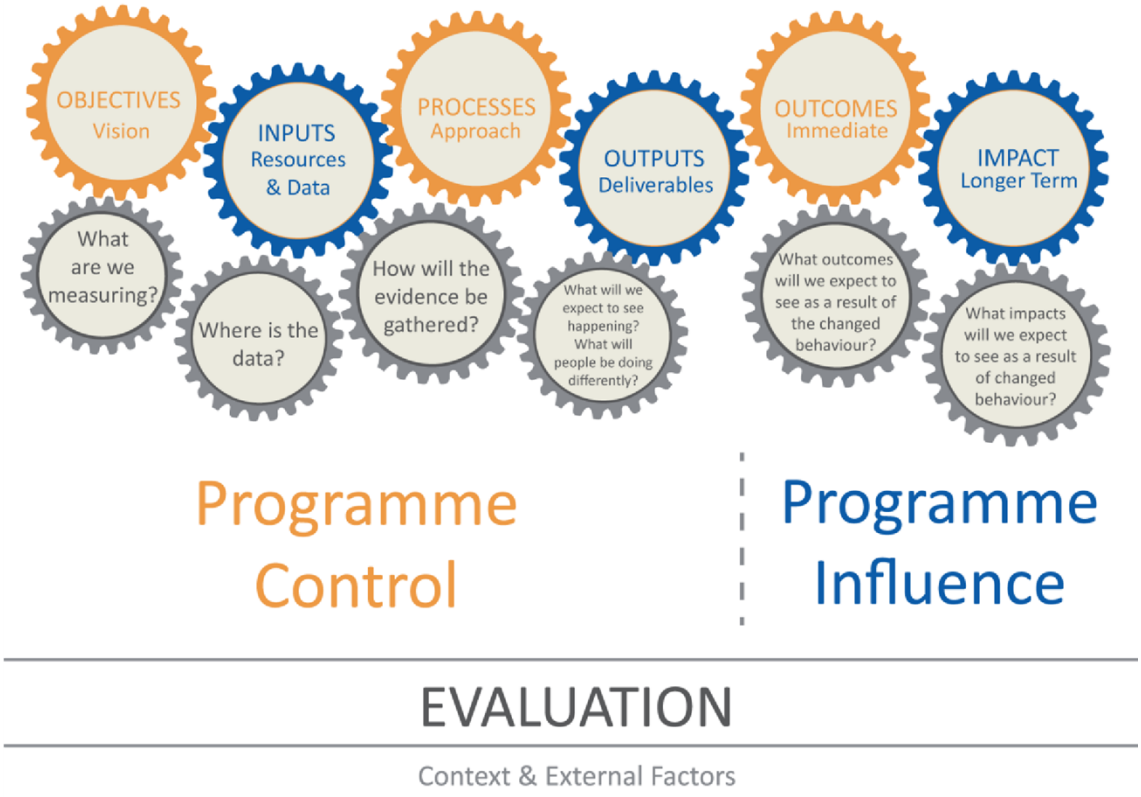
4.2 The programme of work

On 22nd March Optimity presented current Shropshire initiatives as a programme of work. We used the programme theory of change to interrogate the various initiatives and programmes to understand how they fit together as a system-wide programme of work.

Our conclusion was that while there are many initiatives that could have a positive impact on population health, each with a clear internal logic or theory of change, there was a lack of a coherent single system strategy and narrative with a clear vision at its core. As a result intiatives were not being sequenced in a way that allowed them to have maximum impact on popluation health, care quality and financial sustainability.

We used the programme theory of change to understand where there are differences and similarities in the programme logic and have summarized these below.

Figure 4: Programme theory of change



The problem the programme is trying to solve

The difference in the perception of the problem reflects the different positions of the organisations in the local context and in the wider national context of policy priorities and financial pressures. These need not be contradictory and could quite easily be brought together into a single challenge which can be viewed through different lens. In some cases however there may again be a sequencing issue to be addressed. For example, the CCG has immediate and pressing issues around financial savings. Any work

undertaken to achieve this should not undermine the foundations for later population health intiatives or destablise primary care.

Programme objectives and vision

Each stakeholder organisation has outlined a clear objective for their current programme of work (although it should be noted that we cannot validate whether this is shared more widely across these organisations outside of the groups we engaged with). The objectives that are outlined are complementary but there is no obvious point of single alignment.

Programme inputs and processes

There is a significant amount of activity underway across the system and there is a programme theory of change within many of these organisational plans and programmes (although this is more explicit in some plans than others). However there is a disconnect across organisations and programmes because of the differences in the articulation of the problems being solved and objectives being pursued. As a consequence it is therefore unclear how inputs and processes are being sequenced and the critical path idenitified.

Programme outputs

At this level the differences in emphasis start to turn in to potential contradictions. For example, the CCG has a view that neighbourhoods should be organised around general practices, whereas the Council is of the view that they should be organised around communities. Similarly, at this level we start to see dependencies emerge that if not managed at a programme level may result in unintended consequences that cost the system money and impact care quality and negatively impact the experience of care. For example, the CCG wants to reduce community beds whilst the Community Trust wants to reconfigure these. There is a risk that the Healthy Lives programme may make assumptions about the availability of community beds locally when designing new models of place-based integrated health and care that may not hold true even in the short term.

Programme outcomes and impact

In all the documents reviewed on the various initiatives, there is limited information on outcomes and impacts but there is consensus on:

- keeping people well
- keeping people out of hospital cost containment.

None of these have been quantifed for the population of Shropshire so it is will not be possible to track the impact the current plans and programmes are having in these areas. Some programmes set out their outcomes as part project initiaition documents. Many of these are unquantified and some are outputs rather than outcomes.

5. The outputs of the working session

During the working session on 22nd March a number of questions were posed to the stakeholder group and a summary of the discussion is presented below:

What are the challenges you are all trying to address collectively?

A number of challenges were identified although these were sometimes confused with objectives and goals. We have separated these out below:

Challenges:

- Acute, primary and social are are not sustainable in their current form
- We can't afford to carry on as we are
- We have workforce constraints – not enough and not doing the right thing
- Demand is increasing and changing
- Demographics are changing and this is driving demand
- The wider policy context (national) is sometimes stopping us from doing what we think needs to be done Objectives / Goals:
- Keeping people healthy
- We want people to live longer healthier lives (compressed morbidity)

Our reflections:

We would suggest that the development of the overarching challenge (the basis of the case for change) needs to be based on shared data sets, namely a population analysis that all stakeholders contribute to and sign off. This can happen whilst the stakeholders are working through the case for change narrative.

If we were to articulate the shared challenge today, based on what we have heard, we suggest:

"Shropshire's health and care system is not consistently coming together to provide joined-up, quality and sustainable out of hospital care for the local population. The population's needs of health and care are changing, they want to live longer healthier lives, remain independent and contribute to their communities well into old age. Demand for health and care is increasing at a time when resources are not. The result is that when one part of the health and care system feels the pressure it negatively impacts on other parts of the system. Currently there is no overarching programme of work where the health and care system can collectively address these problems for the benefit of the local people and communities of Shropshire".

Is a collective whole system programme of work to tackle the challenges facing Shropshire the answer?

The answer to this question from the room was a resounding yes. There was some discussion about the importance of sequencing particularly to ensure that immediate issues facing the system are addressed at the right time and with the appropriate approach. There was also some discussion about risk appetite and how the stakeholders

could work together to take risks collectively on new and innovative ways of working together across a population health system.

Questions were raised about the point at which the hospitals should be involved in this programme as there are critical dependencies with any secondary care transformation programme. It was recognised that any programme of work to transform out of hospital health and care and more widely population health, cannot be delivered without acute clinician engagement to transform downstream services and avoid hospitalisation. Again the issue of sequencing plays in and this needs to be considered as part of the programme planning process. Some of this work is already being done with acute clinicians under the umbrella of pathway redesign but this may need to be reoriented to ensure it is not just about the "left shift" of the same activity but in a hypothetically lower cost context.

Stakeholders in the room who work at or near the frontline, highlighted the importance of setting out a clear strategy and implementation plan and demonstrating the system leadership to deliver it. Setting this out clearly would enable people delivering at the front line to see how they were contributing to a bigger vision and leadership commitment to that vision.

What is the one objective for a collective whole system programme of work on which you can all agree?

There was agreement that single system wide objective was a critical component of the collective narrative for the transformation of out of hospital care and this needed further discussion in follow-up meetings. However, one clear theme emerged during this discussion and that was a commitment from all stakeholders to "be brave for Shropshire". This emerged from the discussion around risk appetite. The Council representatives talked about the Council's recent years experience of delivering more with less, experiences that can be shared by their health colleagues. The Community Trust stakeholders highlighted their own demonstration of putting the wider system and needs of patients and the local population demonstrated by their decision to dissolve the Trust and seek strong partnership to deliver sustainable care into the future.

There was a commitment in the room for a smaller group of stakeholders to meet again within one week to move forward on this question and others discussed on 22nd March.

What is the question you are asking yourselves as a system, and how will this inform your process of prioritisation and data analysis?

Stakeholders agreed to the following question.

"What are the top 10 things where we are out of kilter with similar areas?"

Our reflections:

There are some methodological challenges to the question above, not least the availablity of comparable data. This is something that the Right Care packs offer but the information is insufficiently dynamic for the analysis to provide systems with an adequate basis for decision-making.

The CCG are already undertaking a review of MSK services, complex care and community beds. We would recommend that stakeholders also undertake a rapid

popluation analysis which could inform each of these reviews. This will identify the groups that are at highest risk and highest cost. The analysis will need to focus not just on specific conditions but on the prevalence of multi-morbidities. Evidence shows that early intervention with emerging co-morbidities is where health and care systems can avoid some of the most significant future costs. We have included in Annex 4 an example population analysis report we have delivered for another health and care system which enabled them to plan a sequenced and resourced programme of work to deliver a community base care model across providers (acute, community, mental health and general practice) with commissioners support mechanisms in place.

6. Our recommendations for the way forward

The commitment of the stakeholders

There was a clear commitment from all stakeholdes in the room to address a system problem. This problem cannot be resolved by individual organisations in isolation or even smaller collaborations of organisations. It requires Shropshire's health and care system to agree and deliver collectively.

Requirements of successful population health systems

Shropshire's health and care system stakeholders will need to work together to deliver the following:

1. Data about the population served should be pooled to identify challenges and needs that can be collectively agreed by all stakeholders as part of their shared purpose;
2. Segment the population to enable interventions and support to be targeted appropriately using the population analysis;
3. Shared goals for improving health and tackling inequalities based on an analysis of needs and linked to evidence-based interventions
4. Place-based leadership, drawing on skills from across the health and care system based on a shared vision and strategy. This leadership needs to operate first at system level and then embed across all levels of the programme of work. There should be common narrative that is clear no matter who across the health and care system in Shropshire you talk to;
5. Effective engagement of communities and their assets through third sector organisations and communities. This work has already started with the Resilient Communities programme;
6. Pool budgets to enable resources to be used flexibly to meet population health needs, at least between health and social care but potentially going much further. This is likely to be a longer term objective as the stakeholders work through arrangements for financial accountability;
7. Contracting shifts to paying for outcomes that require collaboration between different agencies in order to incentivise joint working on population health. Initially this may mean incentivising processes and outputs that are evidence of joint working and will lead to improved population health outcomes.

Next steps agreed on the 22nd March:

The group of stakeholders agreed to take the following steps (recognising the steps needed to be worked up in more detail).

1. To engage with GPs as a matter of urgency. This cannot happen without at least an emerging narrative for the population health system that they can contribute to the development of;
2. To define and identify localities for Shropshire in terms of geographic, population and service parameters. This needs to be supported by a comprehensive population analysis;
3. To identify priorities (conditions / popluations to focus on intitally) ;
4. To consider intiatives currently underway and how they would be sequenced as part of a whole system programme of work. Current priorities are thought to include:
    a. Primary care development
    b. Community services review
    c. Population health management for admission avoidance
    d. Neighbourhood work

Our recommendations on next steps

Our experience of similar whole system programmes show that ***how the programme is planned and implemented*** is as important as what is done. We would recommend that the leadership invest a significant amount of time over the coming months in working through the principles that will govern the way they operate collectively as well as working through the content of the programme. Based on our experience, taking this approach of 'slowing down to speed up' will enable the system to develop strong and sustainable relationships, shared commitment and trust.

An example of a set of principles developed in another system are:

- Accountability needs to be balanced with collaboration – the programme operating model needs to make clear who is accountable for delivery, while also ceding responsibility to partners based on trust. There needs to be clarity around the respective roles of commissioners and providers, with some work requiring collective action and some specific action from identified stakeholders.
- This is not about losing existing organisational identity – each partner brings something distinctive to the whole system, there is real benefit to identifying and building mutual respect around the distinctiveness.
- Duplication of effort needs to be eliminated – 'alignment' of programmes is not enough.
- Build on progress to date and learn lessons where progress has been slow – do not set up another delivery programme in addition to existing provider and commissioner programmes.
- Resource the programme to deliver against clear objectives and defined benefits.
- Build capacity and capability in change management in complex adaptive systems in all organisations at all levels.
- Clearly articulate the benefits to be realised, report against these and make decisions supported by them.

- Be focused and prioritise and where necessary and be willing to stop working on something if it is not working.

Alongside this work, the stakeholders need to agree the ***content of the programme***, building on the foundations that are already in place, filling in the crucial gaps (e.g. primary care), agreeing the sequencing of activity to optimise the effort and resource invested and how they are going to monitor the return on investment and make informed decisions as the programme progresses.

The foundations for the programme in its initial stages will be:

1. A clear and shared population analysis to understand the needs (now and in the future), current capacity and assumptions about future capacity (that are shared across the system)
2. A set of population priorities based on this analysis
3. A sequence of activity for 2017/18 that will deliver some demonstrable early wins.

In order to do this, over the next 6 months, the stakeholders will need to:

1. **Develop and consolidate the shared vision:** In order to engage with and activate the wider system stakeholders, the group that took part in the working session with Optimity (or a sub-group) needs to develop the organisation and system narratives to enable stakeholder buy-in and mobilisation to action during implementation. A small group of senior managers in each organisation could develop the first draft of these narratives over the next 4-6 weeks. The partners could share these narratives at a working session at the beginning of May 2017 and agree the next steps. This group should continue to meet regularly to ensure the momentum is maintained and it is likely to form the basis of the membership of the oversight body for this programme going forward. As part of developing the narratives the commissioners and providers need to agree their separate but complementary roles in the system.

2. **Enlist champions and enable action: Design and build the support function and structure** to deliver the whole-system model of care. This will build on the existing intiatives but bring these together under a single system wide programme of work. There may need to be a radical refresh of some programmes as you move to a wholesystem plan. One stakeholder should "host' the system-wide programme team. A PMO structure would be an obvious mechanism for driving the change that is required across the system. There are a number of obvious advantages to this – notably clear accountability, decision-making and control. However, there is a risk with the traditional PMO approach that the members of the PMO are seen as an additional system silo, not full members of any of the stakeholder organisations embedded in the everyday practice of the system. The focus on implementation planning of a traditional PMO focuses on certainty and what is already known. Shropshire needs an operating model for change that is more flexible and agile and models the type of adaptive culture and behaviours that the system needs to develop.

   We recommend a programme structure that operates alongside the stakeholder organisational structures and is populated by the many of same people as are

embedded in these organisational structures. There may be requirements for additional capability at different times in the programme delivery cycle, but the programme should be owned and delivered by those most invested and interested in getting it right and supplemented with additional capability from outside the system as and when required.

3. **Generate quick wins:** Focus on defining and identifying locality footprints based on the population analysis as well as other agreed criteria. Build on the early work of the Healthy Lives Programme and the Community Trust's initiatives to develop care co-ordination for patients with multiple co-morbidities from the existing, wellestablished integrated care pathways. Specific deliverables for 2017/18 need to be determined with the service leads but should build on current work being undertaken. This work should be led by the providers of health and care services, i.e. the Community Trust, GPs and Adult Social Care.

Make progress visible: Design and develop the performance indicators that can be used to monitor the progress of the whole-system model of care during 2017/18 using the population analysis and existing programme as the starting point for the whole-system model of care implementation plan.

By October 2017, the stakeholders (by then partners) should be able to show evidence of:

A **shared system narrative** with distinct partner narratives that can be communicated to all stakeholders within Shropshire and outside it and which the partners can demonstrate evidence of testing as part of initial mobilisation and delivery.

A **detailed work stream plan** for 2017/18 including but not limited to:

- People (stakeholder activation, workforce and organisational development)
- Process (locality operating model development, pathway development; performance monitoring; population risk management, population analysis)
- Technology (shared care records, performance information sharing)
- Finance (contracting and re-imbursement models, estates)

This plan should be signed off by the relevant governing bodies and implementation should already have started given that it is building on initiatives already underway.

A **structure and operating model for implementation** of the whole-system model of care that is embedded within all the partners and governed robustly.

A set of **agreed performance metrics** for the whole-system model of care during 2017/18 against which a governing board and other stakeholders can monitor progress.

Annex 1: documentation and data

Optimity received over 80 documents from the Council, the Community Trust, the CCG to inform the review, these included a range document packs and data analysis. We have mapped the data analysis below.

Analysis	Description	Publish date	Reference date
JSNA summary	Analysis of health needs of local population and priorities	2012	2011-12*
Frail elderly activity v1	Identification of frail elderly population based on acute inpatient activity for people aged 65 or older	?	?
Left shift activity (FF, SOC, OBC)	Analysis of acute activity that could be shifted into community settings (only outputs of this analysis have been shared)	2014-2016	?
- Left shift by condition	Total left shift activity by HRG chapter and age group	Oct 2016	?
- Left shift by neighbourhood	Total left shift activity apportioned to neighbourhoods based on existing distribution of non-elective admissions	Oct 2016	?
Community service assessment	Analysis of community bed reductions under the discharge to assess (D2A model)	Mar 2016	2015-16
MSK benchmarking (CFV)	MSK focus pack published by NHS Right Care showing cost reduction opportunities in comparison to similar CCGs	May 2016	2014-15

Local JSNAs / place plan area 'tartan rugs'	Public health indicators by place plan area colour coded in comparison to area average	Aug 2016	2014-15*
Neighbourhood analysis packs	Analysis of demography, activity and costs for health care service users in Shropshire and T&W, broken down into GP practice neighbourhoods	Oct 2016	2014-15
MSK benchmarking (bedfordshire)	Calculation of potential reduction in activity and cost if Shropshire had the same performance as Bedfordshire	Nov 2016	2014-15
Falls and stroke reduction	Projection of reduction in admissions and social care for falls and strokes	Nov 2016	2011-15
Frail elderly activity v2	Update of original analysis but extended to include costs associated with frail elderly activity	Dec 2016	2015-16

** includes a variety of indicators, some are based on older data*

In addition to the above we were also made aware of a significant amount of adult social care data including:

- Demographic information including geographic analysis and projections/forecasting
- Rurality and population density
- Adult Social Care (ASC) service user needs
- ASC service user health needs
- ASC service user profiles – new requests for support by year, age band and service type (including requests for support, Let's Talk Local hubs, assessments, and long term care)
- ASC service user profiles – all requests for long term care
- Carers
- Care type and profile
- DToC analysis

Prevention and Independent living:

- Housing Support service user profiles – age group and need
- Information Advice and Advocacy – service user profile of need
- Handy Person Scheme – usage and profile of work done
- Independent Living Centre – usage information on assessments for equipment and adaptations including OT Assessment consultations
- Telecare – referrals, profile of equipment and geographic analysis
- Community Equipment Services – usage figures and equipment type
- Housing adaptations and DFGs = adaptation type, age profile of service user, and housing tenure

Customer Feedback – Annual surveys, and complaints, compliment and comments

- Care Markey information:
- Residential Care
- Nursing Care
- Domiciliary Care
- VCSE
- Brokerage Service information

Provider issues – including finance and sustainability, workforce, changes in care, demand for services, volunteering and infrastructure
Housing data – including Housing Market Assessment and Fuel Poverty
Financial analysis and forecasting

Annex 2: list of stakeholders engaged

Name	Role
Simon Freeman	Accountable Officer, CCG
Julian Povey	Clinical Chair, CCG
Jessica Sokolov	GP Member, CCG
Sam Tilley	Head of Partnerships and Planning, CCG
Michael Whitworth	Director of Contracting and Planning , CCG
Meeting of Executive Directors, Shropshire Council	Involving Clive Wright, Chief Executive Rod Thomson, Director of Public Health for Shropshire, Andy Begley, Director of Adult services and Karen Bradshaw, Director of Children's Services
Jan Ditheridge	Chief Executive, Shropshire Community Trust
Shropshire Community Trust focus group	Mel Duffy, Director of Strategy and 12 key service and corporate staff
Healthy Lives Steering Group	Kate Garner – Locality Commissioning Manager Sam Tilley – Head of planning and partnerships Tom Brettell- Manager, BCF Emma Sandbach – Public Health Specialist Neil Felton – Manager, Business Design Mel France – Business Design Miranda Ashwell – Physical Activity / Falls Lead
Penny Bason	Health and Wellbeing, Public Health
Dr Ian Rummens	LMC
Dr Mike Matthee	GP
Dr Steve James	GP Member, CCG Clinical Directors
Jo Robbins	Public Health Consultant & Chair of the Healthy Lives Steering Group

Annex 3: Attendee list – Working session 22 March 2016

Name	Organisation
Clive Wright	Shropshire County Council
Rod Thomson	Shropshire County Council
Penny Bason	Shropshire County Council
Kevin Lewis	Shropshire County Council
Kate Garner	Shropshire County Council
Tanya Miles	Shropshire County Council
Mel Duffy	Shropshire Community Health Trust
Jan Detheridge	Shropshire Community Health Trust
Ros Preen	Shropshire Community Health Trust
Simon Freeman	Shropshire CCG
Julian Povey	Shropshire CCG
Geoff Davies	Shropshire CCG
Sam Tilley	Shropshire CCG
Michael Whitworth	Shropshire CCG
Steve James	Shropshire CCG
Phil Evans	Shropshire Telford & Wrekin STP
Debbie Vogler	Future Fit Programme Lead

Annex 4: Interview / focus group protocol

Overarching questions	Sub questions
What problem or challenge are you trying to solve?	Is there a shared view of the problem across the system?
How do you know that it is a problem?	What is the evidence? What is the data telling you?

How are you identifying the solutions* to address the problems? **By solutions we mean the current initiatives underway in Shropshire*	What is your process for decision making? Are the right stakeholders involved in the decision making? What is the evidence for the solutions you are identifying? How will the solutions address the financial challenge?
How are you prioritising/ assessing the relative importance of the solutions to address the problems?	What is the process for prioritisation? Where are the 'start, stop, continue' conversations take place?
How will you know when you have solved the problems?	What shorter-term outcomes do you expect to see as a result of the changes? What longer term impacts do you expect to see as a result of the changes? What metrics are you using to assess progress? Is there consensus on what success will look like?

Annex 4: Example of population analysis report

Introduction

This appendix sets out the findings of analysis of the demographics and health status of the population covered by XYZ Clinical Commissioning Group. The aim is to identify key demographic and health characteristics, and trends, amongst the population of XYZ to help XYZ CCG, ABC Trust, MH and the

London Borough of XYZ identify where an initial focus for developing integrated care pathways could be directed to have a significant impact on the health status of XYZ residents, as well as potentially deliver improved efficiencies and savings to the CCG.

Data Sources and Definitions

- Acute activity data provided by XYZ CCG and covered A&E, Inpatient and Outpatient settings for all patients registered with XYZ GP Practices from April 2011 through to November 2014).
- This analysis is based on the period from April 2013 to March 2014.
- Additional data on population profiles and projections is sourced from ONS and the 2011 Census.

Exclusions

- Any activity provided by providers that XYZ CCG does not have a contract with was excluded from the analysis (for example, patients who were treated whilst on holiday).
- Activity related to maternity services.

Conditions

- Conditions were identified based on ICD10 diagnosis codes found in the data.
- For each patient over the 3 years of activity data, all 24 diagnosis code fields were checked against a pre-defined list of codes for each condition
- The costs associated with the patient activity data were pre-calculated in the data and based on the PbR Tariff

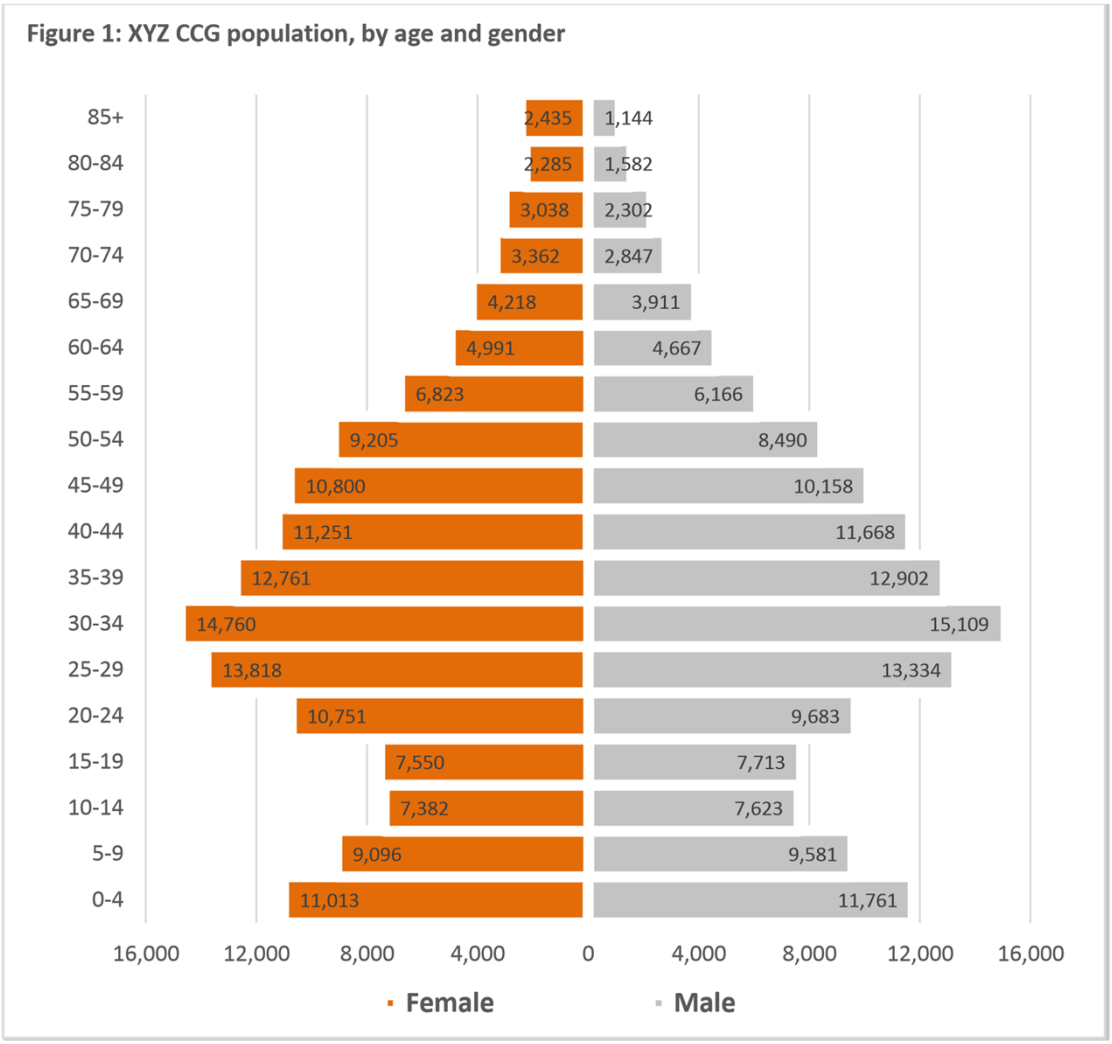
Condition	ICD10 codes
Arthritis	M*
Cancer	C*
Circulatory	I* (excl. I50)
COPD	J44
Dementia	F00-F07

Diabetes	E10-E14
Genitourinary	N0-N7

Population Profile

According to the Mid-2013 Clinical Commissioning Group population estimates, the total population covered by XYZ CCG is was 286,180. The age profile of the population includes a high proportion of younger population: the proportion of older population (aged 60 and above) in XYZ CCG is 13%, which is relatively lower compared to London (15%) and England (23%).

Figure 1: XYZ CCG population, by age and gender

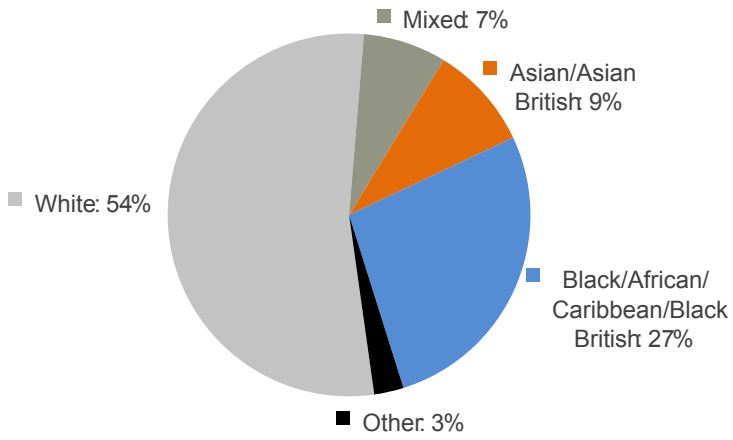


Source: Clinical Commissioning Group Population Estimates, Mid-2013 (Census Based), ONS

Ethnicity

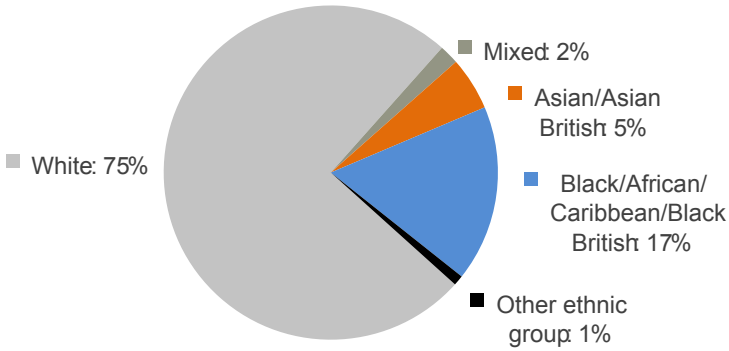
As with the majority of London, the ethnic composition of XYZ is diverse. According to 2011 census, Black and Minority Groups (BME) form 46.5% of total population. And, among the population aged 60 and over, 75% are White and 25% are from BME groups.

Figure 2a: XYZ ethnicity breakdown



Source: Census 2011, ONS

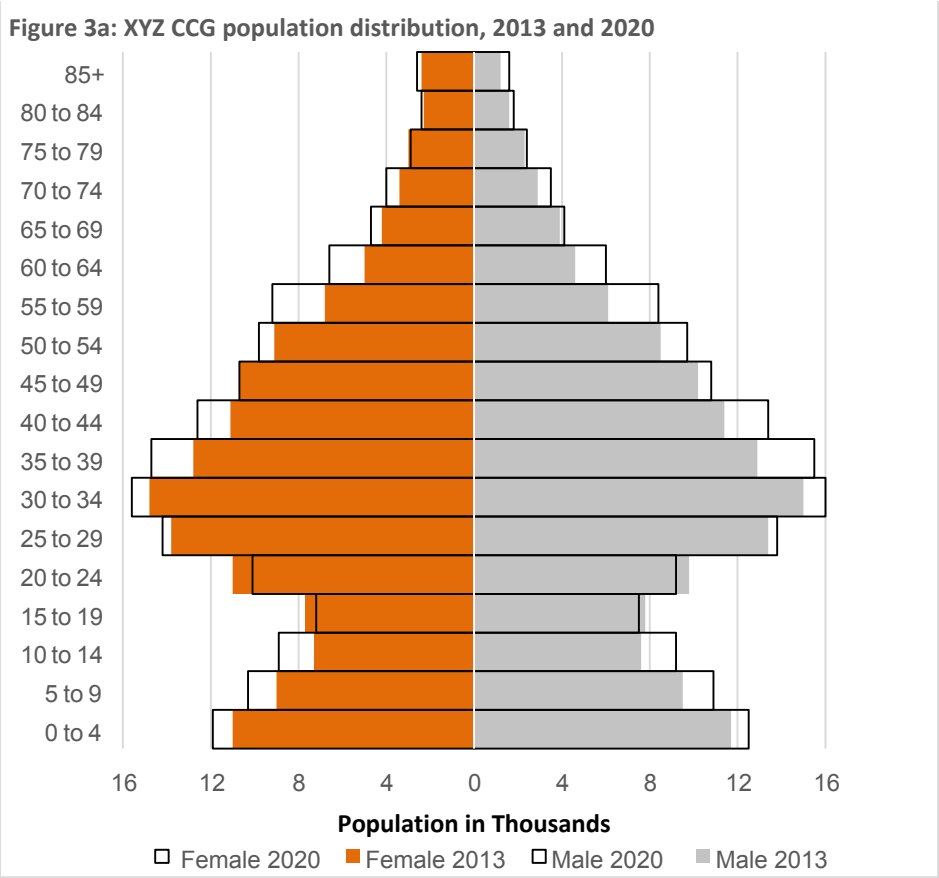
Figure 2b: XYZ ethnicity breakdown of Population aged 60 and above



Source: Census 2011, ONS

Population Projections

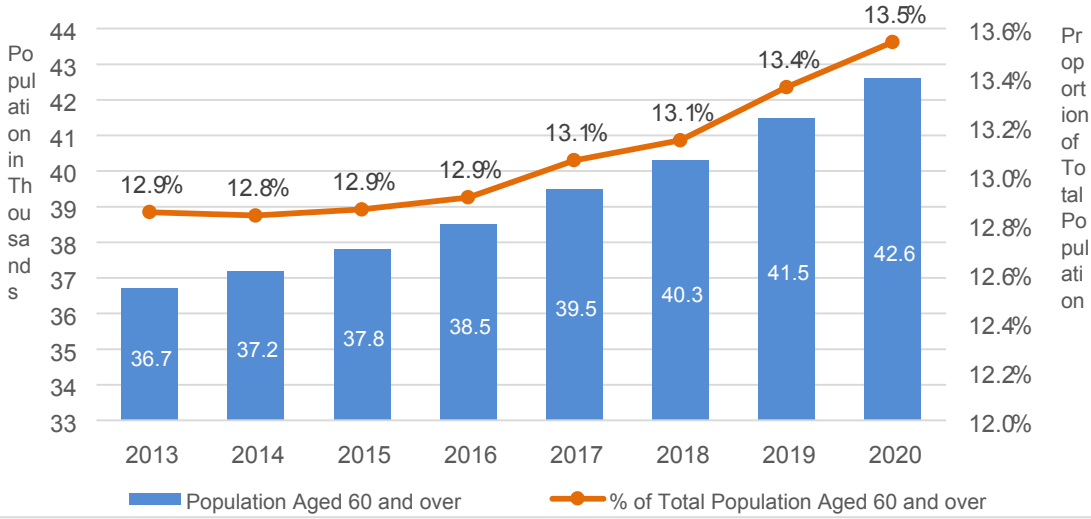
The XYZ CCG population is predicted to rise by 10% in between 2013 and 2020. In London and England, the population is expected to experience a 9% and 5% growth, respectively. By 2020, it is expected that there will be 16% rise in the number of over 60s in XYZ CCG compared to 2013, which is higher in comparison to the growth rates projected for London (15%) and England (13%) as a whole. A key conclusion that can be drawn from this is that future service development and delivery for the care of older people (both health and social care needs) is likely to have to expand faster than other parts of the capital.



Source: 2012-based Subnational Population Projections for Clinical Commissioning Groups, ONS

Figure 3b below shows the projections for older population aged 60 and above. According to the projections, the proportion of over 60s is expected to rise sharply from 2016. It is predicted that 13.5% of the total population of XYZ CCG will be aged 60 and above in 2020, which is relatively lower when compared to London (16% of total population to be aged 60 and above) and England (24% of total population to be aged 60 and above).

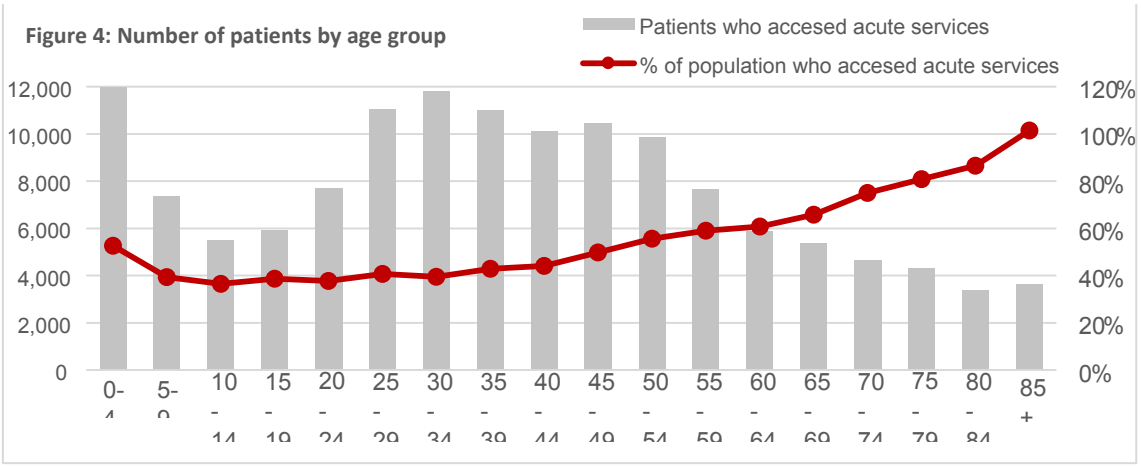
Figure 3b: Over 60s population projections



Source: 2012-based Subnational Population Projections for Clinical Commissioning Groups, ONS

Patient profile

The proportion of the population accessing acute services increases with age, and 48% of the total population (2013 CCG population) accessed acute services in 2013/14. Of this figure, 74% of over 60s population accessed acute services, and nearly 100% of the 85+ age group have accessed acute services in 2013/14.

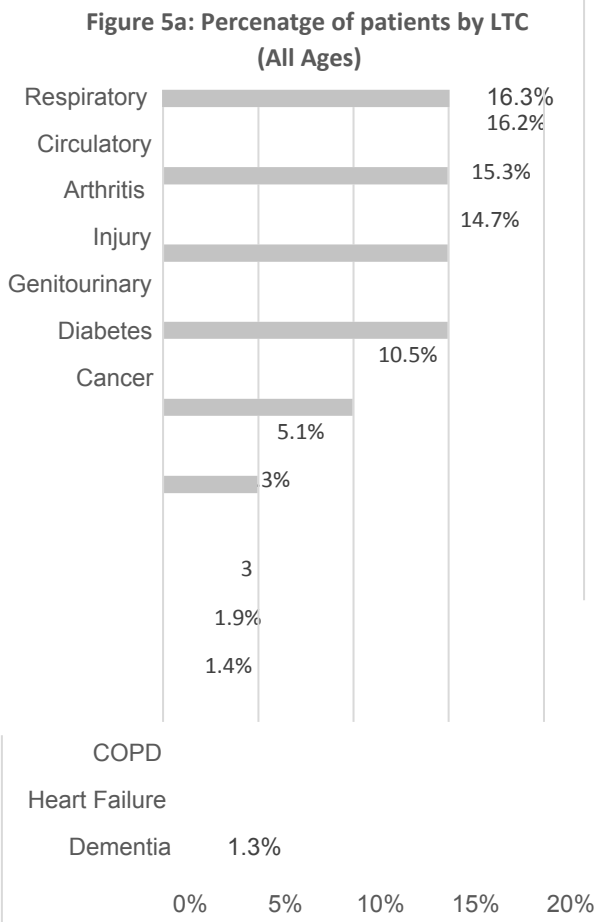


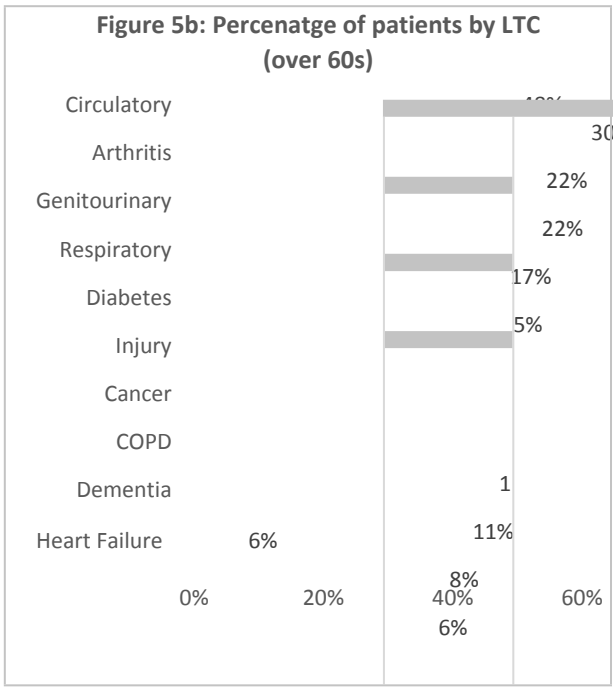
Source: NHS XYZ CCG patient activity data 2013/14; Mid-2013 population estimates, ONS
Note: The ONS mid-2013 population estimates are based on grouped lower layer Super Output Areas (LSOAs) boundaries.

Prevalence of long term conditions among patients

Of the population of XYZ who had used acute care services in 2013/14, respiratory, circulatory, arthritis and genitourinary conditions were the most prevalent, with16.3% of the patients diagnosed with respiratory conditions, 16.2% with circulatory conditions and 15.3% with arthritis. Among patients aged 60 and above, 48% had diagnosed circulatory conditions and 30% with arthritis.

This highlights the fact that to have an impact on a large proportion of the population, any initiative to bring together services in an integrated way is likely to need to involve services that address both respiratory and circulatory conditions.



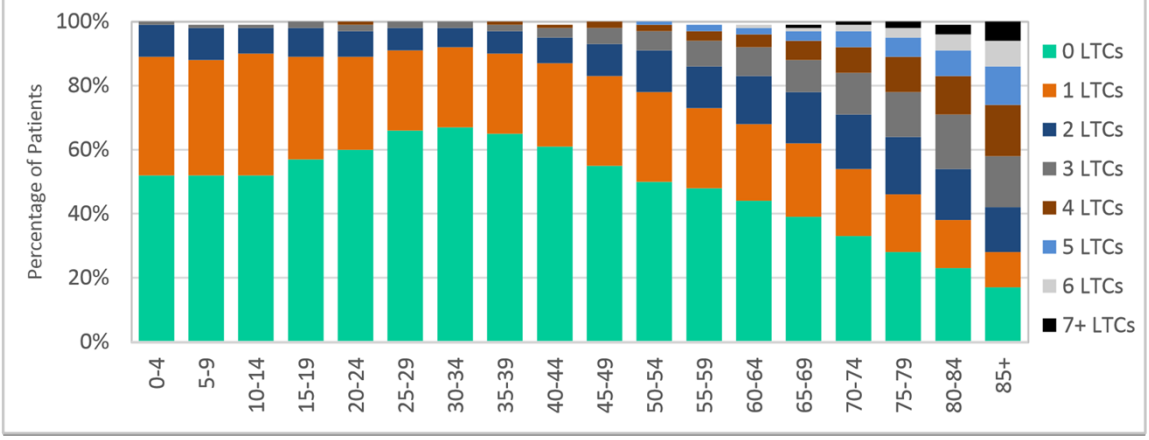


Source: NHS XYZ CCG patient activity data 2013/14

Long term conditions among patients, by age group

Among all patients seen by ABC Trust, 47% have at least one long term condition (LTC) and 20% have two or more LTCs. The number of long term conditions increases with age. For patients aged 60 and above, 68% have at least one LTC, with 48% having two or more LTCs. And, among patients aged 75 and above 77% have at least one LTC and 62% have two or more LTCs.

Figure 6: Number of long-term conditions by age group



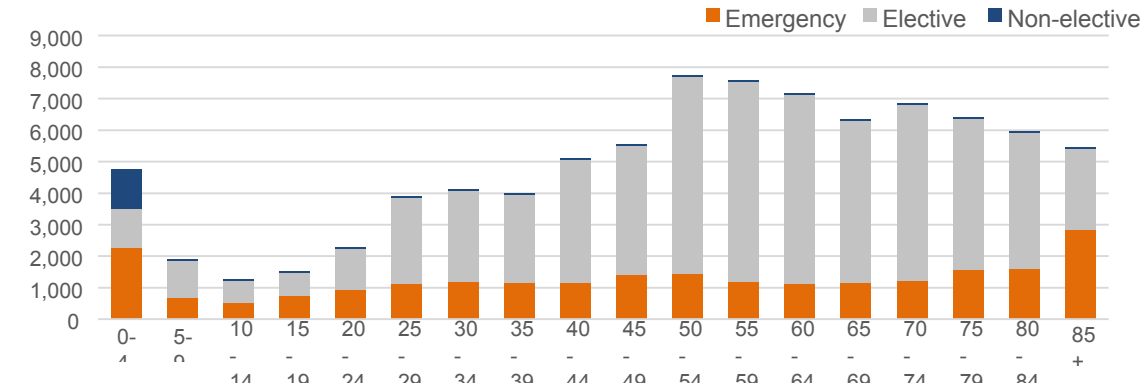
Source: NHS XYZ CCG patient activity data 2013/14

This analysis demonstrates that whilst there are a few major conditions (as shown above), co-morbidities and secondary conditions are widespread, particularly among the older population. As a result, proposals to develop an integrated care system will need to accommodate this level and variety of co-morbidities, and the services provided will need to be relatively broad in scope.

Activity analysis

In 2013/14, a total of 88,077 inpatient admissions were recorded. Of these 23,334 were emergency admissions, 62,999 were elective admissions and 1,744 were nonelective admissions.

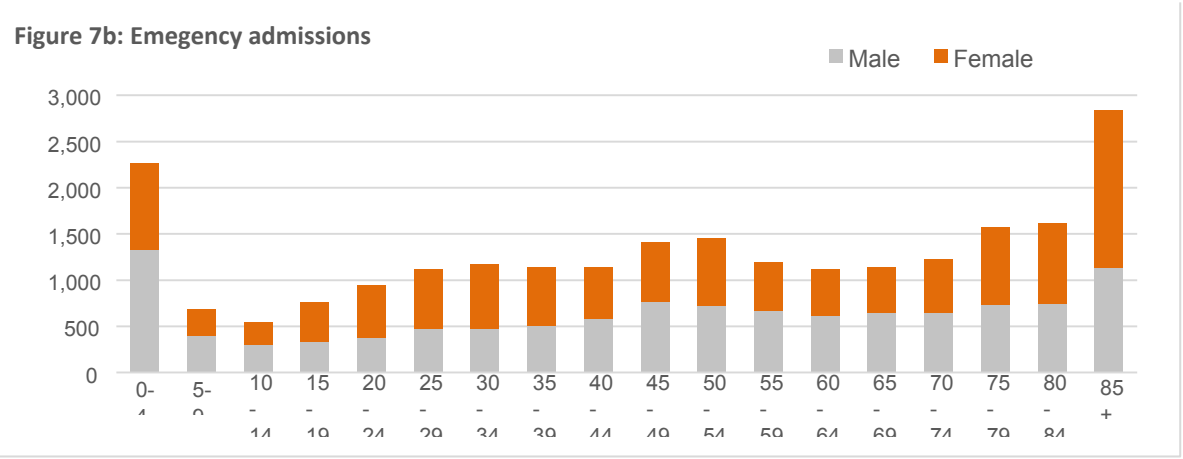
Figure 7a: Inpatient admissions



Source: NHS XYZ CCG patient activity data 2013/14

Patients aged 60 and above contributed to nearly 41% of the total emergency admissions. High numbers of emergency admissions are recorded among 0-4 and 85+ age groups, with these two age groups contributing to nearly 22% of total emergency admissions.

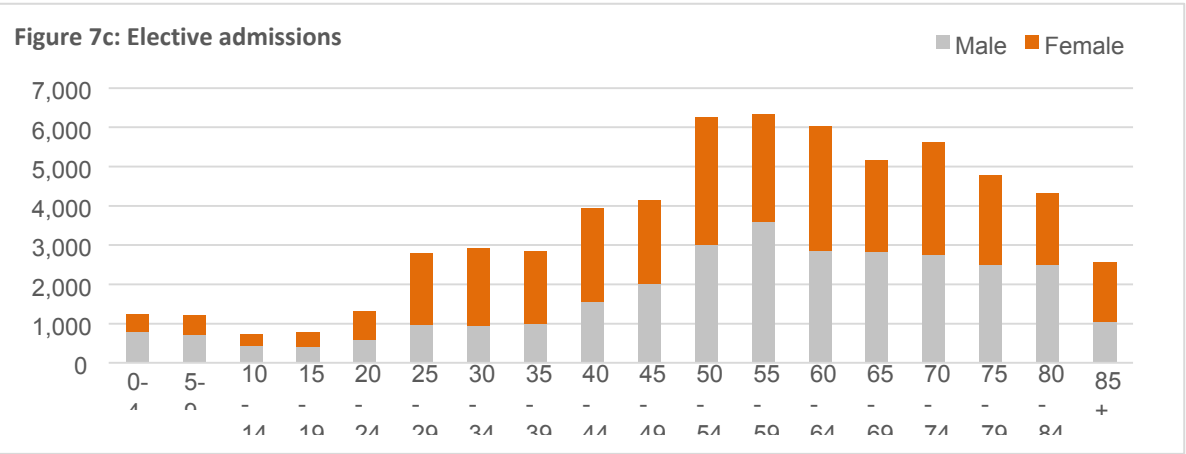
Figure 7b: Emegency admissions



Source: NHS XYZ CCG patient activity data 2013/14

The number of elective admissions (figure 7c) is lower amongst younger age bands. Patients aged 60 and above made up nearly 45% of the total elective admissions.

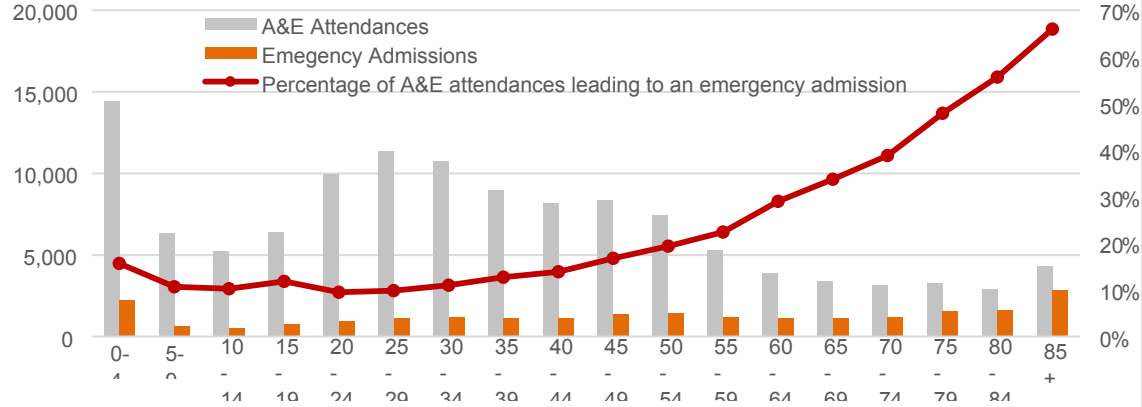
Figure 7c: Elective admissions



Source: NHS XYZ CCG patient activity data 2013/14

The chart below (figure 7d) shows the A&E attendances and emergency admissions by age bands. A&E attendances are higher among younger age bands. 52% of A&E attendances were recorded by patients aged under 30, which is significantly large compared to 17% by patients aged over 60s. The figure illustrates that the rate of emergency admissions increases with age.

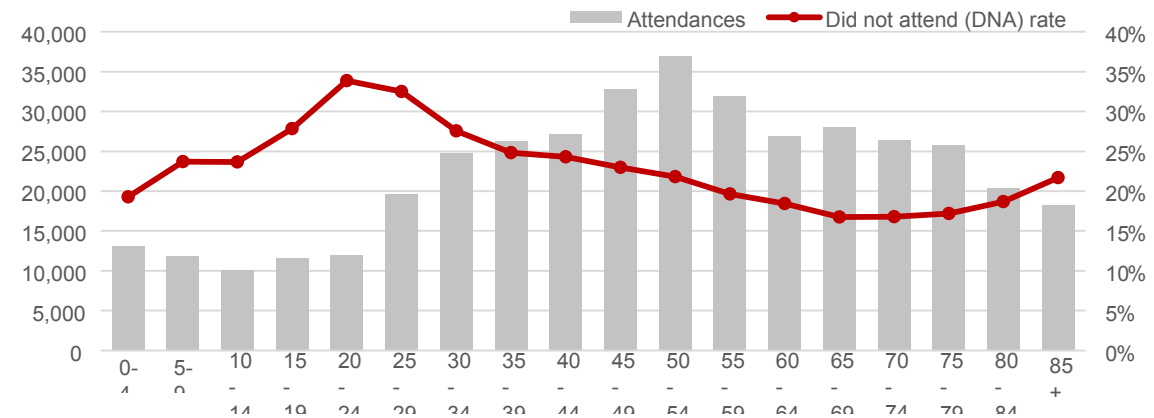
Figure 7d: A&E Attendances and Emegency Admissions



Source: NHS XYZ CCG patient activity data 2013/14

Figure 7e shows the outpatient appointments and DNA (did not attend) rate by age band. In 2013/14, 406,344 outpatient appointments were recorded with the average of 3 appointments per patient (figure 7. For patients aged 60 and above, the average number of appointments per patient is 5.4. The overall DNA (did not attend) rate is 22%, which equates to 90,067 lost appointments. The DNA rate is higher among younger patients. For patients aged under 30, the DNA rate is 27% which is relatively high when compared to 18% for patients aged 60 and above.

Figure 7e: Outpatient appointments

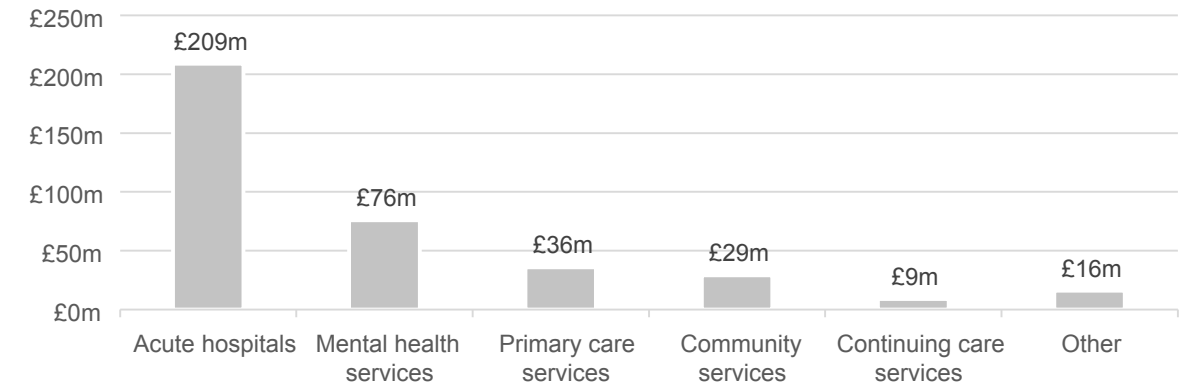


Source: NHS XYZ CCG patient activity data 2013/14

Cost of acute hospitals

NHS XYZ CCG was allocated £375 million for the financial year 2013/14. Acute hospitals consumed 56% of this total allocation. Therefore, the bulk of any potential efficiency savings is likely to be generated through moving activities out of the acute system into the community.

Figure 8a: XYZ CCG 2013/14 spend breakdown



Source: NHS XYZ CCG Annual Summary Report 2014

Inpatient, Accident and Emergency and Outpatient services paid for by tariff consumed almost £163 million (figure 8b), which is 80% of the total acute hospital spend. The breakdown of other costs (£47 million) of acute hospital spend is shown in figure 8c.

Figure 8b: Acute hospitals cost

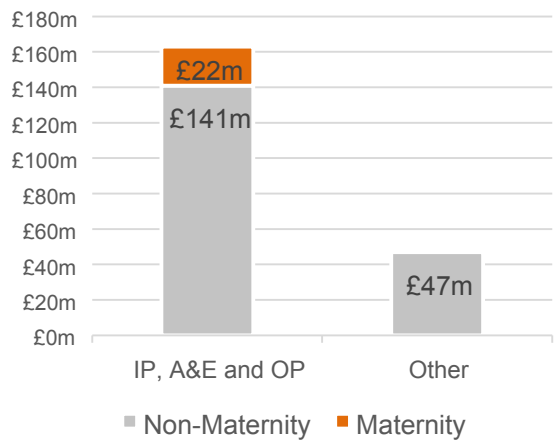
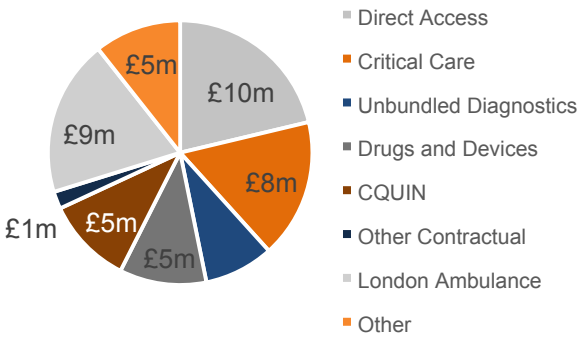


Figure 8c: Other cost breakdown

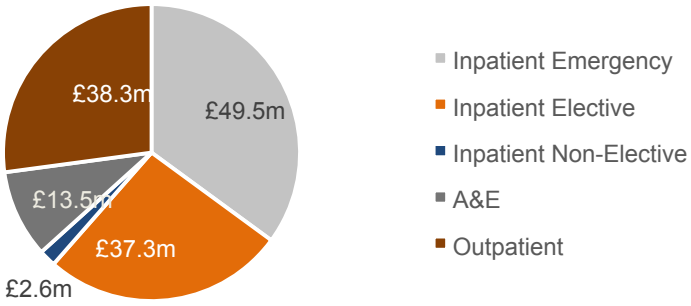


Source: NHS XYZ CCG patient activity data 2013/14

Inpatient, A&E and outpatient spend analysis

As shown in figure 9a, inpatient admissions (emergency, elective and non-elective) consumed 63% of the total acute hospital spend. Whereas outpatient and A&E consumed 27% and 10% of the total acute hospital spend, respectively.

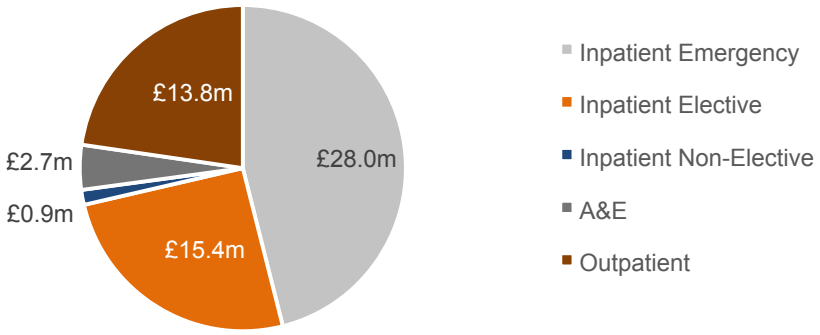
Figure 9a: Inpatient, A&E and Outpatient spend (all age groups)



Source: NHS XYZ CCG patient activity data 2013/14

Out of the total spend on patients aged 60 and above (figure 9c), nearly 73% was accounted for by inpatient admissions (emergency, elective and non-elective). Outpatient and A&E services were responsible for 22.6% and 4.4% respectively. This suggests that by developing an integrated care system and reimbursement mechanism that incentivises service delivery away from inpatient acute admissions could have a significant impact on the workload of the acute trust, and on the expenditure of the CCG.

Figure 9c: Inpatient, A&E and Outpatient spend (population aged 60 and above)



Source: NHS XYZ CCG patient activity data 2013/14

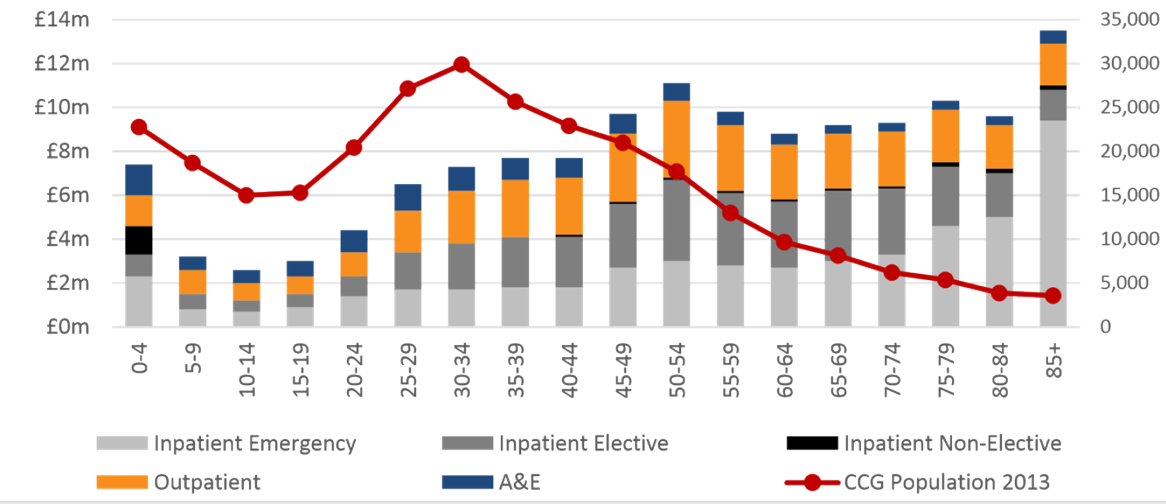
Specific conclusions that can be drawn from the analysis of spend at this stage are limited (e.g. what services should be involved, and how should the

reimbursement mechanism be designed) and will require further finance and activity modelling.

Spend by activity & age band

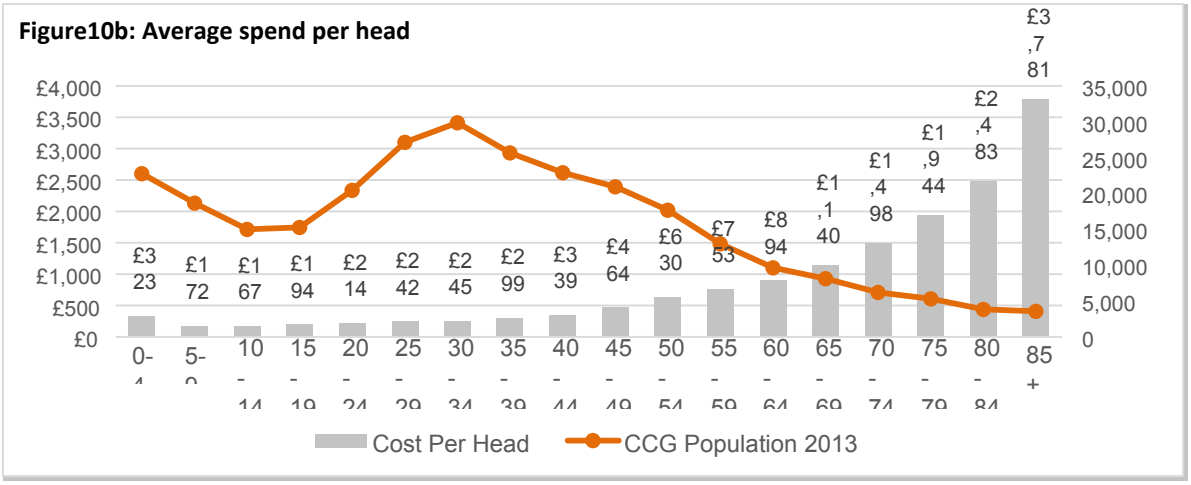
Health care costs increases with patients' age. The increase is driven mostly by an increased use of emergency admissions. As shown in the below chart, the average cost per head significantly rises over the age of 60. In particular, a steep increase in emergency admissions cost is observed for 75 to 85+ age groups, and it increases almost by 90% for 85+ age group.

Figure 10a: Total spend by age band



Source: NHS XYZ CCG patient activity data 2013/14

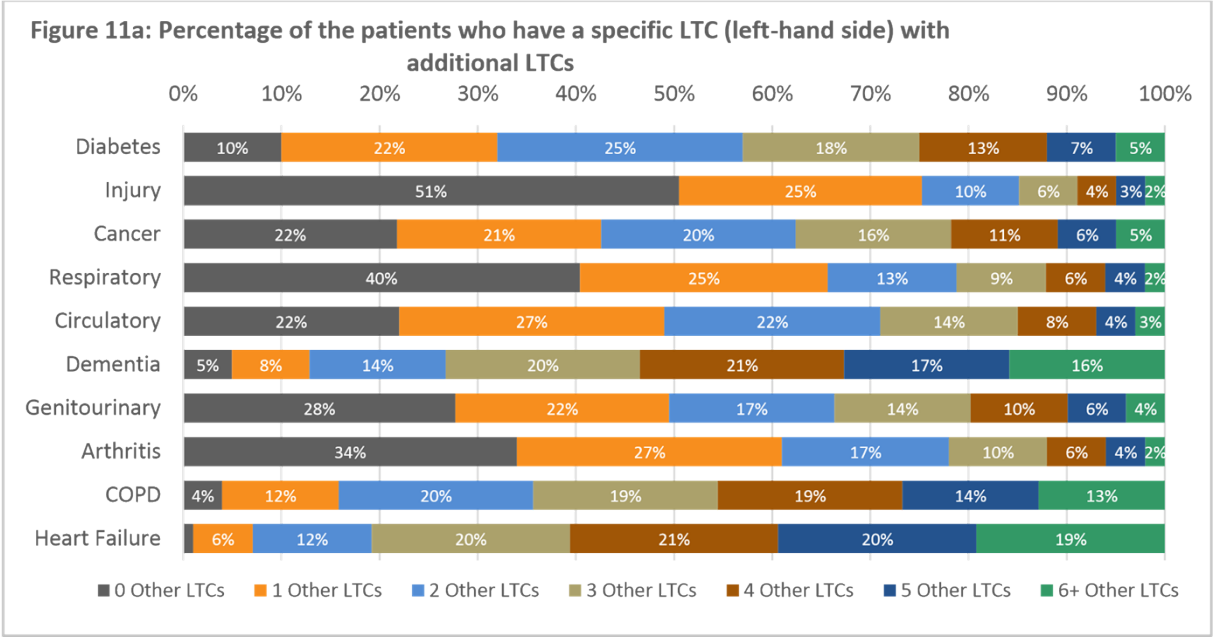
Figure10b: Average spend per head



Source: NHS XYZ CCG patient activity data 2013/14

Comorbidity (all age groups)

Over 99% of people with heart failure have one or more additional LTCs and nearly 40% of people with heart failure have five or more additional LTCs. Among the patients with chronic obstructive pulmonary disease (COPD), 96% have one or more additional LTC and 27% have five or more additional LTCs. Comorbidity is also high among patients with dementia. 95% of patients with dementia, have at least one additional LTC and 33% have at least five additional LTCs.



Source: NHS XYZ CCG patient activity data 2013/14

The pattern of comorbidities varies by long term condition. Figure 11b shows the number of patients with each LTC on the left-hand side. The percentage values show the proportion of these patients that also have the condition identified in the columns. Of the patients who have heart failure, 97% of them also have circulatory conditions and 68% have respiratory conditions. Among the patients with dementia, 51% also have a respiratory condition and 82% have a circulatory condition.

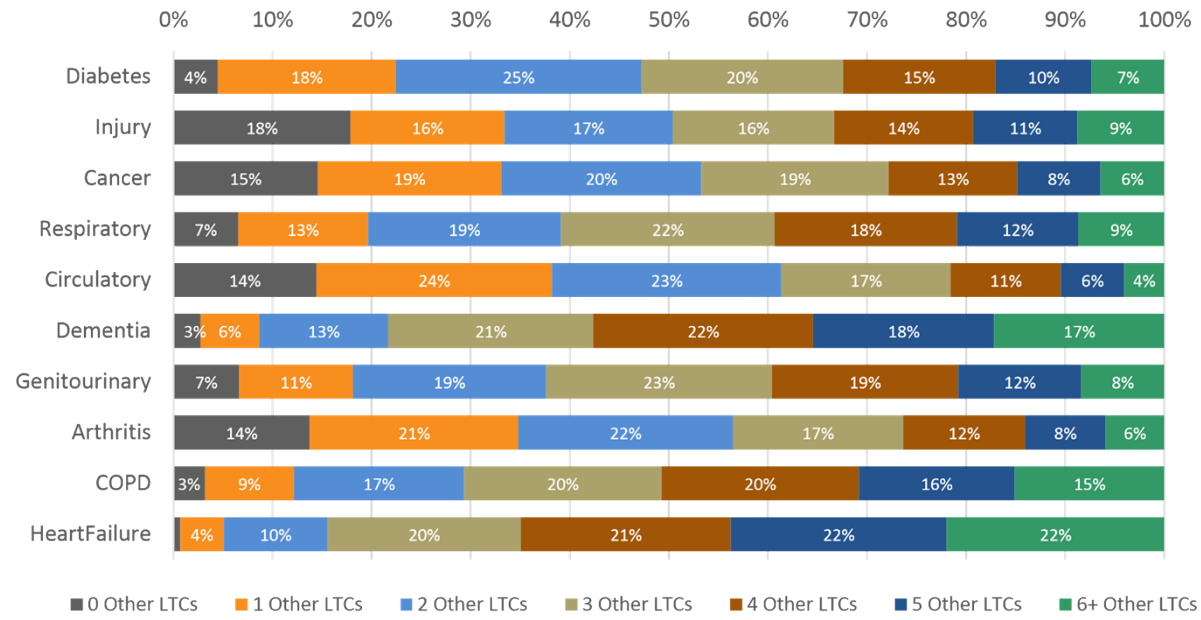
Figure 11b: Percentage of patients with a specific LTC (left-hand side) with additional specific LTCs

Source: NHS XYZ CCG patient activity data 2013/14

Comorbidity (patients aged 60 and above)

Figure 12a shows comorbidity among patients aged 60s and above. Among patients aged 60 and above, 99.5% of the patients with heart failure have one or more other LTC and nearly 43% of patients with heart failure have five or more other LTCs. Among the patients with chronic obstructive pulmonary disease (COPD), 98% have one or more additional LTC and 32% have five or more additional LTCs. Nearly 95% of patients with dementia have one or more other LTC and nearly 35% of them have five or more LTCs.

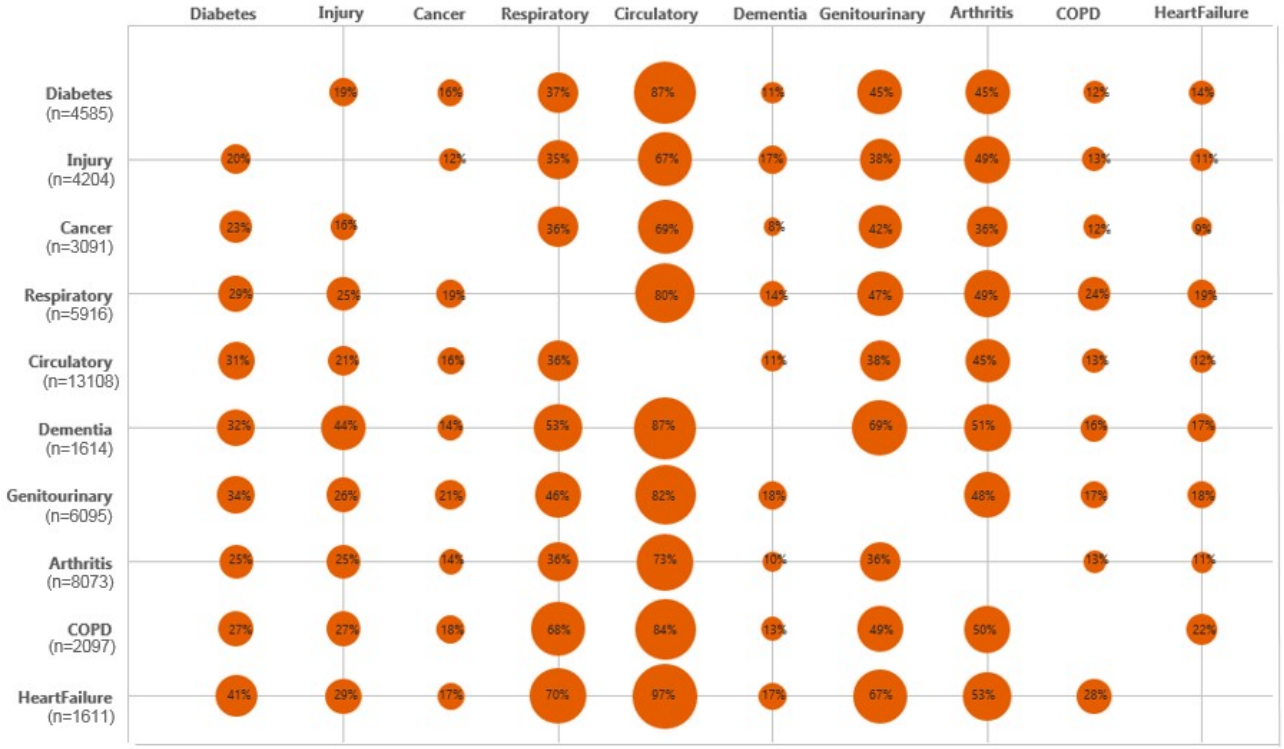
Figure 12a: Percentage of the patients (aged 60 and above) who have a specific LTC (left-hand side) with other LTCs



Source: NHS XYZ CCG patient activity data 2013/14

Figure 12b, shows the number of patients aged 60 and above with each LTC on the left-hand side, and the proportion of these patients that also have the condition identified in the columns. Of the patients who have heart failure, 97% of them also have circulatory conditions and 70% have respiratory conditions. Among the patients with dementia, 53% also have a respiratory condition and 87% have a circulatory condition.

Figure 12b: Percentage of patients (aged 60 and above) with a specific LTC (left-hand side) with additional specific LTCs



Source: NHS XYZ CCG patient activity data 2013/14

Multi-morbidity and the cost of healthcare (all age groups)

The cost of healthcare increases with multi-morbidity. Figure 13a, shows the number of patients and total spend by numbers of long term conditions. Patients with 5 and 6+ LTCs amounts to 2% of the total patients, but consumes 18% of the total acute hospital spend.

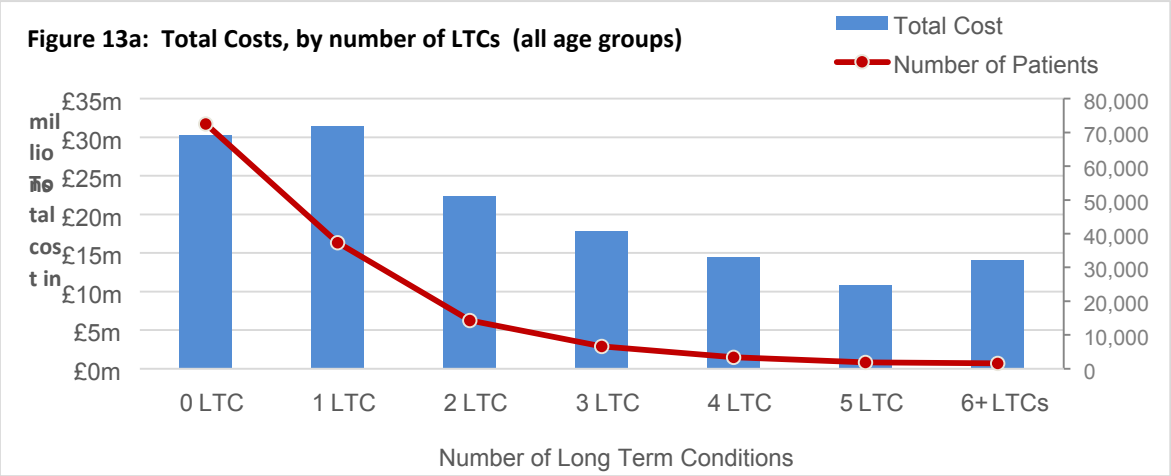
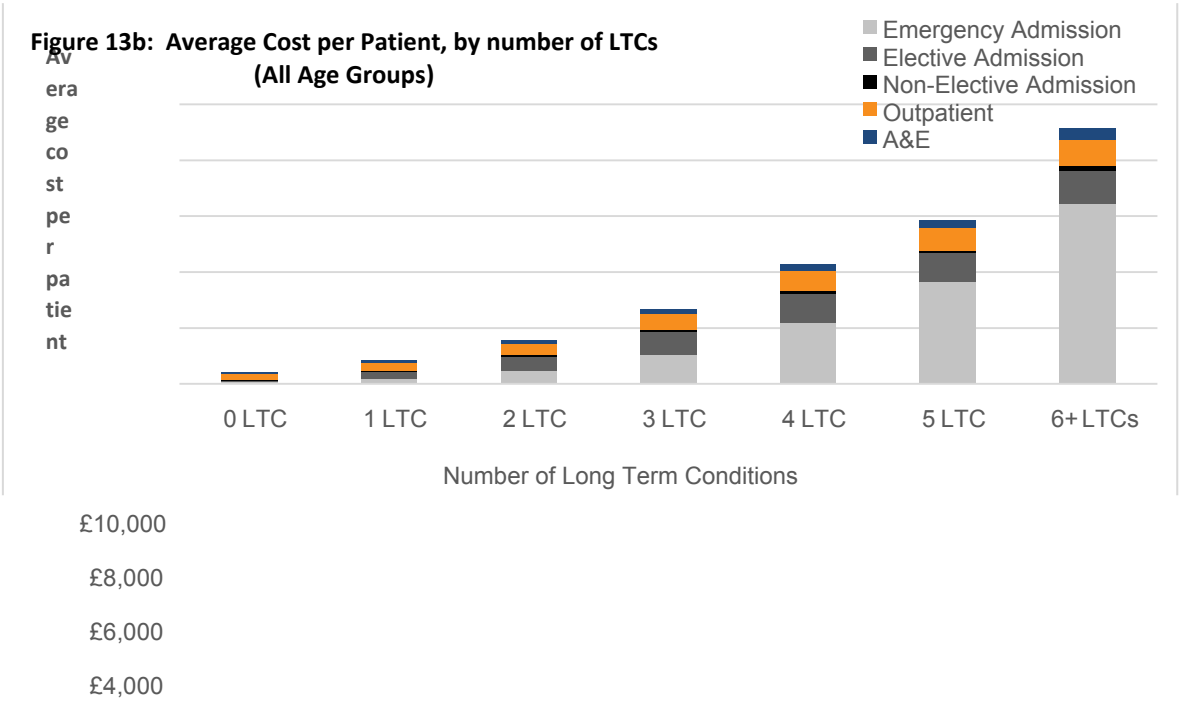


Figure 13b shows the average cost per patient by number of LTCs. The average cost per patient with one LTC is £842, whereas the average cost per patient with six and above LTCs is approximately £9,162. The increased health care costs for patients with greater multi-morbidity is driven mostly by emergency admissions. The increase in cost with multi-morbidity is exponential. With each additional LTC, the average cost per patient increases by 160%.



£2,000

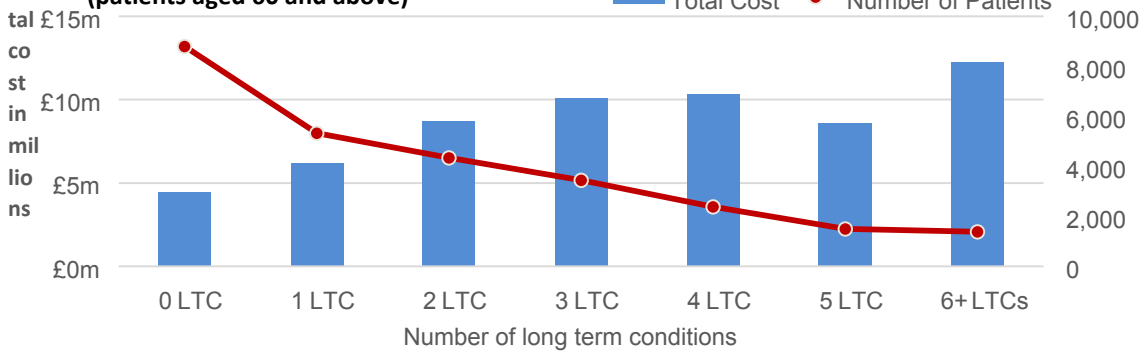
£0

Source: NHS XYZ CCG patient activity data 2013/14

Multi-morbidity and the cost of healthcare (patients aged 60 and above)

The prevalence of multi-morbidity increases with age and thus, there is an increase in the healthcare costs. Figure 14a shows the prevalence of multi-morbidity among patients aged 60 and above, and 5% of the patients aged 60 and above have six or more LTCs and consume 20% of the total spend on patients aged 60 and above.

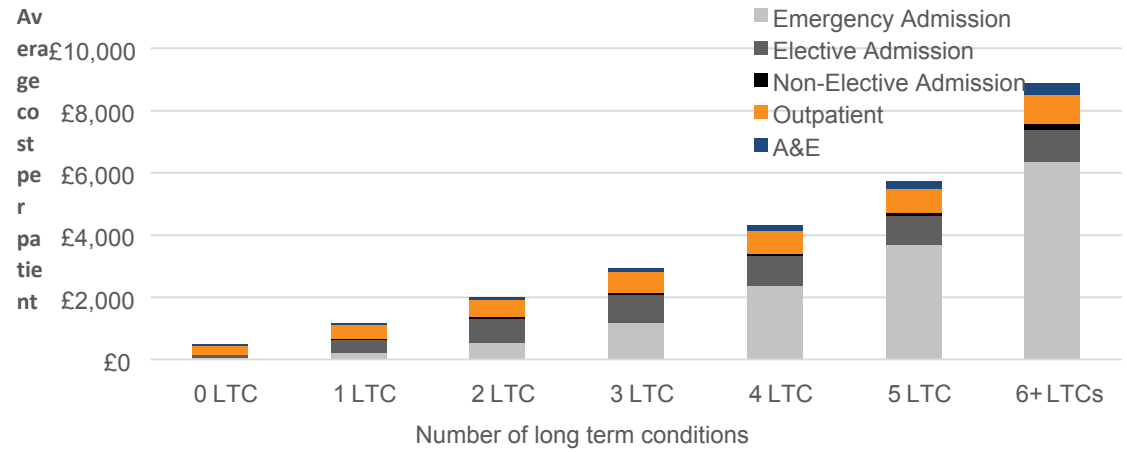
Figure 14a: Total Costs, by number of LTCs (patients aged 60 and above)



Source: NHS XYZ CCG patient activity data 2013/14

Figure 14b shows the average cost per patient for patients aged 60 and above by number of LTCs. Among patients aged 60 and above, the average cost per patient with one LTC is £1,165 and the average cost per patient with six and above LTCs is approximately £8,887. With each additional LTC, the average cost per patient increases by 150%.

Figure 14b: Average cost per patient (aged 60 and above), by number of LTCs



Source: NHS XYZ CCG patient activity data 2013/14

The general message associated with multi-morbidity is that certain co-morbidities are associated with greater levels of co-morbidities, e.g. circulatory diseases. In addition, as would be expected, the costs associated with treating people with higher levels of co-morbidity increases exponentially, and although the numbers of people with five or six LTCs is relatively low, the average cost of treating these patients is high. Therefore, it reinforces the point that an integrated care system, even if it is targeted (in the first instance) and patients with a specific set of condition(s), the nature of health and social care delivery is likely to need to be relatively comprehensive if it is to have an impact on the nature of service provision, the quality of care received by the patients and the overall cost to the CCG.

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Appendix B

Draft Neighbourhood/ Out of Hospital Governance Structure