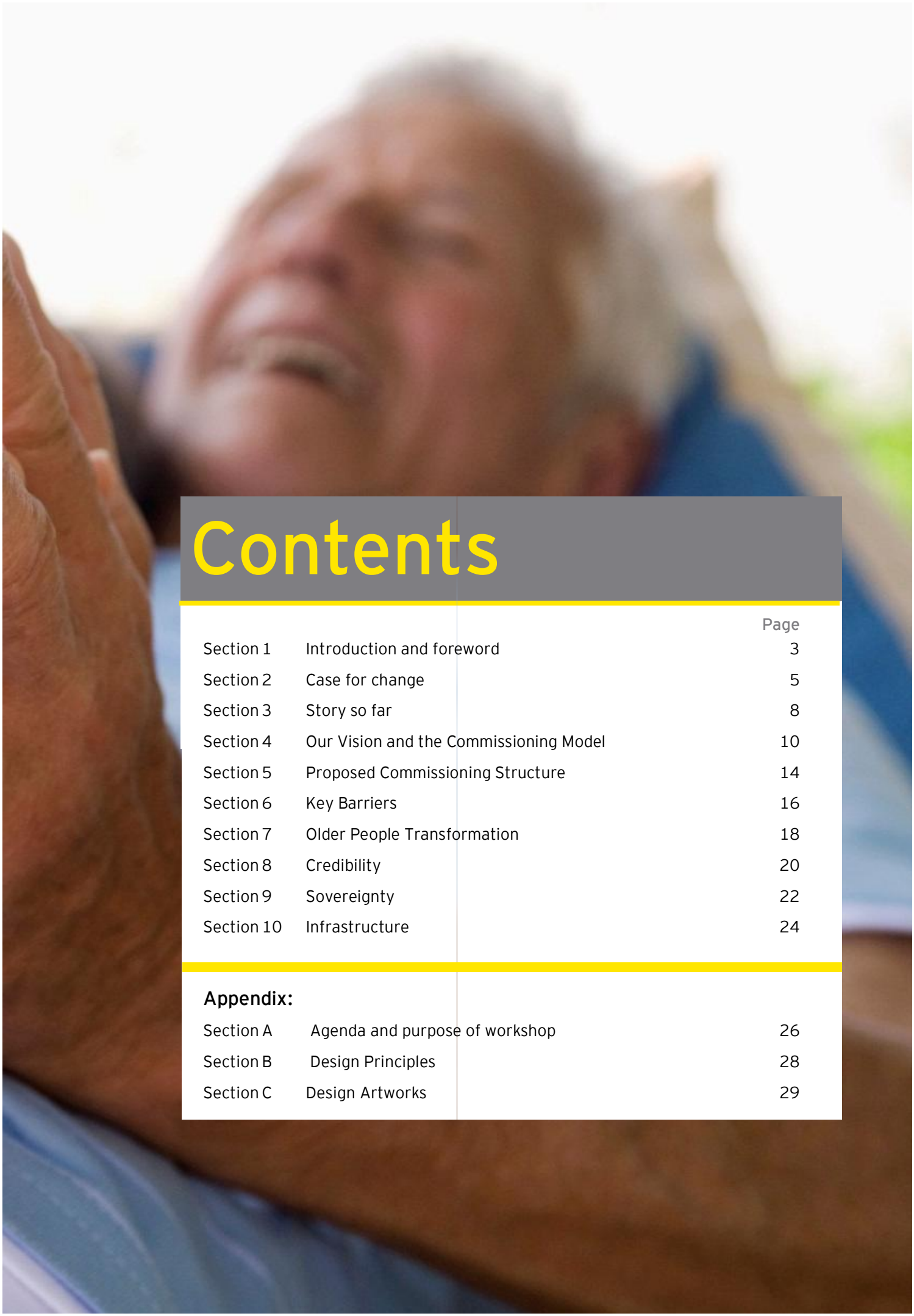
Health and Social Care Integration Workshop

18/19th June 2013

Building a better working world

NHS

Essex County Council



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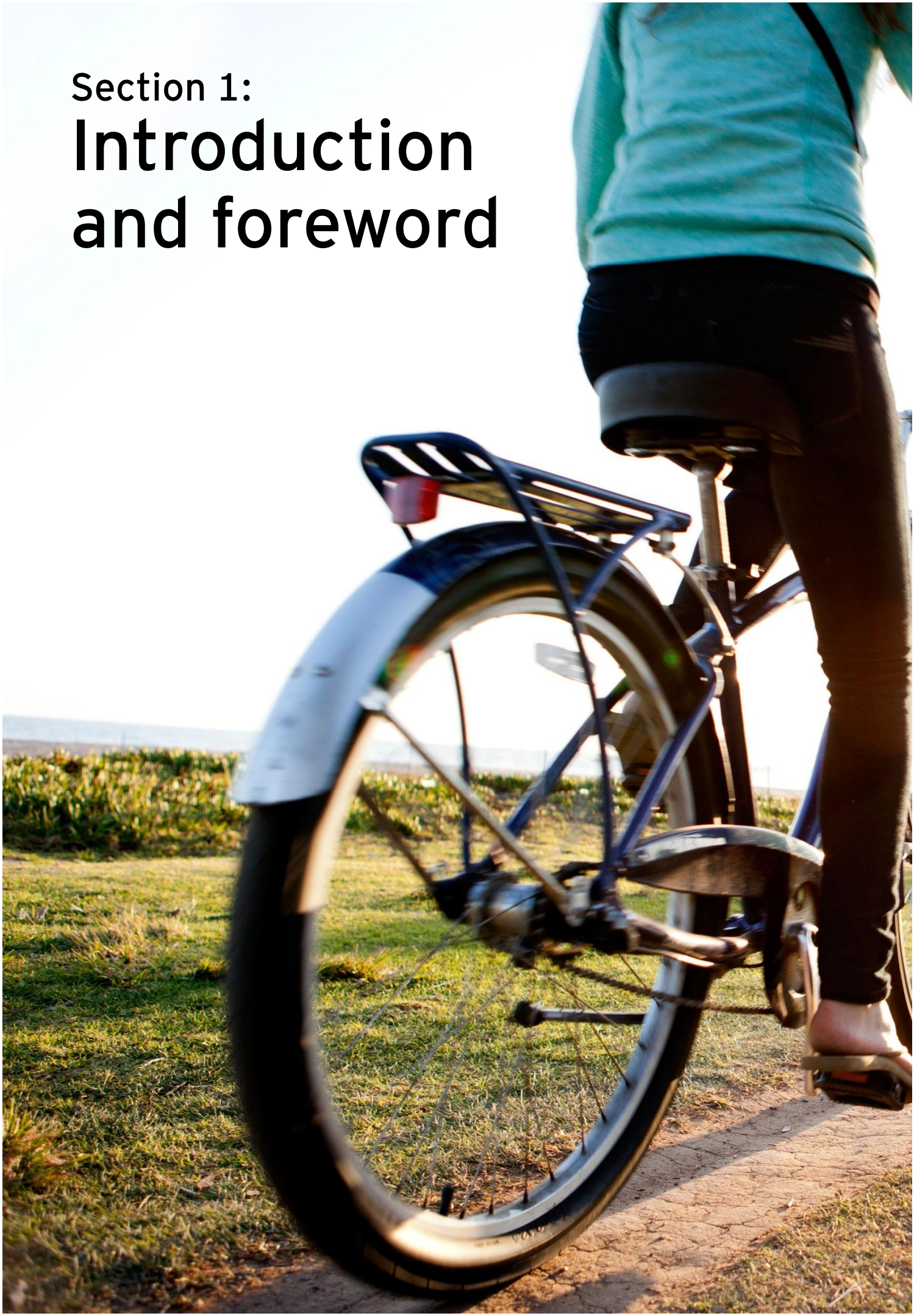
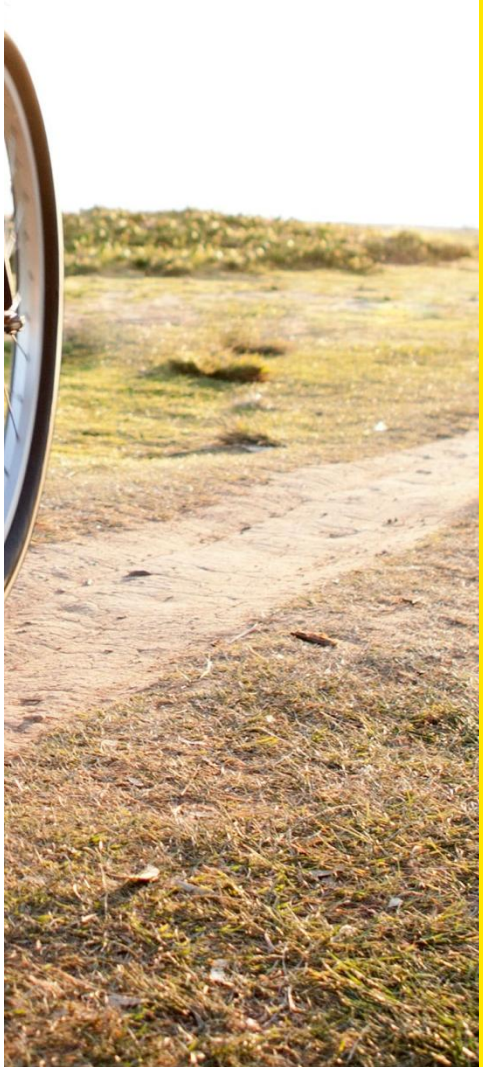
Introduction and foreword





Introduction to the Health and Social Care integration workshop

Introduction

Delivering our ambition for the integration of health and social care services will improve the quality of life for the people of Essex. This is ultimately the reason that you spend your time working hard to improve services and achieve better outcomes on a day to day basis. The challenge facing Essex County Council and the Essex CCGs is great – the coming years will involve more people needing services, greater public scrutiny over the quality of services, and less resources. Integration offers the opportunity to address this challenge.

To continue the good work we all do everyday, to improve the lives of the people of Essex won't be easy. We have a history of re-organising public services locally and have attempted this many times before. The size and scale of Essex, the complexity of the landscape, the multiple tiers and geographies, not to mention the local complexities around population needs make this a daunting challenge. A geography like Essex has never seen integration in the whole of the history of the NHS and modern welfare state. However, the opportunity presents itself like never before: we can't afford to fail because failing will impact those we profess to serve. If we succeed we will be a shining star in the UK public sector.

Our 2 day workshop

Our two day event was a unique opportunity to take control of our destinies and shape the future of services in Essex! Thank you all for coming and engaging, challenging and discussing. We had an agenda which has enabled us to work with some highly experienced, talented and enthusiastic individuals in the health and social care space in Essex and develop relationships with your counterparts at the CCGs/Council. Like most of you, I found the workshop inspiring, connecting and enjoyable.

What we need from you

We have made good progress to date. We have good intentions, an increasingly strong partnership and robust plans. What we now need is to build upon this momentum and ensure serious organisational commitment at all levels are in place, which translates to driving integration through.

At the two day event, we agreed a number of things that are outlined in this document:

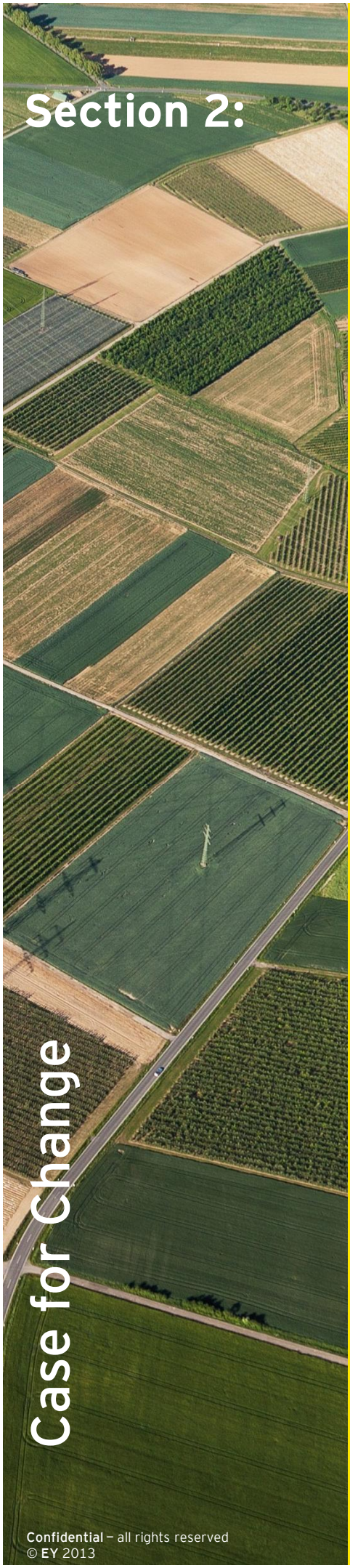
- Our vision for service users and for commissioning
- Our collective ambition for commissioning
- How we want to work together
- Identified priority areas for service redesign and developed plans around them
- Identified key barriers and strategies for overcoming

We also committed to:

- Mobilising this action plan by the 28 June
- A follow up 1 day event in autumn

The key test for all of us is how we translate the rich discussion and agreement into action. I hope you will join us in driving this forward.

Dave Hill Clare Morris Shane Gordon



Case for Change

The Challenge

- Delivering our ambition for the integration of health and social care services will improve the quality of lives of the people of Essex.
- Essex County Council and Essex CCGs have the collective ambition to improve the quality of the services we deliver.
- However, the challenge is great – the coming years will involve more people needing services, more complex needs and greater public scrutiny over the quality of services, and less resources. Integration offers the opportunity to address this challenge.

National context

- Nationally, regionally and locally, services focused on Adults and Children across Local Authorities and Health Authorities are going through a significant transition.
- Current legislation across all these services is increasing the push for a system wide perspective, recognising the need for services to be designed around patients and service users rather than from the point of separate organisations.
- The Health and Social Care bill radically changed the operating model for the NHS bringing clinicians to the heart of commissioning and expanding the obligations for local and health authorities to commission and provide services in an integrated way.
- This significant change to the way services are commissioned explicitly aims at taking a patient centred perspective which will result in system wide reform.
- In this context ECC and Essex CCGs have seized the opportunity created by sector wide reform. The local public service landscape in the Greater Essex area is complex with a County Council, two unitary authorities and seven CCGs.
- The existing way of delivering services has achieved a significant amount but cannot continue within the limited financial envelope available especially in the context of the complex needs of the local population resulting in increased demand.

Case for Change (cont'd)

Local Context

- The population of Essex is close to 1.74million. The older population is expected to grow to 28% by 2033, with a 5% reduction in the working age group. Currently 12.4% of the population are from ethnic backgrounds.
- The County holds some of the most affluent and some of the most deprived areas in the country, with further pockets of disadvantaged communities that are hard to identify.
- The number of young people in Essex not in education, employment or training (NEET) is higher than national and regional averages.
- The prevalence of dementia, which increases rapidly with age, is projected to increase by 38% by 2021 which we expect will have a significant impact on public services.
- The prevalence of diabetes is likely to rise over coming years, especially with poor lifestyle choices
- The mortality and morbidity rates for conditions related to liver disease are increasing, especially among younger people, primarily due to the excessive consumption of alcohol.
- To continue the good work conducted everyday and improve the lives of the people of Essex with these constraints integration is the only option available.
- In this context ECC and Essex CCGs have seized the opportunity created by sector wide reform. The local public service landscape is complex with a County Council, two unitary authorities and five CCGs.
- To continue to provide quality services which achieve the outcomes both want to achieve, they have taken the bold step to explore a more developed commissioning partnership which will ultimately reshape the delivery of services aiming to make the most of the limited resources available.

Health and Social Care services in Essex collectively spend around £3.1bn

All services are facing demand pressure, increased public scrutiny over service quality and reductions in funding. These pressures make the provision of health and social care services unsustainable in their current form.

Essex County Council has a budget of £969m in total for 2013/14. There are five CCGs in Essex. For 2013/14 North East Essex has a budget of £368m, Mid Essex also £368m, West Essex £310m, Basildon and Brentwood £292m and Castlepoint and Rochford £192m.

Essex County Council

"The projected gap between available budget and demand for ECC services is forecast to be £200m by 2016/17"

- Increased demand particularly in the Adults, Health and Wellbeing service area represents close to half of ECC's controllable budget.
- Overall ECC will shrink from being a £930m organisation in 2012/13 to an £850m organisation by 2016/17 (excluding new responsibilities in Public Health and the Learning Disability Grant).
- This shift will occur after Essex has already reduced expenditure significantly. Over the last 4 years Essex County Council has embarked on an ambitious transformation programme and achieved savings of £300m by 2013. This is one of the largest savings targets of any local authority in the country.
- If Essex CC is to continue to provide quality services and achieve the desired outcomes for its residents and particularly its vulnerable people a radical shift in the commissioning operating model is required.

Essex Health Services

"Essex CCGs are faced with a collective funding gap of £354m in years 2013-2017"

- The NHS in Essex face comparable cost pressures and similar growth in demand for services.
- While not losing cash in the same way as the County Council (due to variation in central government reductions) the NHS in Essex faces unprecedented efficiency demands which equate to on average a 5.5% reduction.
- In 2013/14 alone the Clinical Commissioning Groups' QIPP challenges require savings of c£84m to meet growing demand and cost pressures.
- The NHS and the County Council both face significant financial and demographic challenges which, if not addressed in partnership, create the risk of even greater fragmentation of service quality.

Section 3:

The story so far

Summary story so far

Public service reform is not new to Essex. There have been numerous attempts at moving towards integrated services which have made significant progress but never managed to achieve the level of success we all know Essex is capable of. This latest wave of change has to be different. We have already made some significant progress:

The Whole Community Budgets pilot achieved a high level vision and approach

> *"Community Budgets are not about any one local public service provider having a monopoly on power and resources, but about how partners come together to jointly transform local public services."*
>
> **Community Budgets Prospectus 2011**

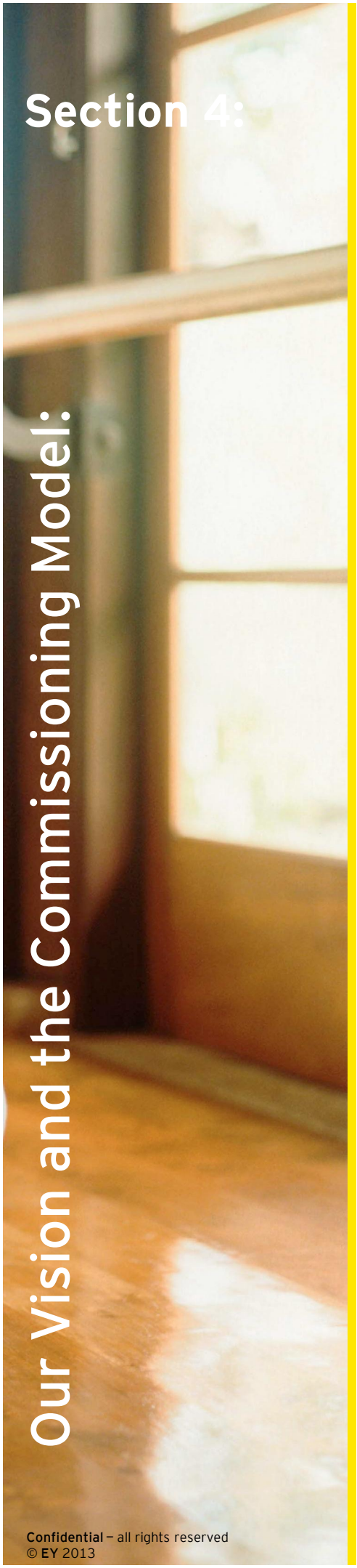
The integrated commissioning plans are a practical basis for taking forward the vision and the CCGs and Council have created an overarching programme approach to bring together these plans

An outline framework to progress integrated commissioning has been agreed by partners across health and social care. This framework is shaped through five key service areas:

- Older People
- Mental Health services
- Learning Disabilities
- Children's services
- Public Health

We have spent time engaging you as stakeholders which has involved building mutual trust, understanding around financial pressure, aligning commissioning cycles and transformation programmes transparency. These developments will form a key part of the programme plan going forward.

In addition, ECC and the CCGs supported by the HWB have submitted an application to the Department of Health for pioneer status.



Section 4:

Our Vision and the Commissioning Model:

Our vision

Our vision for patients, service users and the people of Essex is for a system of care which is designed with them at the centre. We agreed on five overarching vision statements for the people who receive care in Essex:

- We commission and deliver integrated care that is person centred
- The care we deliver will be consistent in quality with an appropriate response across the whole of the County
- We are able to predict and prevent needs including proactively identifying long term needs
- Our responses will be delivered in a timely fashion. We should be available 24 hours where appropriate
- We will be fair in delivering care. This means being 'uniform' across our patients and service user groups
- Our care will take account of the wider context of peoples lives including their families, carers and communities

These statements have significant implication for how care is commissioned. On the basis of the above statements, we identified five statements on our vision for commissioning:

- We will practice outcomes based commissioning on the basis of robust evidence and strong analysis, identifying clear triggers for interventions
- We will have a commissioning strategy for the whole of Essex which aims to provide care that is sustainable over the long term
- We will consistently engage with providers to manage markets and aim to reduce the number of providers responsible for delivering the pathway(s)
- We will align budgets and finances to where they can have the most impact, integrating resources where necessary
- We will incentivise provider behaviour which aligns to our overall strategy

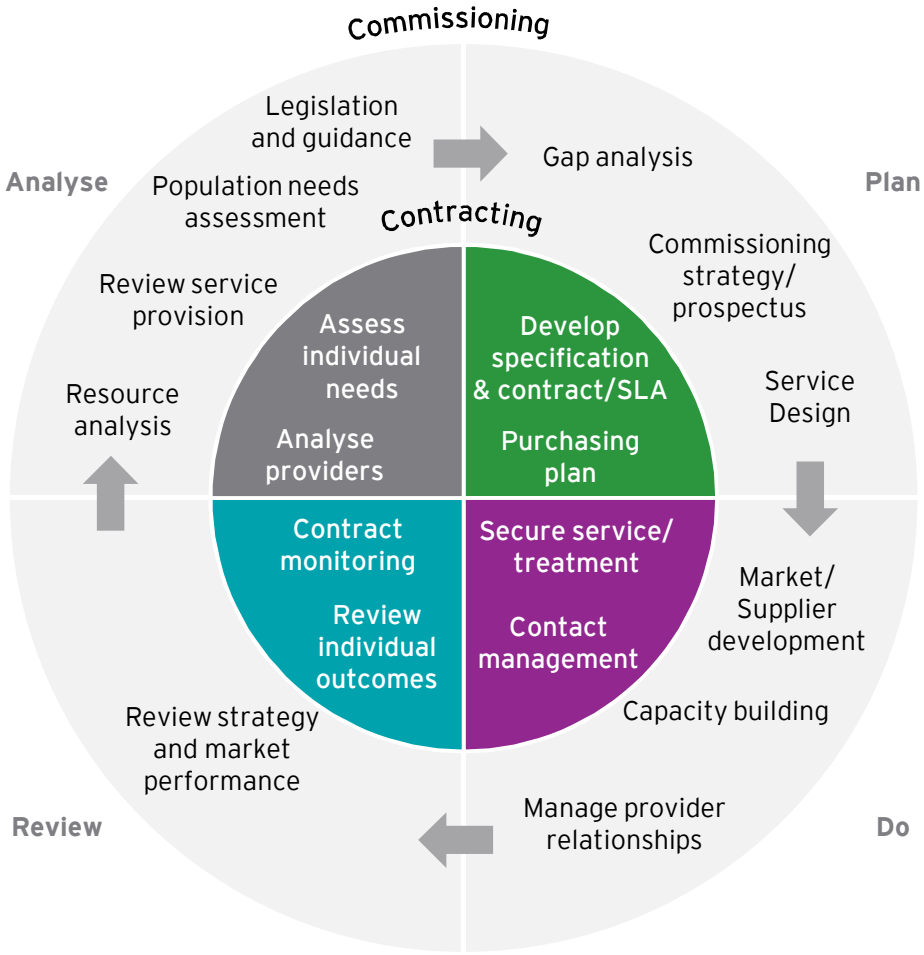
We also agreed on a set of design principles which will be applied through the service redesign to achieve the vision. These are listed in Appendix A.

One of the core objectives of the two day event was to redefine the way in which stakeholders from different organisations behaved towards each other and worked together. We agreed a list of behavioural values which they committed to living in their interactions with each other. These are:

- Trusted
- Honest
- Collaborative
- Pragmatic
- Disruptive

What is commissioning?

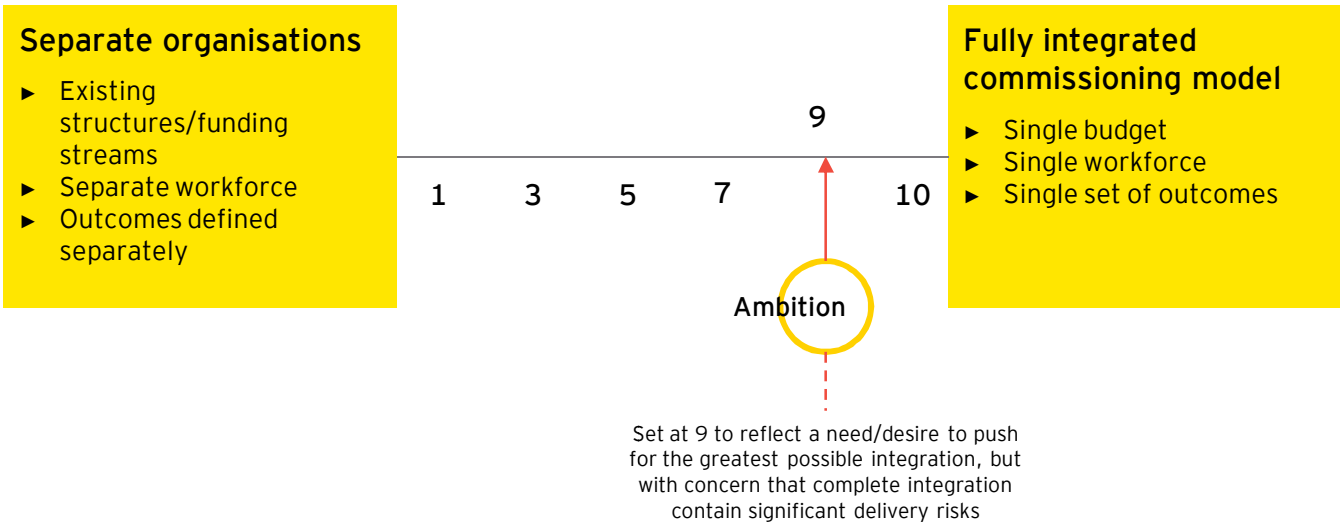
The integrated commissioning cycle for Essex CC relates to the achievement of service outcomes at the strategic or aggregated level. Integrated commissioning in our definition does not relate to the micro-commissioning of individual care packages. The Essex commissioning cycle is shown below.



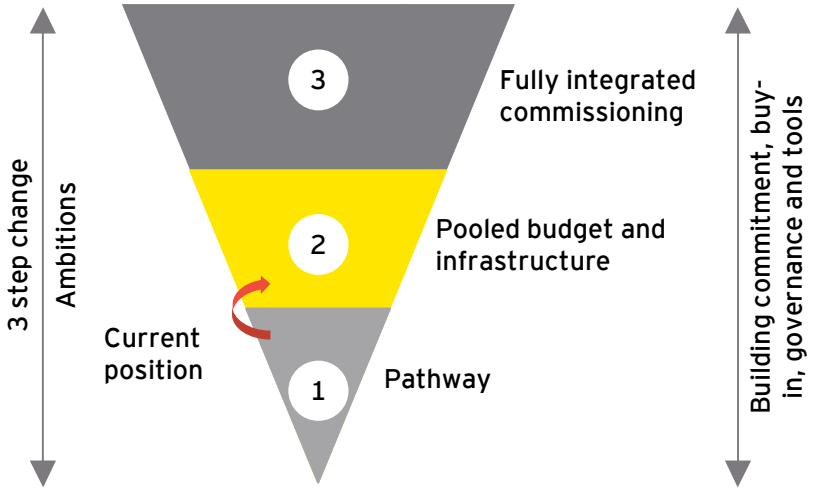
The commissioning model

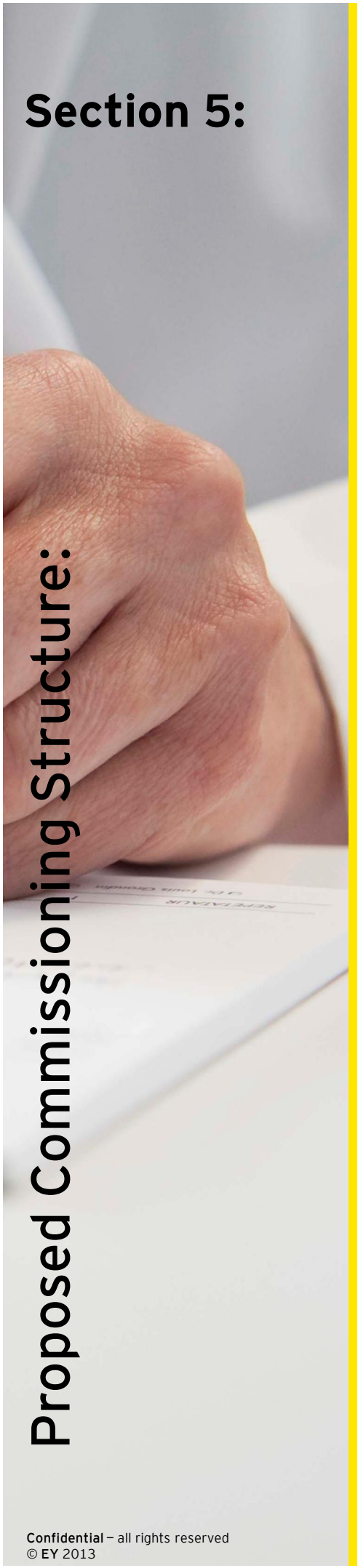
During the course of the event, we described our ambition for the Essex commissioning model. The group were presented with a spectrum ranging from, at one end, separate organisations with separate funding, structures, workforce and outcomes to a fully integrated model with single funding structures, workforce and outcomes.

We rated our ambition from 1 to 10 as shown in the diagram below. The results show the average ambition across stakeholders.



We further developed our thinking in the phasing for realisation of this vision. The model below shows a 3 phase approach for integrating the commissioning model. We recognised that progress towards integration is currently between phases 1 and 2 and further progress requires development of integrated funding processes and infrastructure.





Section 5:

Proposed Commissioning Structure:

Decision Making & Governance

Overview

One of the key areas of focus for the group was to test the structure of the commissioning programme as a basis for defining the governance of the overall economy. The original commissioning structure is included below.

Service	System Level (at which commissioning will take place)	Lead Commissioner/ Commissioning Coordination
Older People	► CCG level ► Essex for CHC	► CCG or ECC (to be agreed) ► Lead CCG or ECC (to be agreed)
Mental Health	► South Essex Cluster ► North Essex Cluster	► CP&RCCG ► NEECCG
Learning Disabilities	► North and South Essex Clusters to start ► Potential move to Essex-wide	► ECC lead commissioner with WECCG as Coordinating Commissioner in the North Cluster. ► ECC lead commissioner with CPRCCG as Coordinating Commissioner in the South Cluster (TBC)
Children's services	► Some at local level (e.g., maternity and early years, including children's centres) ► Some Cluster or Essex-wide (e.g., Integrated CAMHS & Behaviour)	► NHS or ECC (to be agreed) ► Note the NHS CB role also in Health Visiting to 2015.
Public Health	► Essex for population health programmes (e.g., Sexual Health) ► CCG for some very specific interventions (e.g., case finding) ► Public Health England for immunisations and screening programmes	► Mostly ECC for Public Health

The above table was presented to small groups and each of the assumptions in the table were tested for agreement against the following questions:

- Where commissioning decisions will be made in the system
- Who will lead on commissioning decisions
- Principles of where commissioning decisions will be governed

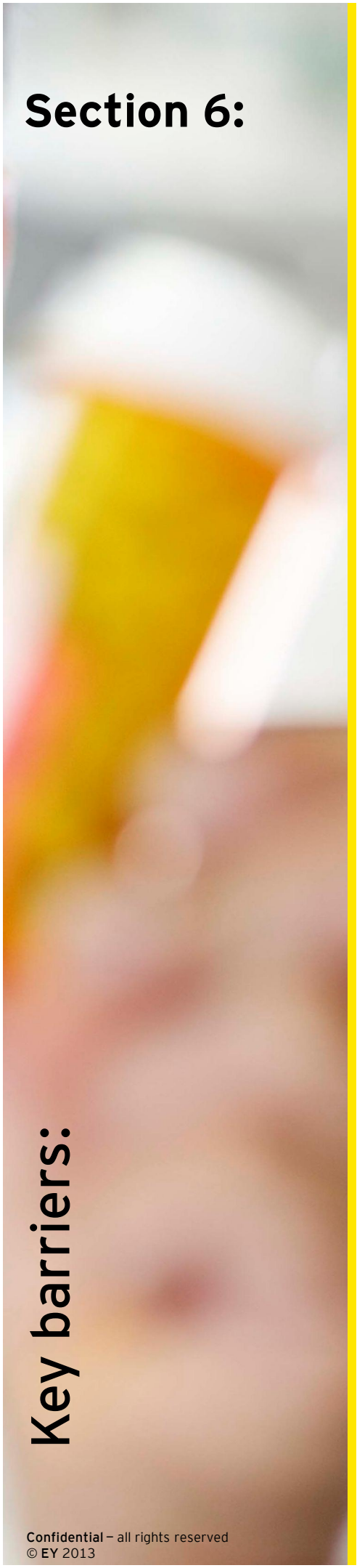
Decision Making & Governance (cont'd)

The table below shows the results of the exercise and demonstrates there is broad agreement around the current commissioning structure. Disagreement, comments or challenges are also included in the table below and will form the basis of the work identified in the section on key barriers.

		Key statements and principles	Approve/Not Approved	Key comments/challenges
Key Statements	1	**Older People (CHC only).** *Decision required if ECC or Lead CCG*	Approved by majority	▸ Risk of not understanding locality and its needs ▸ Need to fully understand the benefits of centralisation ▸ Further work to clarify why this is done as a single service ▸ NHS cannot legally devolve , need to understand challenges of this if LA use a localised approach
	2	**Public Health (PH) – Wider population health.** *Led by: ECC*	Approved by majority	▸ Understand the nuances between PH general commissioning and specific interventions commissioned locally, ▸ PH principles are fragmented ▸ Further work needed on categorisation
	3	**Children's Services – integrated CAHMHS & Behaviour.** *No agreed lead currently*	Not approved by majority	▸ Need s to be part of wider commissioning for children ▸ Need to align with MH & LD services ▸ Solution needs to be a stratification of risk based on wide varying complexities and need
	4	**Mental Health (MH)** ***Led by CPRC CCG/NEE CCG***	Approved by majority	▸ Outcomes need to be established at an Essex level ▸ Currently significant differences on the North approach to the South approach which need to be considered ▸ Local by default and aggregate up? ▸ Cluster approach is interim/medium-term solution , locality is long-term model
	5	**Learning Disabilities (LD)** ***North = ECC Lead & WECCG as co-ordinating South = CPR CCG***	Not approved by majority	▸ High dependency on funding levels ▸ Shared overarching framework (ECC) but has a localised approach, this is to support local needs but to avoid 8 different commissioning models ▸ Understand where the linkage is to children's services
	6	**Older People (exc CHC).** *Led by CCGs*	Approved by majority	▸ Shared overarching framework but local by default ▸ Imperative to ensure alignment with CHC
	7	**Children's Services – including Maternity/Early Years/Children Centres.** *No defined lead currently*	Not approved by majority	▸ Further work needed to define this more clearly ▸ Overarching framework and ECC led but needs to be localised
	8	**Public Health – specific interventions.** *Led by: CCGs*	Approved by majority	▸ Need to clearly define localised specific interventions
Principles	1	**Each 'system' level uses established governance bodies and does not re-create decision making protocols**	Approved by majority	▸ Established bodies need to be more clearly aligned ▸ Determine whether H&W board could play a key governance role ▸ CSU Commission and NHS England could pose a challenge ▸ Need to clearly define the function of each body
	2	**You will create formalised cluster commissioning groups to oversee decisions at this level**	Not approved by majority	▸ What are the inter-relationships with existing structures? ▸ Need to understand where it is necessary to delegate upwards ▸ Impact of specialised roles such as MH
	3	**You will have one overriding integration board to manage the transition to integrated working and co-ordinate the programme**	Approved by majority	▸ Who would sit on this board and how would we include political leadership? ▸ Need to reflect a system wide approach for example; including a dialogue with trusts ▸ Create one with delegated powers and understand any overlaps or duplication

Comments/challenges applicable to all: 2 Unitary authorities need to be reflected/considered in all approaches
Direction of travel should be towards integrated or aligned budgets so that financial mechanism supports approach

Majority approval **Majority not approved, as further work required**



Section 6:

Key barriers:

Overcoming potential challenges

One of our objectives going into the session was that we were keen to identify and overcome any potential barriers to achieving the vision for integrated commissioning. Four sessions were run which aimed to identify the key barriers and the potential solutions to overcoming them.

Key Barriers

Identified barriers were grouped into five overarching themes as shown below:

- **Sovereignty:** Health and Local authority organisations in Essex are independent organisations which have responsibilities and accountabilities that are set out in statute. When aiming to bring together funding and resources to support integration, there are a number of challenges which relate to management of these independent accountabilities to support a strong, Essex wide partnership whilst allowing for the appropriate level of scrutiny and devolved political and strategic autonomy.
- **Credibility:** Health and Local authority organisations in Essex have tried to move forward on integration a number of times in the past and have had mixed success. There are three key groups critical to the success of the integrated commissioning programme which rely on strong credibility that the programme will be delivered. These are:
  - People of Essex, patients and service users: Without the support of this group, decision makers are unable to take the bold decisions necessary to make integrated commissioning a reality
  - Staff: The transition to integrated commissioning must be whole organisation, from top to bottom, front line to back office. Without the support of the commissioning workforce, integrated commissioning is likely to be unsuccessful
  - Providers; Integrated commissioning is ultimately about the quality of care and experience of those who receive it. Without provider belief that integrated commissioning will become a reality and change the commissioning model, the overall vision is likely to be unsuccessful
- **Identifying priority areas and taking action:** there was broad consensus that a significant amount of planning work had been progressed over the past 12-24 months and that the programme needed targeted action to support building of momentum, development of integrated decision making, funding and infrastructure, which would see a step change in the delivery of the programme. Common consensus around priority areas of focus was seen as a significant barrier to success.
- **Infrastructure:** health and social care organisations operate different systems, different structures and have various levels of capacity and capability in multiple locations. This variation creates a significant challenge in providing a consistent integrated offer to the people of Essex, e.g., sharing information to identify a single view of patient need. Two priority areas were identified as presenting particularly large challenges;
  - Information and communications technology and governance
  - Commissioning support

Section 7:

OP Transformation Programme:

Older People Transformation

With an increasing ageing population leading to a rise in demand for services, the provision of health and social care services for the older population in Essex is unsustainable in its current form. The projected imminent gap in supply and demand for these services has highlighted the need for expeditious transformation in their commissioning and delivery and this has been the driver for the creation of an Integrated Transformation Programme for Older People's services.

This session was intended to identify key objectives, key deadlines and milestones, programme of work, key stakeholders and next steps for the implementation of this Programme.

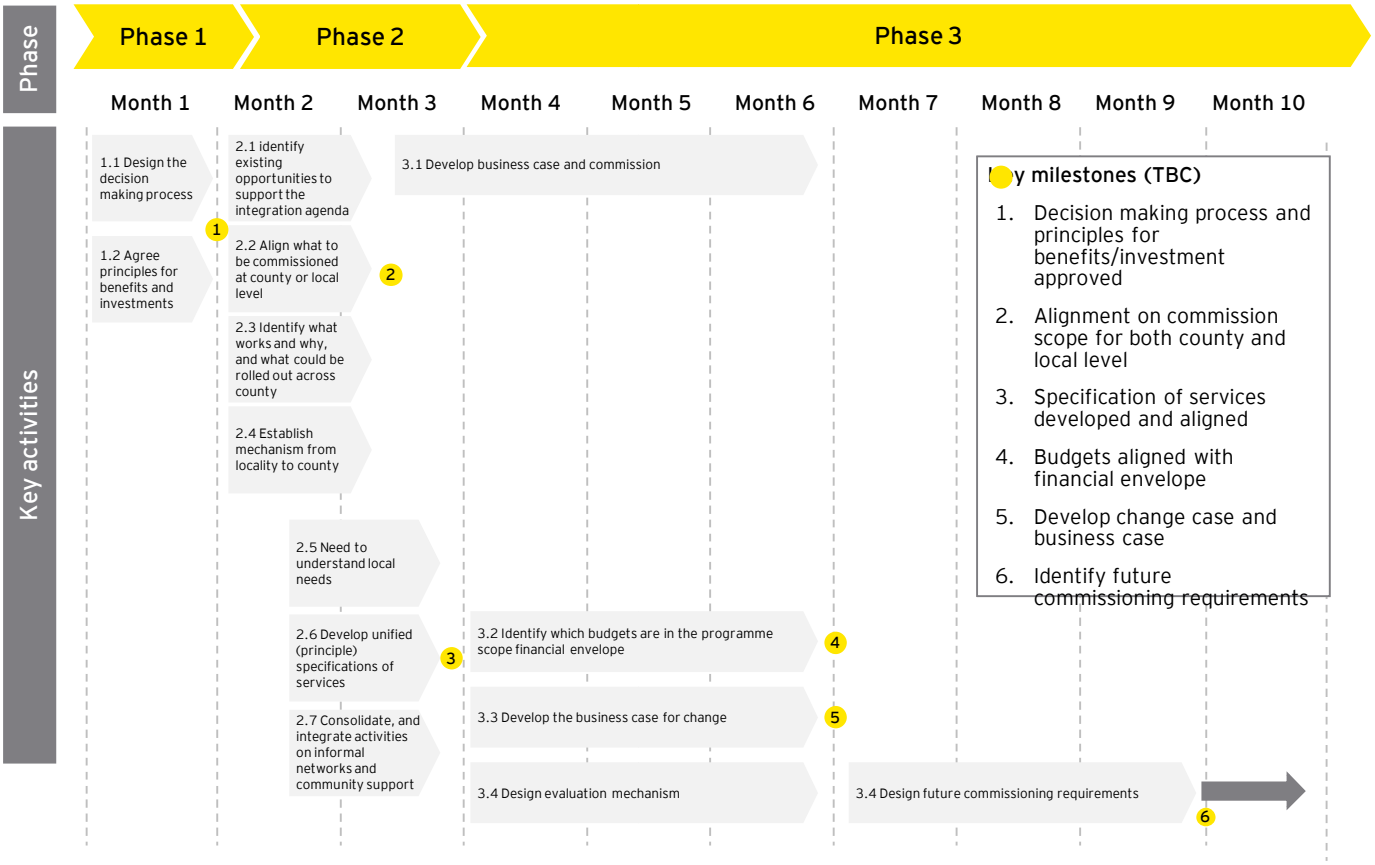
Ambition

To commission enhanced services at a reduced cost, providing a seamless customer experience for the older people of Essex

Overview plan

- An overview approach to designing an integrated commissioning of services for Older People (OP) is outlined below. The plan shows initial work carried out during the event and is subject to further review and revision in building a more robust, aligned and accountable action plan.

Older People Transformation (cont'd)



The table below shows the initial analysis of services in scope:

1. Community Geriatrician
2. Hospital
3. Out of Hours
4. OT – Health and Social Care
5. Community physio
6. Community matrons
7. Reablement

8. Home care
9. Social Work
10. Residential & nursing care
11. MH assessors/CPN
12. District nurses
13. Voluntary sector services
14. Housing/benefits advice

Section 8:

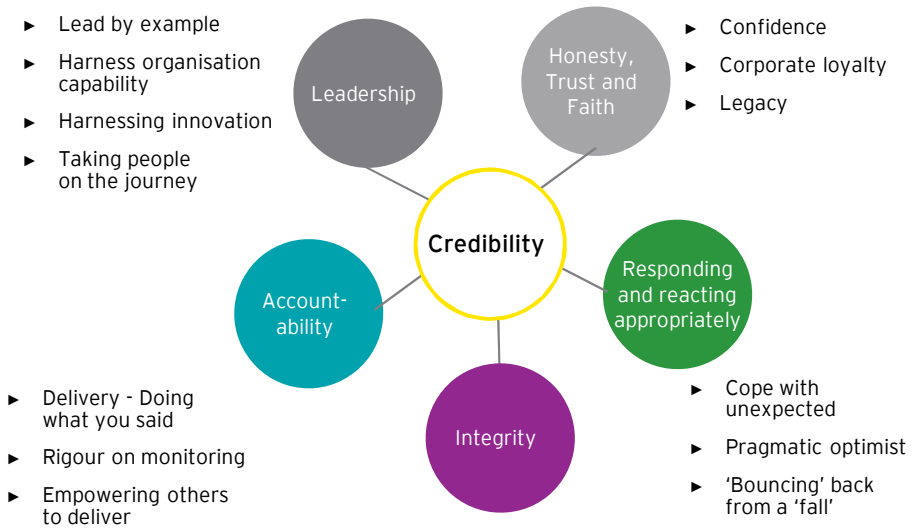
Credibility:

Credibility

Credibility is not an independent work stream but something that will be achieved by delivering the Vision described above. Credibility fundamentally underpins all areas of the programme, it can only be earned through consistently demonstrating the principles of being credible and keeping the values at the core of any change journey.

What is Credibility and how do you demonstrate it?

Credibility will be achieved by continuously demonstrating a set of Values and behaviours, some of which are outlined below:



- Lead by example
- Harness organisation capability
- Harnessing innovation
- Taking people on the journey

- Confidence
- Corporate loyalty
- Legacy

- Delivery - Doing what you said
- Rigour on monitoring
- Empowering others to deliver

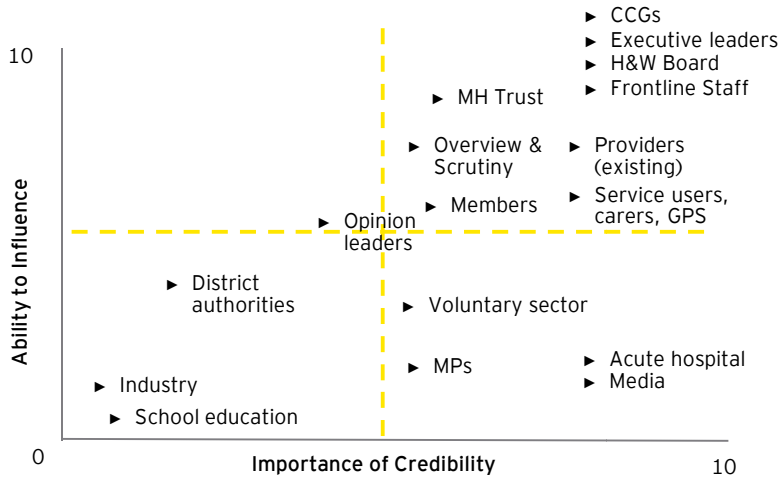
- Cope with unexpected
- Pragmatic optimist
- 'Bouncing' back from a 'fall'
- Responding to the challenge

- Every voice matters
- Care about what we want to achieve
- Shared values and ethos
- Collaboration

Credibility (cont'd)

Credibility – importance vs. influence

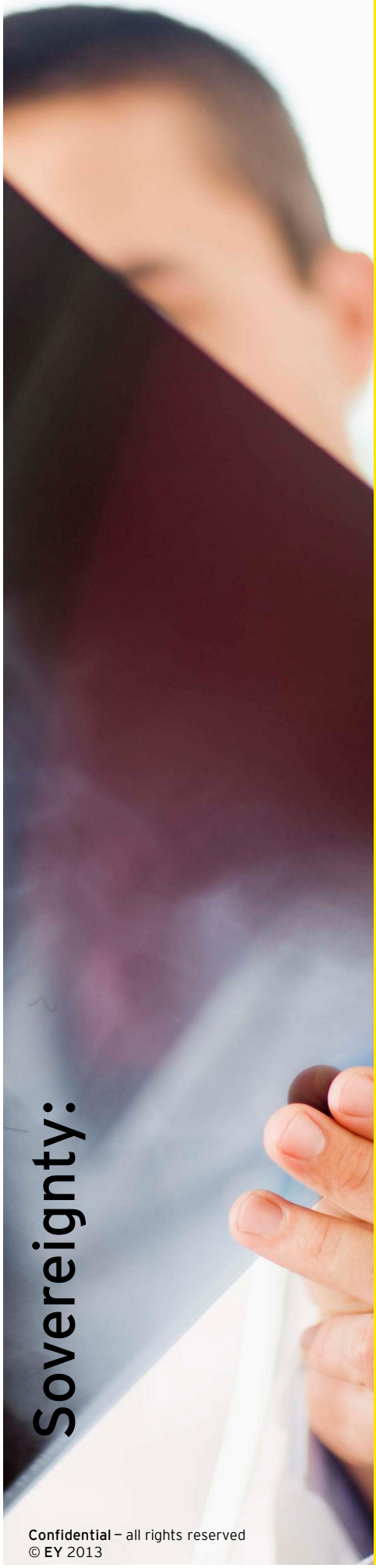
One of the most important elements when building and maintaining a relationship with your key stakeholders - you say what you are going to do and you do what you say. The chart below shows an initial view of key stakeholders, recognising that this continually evolves and changes, and to what extent is being credible important versus the ability to influence credibility:



Next step:

This analysis is based on only a brief discussion during the workshop.
It is proposed to update and finalise this analysis, so that it can be incorporated in all future communication strategy

Section 9:



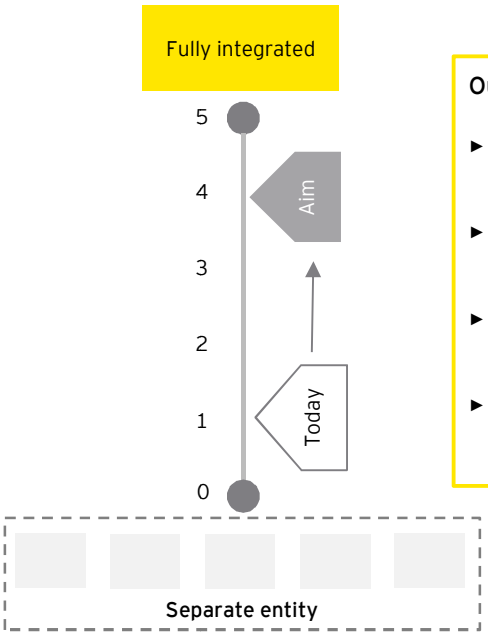
Sovereignty:

Sovereignty

Sovereignty is a key element for the integration of the commissioning function and needs to be managed effectively. How the multiple commissioning organisations make effective decisions in a timely manner whilst achieving the legislative accountability set out in statute is critical to the success of the overall integration programme. This section outlines our ambitions and the set of work products that we need to proceed with across the next 12 months.

Integration level

This is an opportunity for us to think outside our norm and shape up Essex with a high degree of integration. The chart below demonstrates (on a scale from 0 to 5) the extent to which we would like to have a fully integrated model.



Our Ambitions are strong:

- Reduce the number of 'kings/queens' from 22 (current). Eg. 7
- Keeping domestic mandate, but support shared structure and agreement
- Realistic level of achievement, while enabling and protecting locality and legislations
- An opportunity to further enhance the relationship between citizen and local council

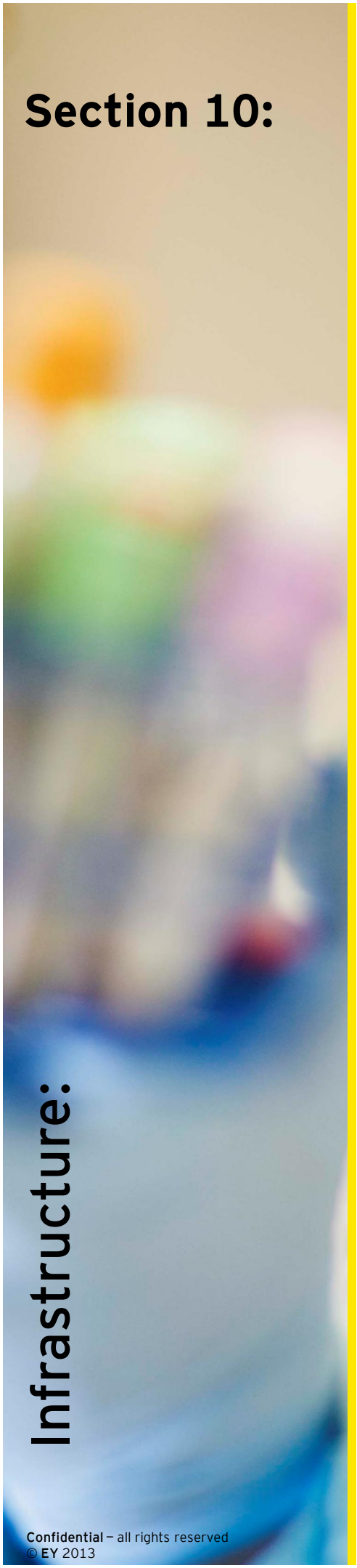
Sovereignty (cont'd)

Key Work Products

The table below specifies 7 distinct work products that are required to achieve the ambition outlined above. Out of this list there are 3 key work products which are recommended for an immediate start.

	Work Products	Comments/Key questions to address	Timeline
1	The vision	► Shared vision statement ► What is the end prize or gain?	HIGH PRIORITY Immediately (0-6months)
2	Route map	► Resource and communication plan aligned ► Single PMO approach across transformation ► Change management process aligned	
3	Leadership and decision making model	► Support the development of an agile commissioning service ► Stakeholder mapping for decision making	
4	Enablers	► Data analytics and predictive tools ► Shared and/or integrated information systems	
5	Evidence base	► Align function and organisation structure (avoid duplication) ► Mapping pathway with decision points	Within 12 months
6	Performance and quality framework	► Quality framework and metrics agreed ► Embed continuous learning process ► Encourage the right behaviours in moving forward	
7	Planning and budget	► Incentived sharing model (pooling of budget and savings)	

* There is a need to ensure that there is an evidence base underpinning all of these products



Section 10:

Infrastructure:

Infrastructure

Integration of commissioning will require effective alignment of infrastructure. This session explored the key ambition and requirements around IT and Commissioning Support in order to enable effective integration between Health and Social Care commissioning.

Our approach

We have identified two key elements of establishing the infrastructure for the integrated commissioning function – IT Governance and the underlying Commissioning Support. To actively proceed, the focus group discussed and identified key actions and a set of work products required across the next 3 -6 months as outlined below.

1 IT Governance

Ambition	1. Link H&SC data sets through appropriate systems 2. Establish universal access to data to inform smart commissioning 3. Establish a shared approach to consent
Actions	1. Develop single purchasing and strategy for hardware, software and commissioning 2. Get CCG buy-in to integrate system at H&WB level 3. Get principles of agreement from H&WB
Work products	1. Joint procurement strategy for ICT 2. Supporting data sharing, protocol consent and integrated proposal 3. Joint IT commissioning strategy
Deadline	19 October (in 3 months); Next board (planning strategy)

2 Commissioning Support

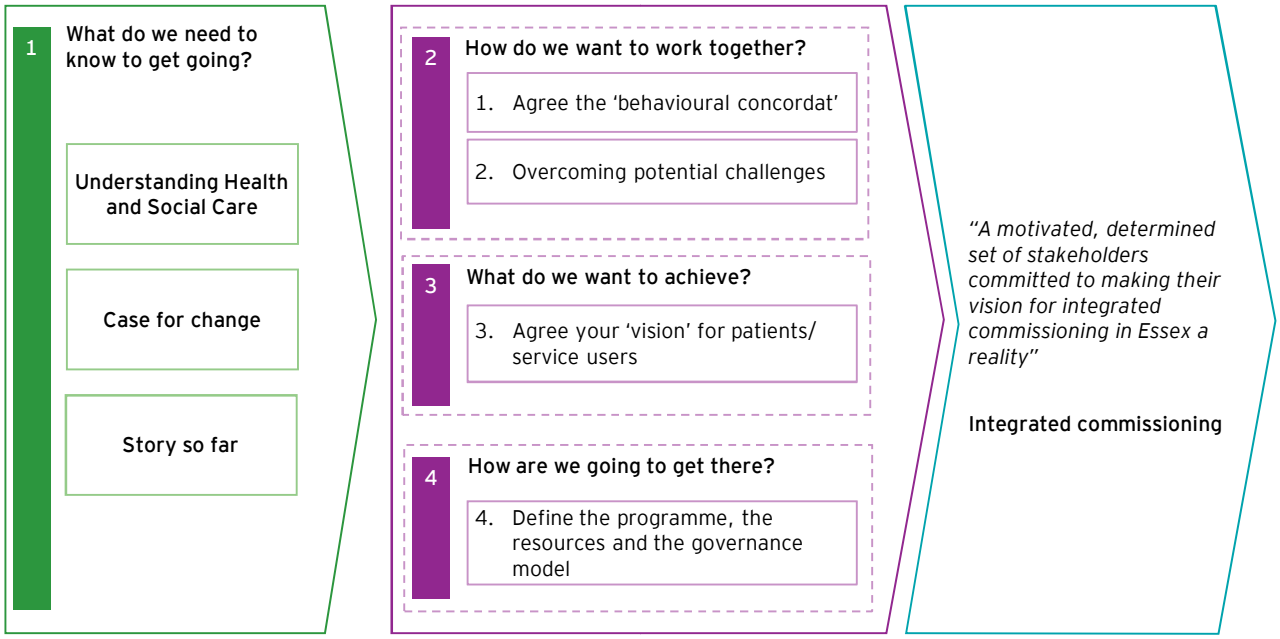
Ambition	Achieve a flexible model which varies according to local commissioning requirements
Actions	1. Integrated commissioning will be flexible to accommodate the local needs and priorities of local commissioning organisations 2. Commissioning support needs will be efficient, allowing resources to be directed towards the front line 3. Align commissioning support with integrated model. Eg. pathway 4. Co-ordinate approach avoiding instability and supporting the long term sustainability
Work products	Joint and integrated options on commissioning support for future state of CSU across Essex, including council commissioning strategy
Deadline	3 – 6 months (19 January 2014) – adjusted against OP and LD

Appendices:

Appendix A: Agenda and purpose of workshop

Integrated Commissioning Programme

This section outlines the key focus and agenda that was developed for the 2 day workshop, based on the inputs required to form and plan an integrated commissioning programme. In order to move forward with integrated commissioning, elements of the vision must be developed as inputs as outlined below.



Key section	Session	What will we cover?	Who will facilitate this?
1. What do we need to get going?	Case for change	Identify demand, funding and operational pressures	Pre-reading
	Story so far	They key agreements, decisions and progress made to date	Pre- reading
2. Agree barriers to change and how to overcome them?	Agree the 'behavioural concordat'	Agree and commit to the personal behaviours that will positively support the delivery of the programme	Robin Fritz/Howard Karloff (Engagement Specialists)
	Agree the potential challenges to change and how to overcome them	Identify they key barriers covered in constraints and how we overcome them. Identify what additional elements are needed for integration to be successful, e.g., How will investment work?	Darra Singh & Matt Huxley (EY Local Government/Health)
3. What do we want to achieve?	Agree your 'vision' for patients/service users	Identify what integration means for individuals and how commissioning/provision will change	John Baker & Emily Tuft (EY Health & Social Care)
4. How are we going to get there?	Agree the programme, resources and governance arrangements	Agree how to organise change activity, process for moving forward and identify the necessary resources	Neil Sartorio & Victoria Evans (EY Health & Social Care)

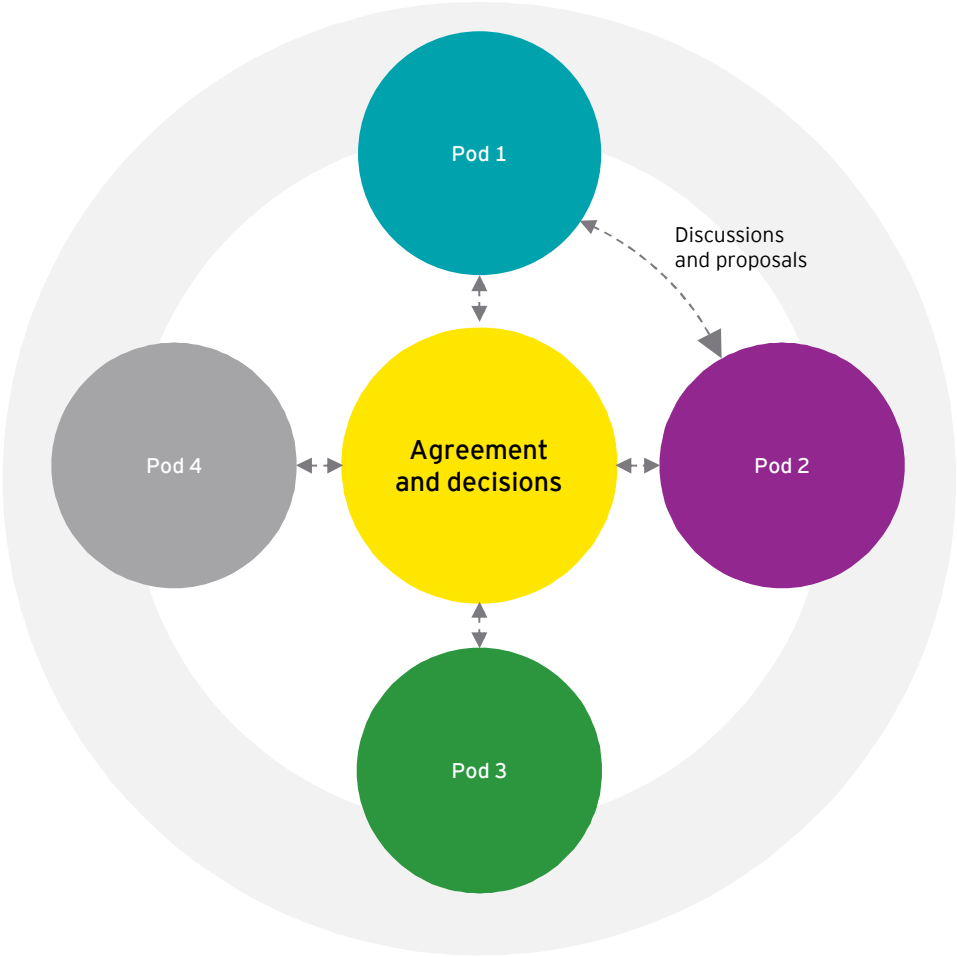
Additional Specialist Speakers

- Derek Myers – Joint Chief Executive at R B Kensington and Chelsea and LB Hammersmith and Fulham
- Joanna Killian – Chief Executive Essex County Council
- Robin Fritz and Howard Karloff– Engagement specialists

Appendix A: Agenda and purpose of workshop

Facilitation of the event

- The event was run through a combination of whole group sessions and smaller 'pod' group sessions for targeted discussion of particular topics. The whole group sessions was held in a main room and lead by EY. Speaker sessions were also held in this room.
- The attendees were split into groups of 4. There were 4 pod discussion topics, each of which were owned by a facilitator or two facilitators. Groups were circulated from pod to pod in each discussion session joining a new facilitator each time.
- There were 'runners' feeding in key points and information to the central plenary for feedback and discussion. There was also a visual presenter artist capturing discussions in each pod and representing these in the central plenary.
- Information captured in the pods were collated and fed back in the central plenary where key issues and themes were identified, a plan was developed for day 2 accordingly.



Appendix B: Design Principles

Design Principles and Values

Design Principles and Values

Design principles form the basis of the commissioning model and will be the guiding principles during the design phase. The Key values underpin the design of the commissioning model and provide the ethos and philosophy for how the model should be designed to operate.

The following principles and values were identified. These will be used to inform and test the design of the commissioning model.

Key Design Principles

1. Patient centred, and empowering individuals
2. Value and needs based
3. Proactive approach of prevention, early identification and intervention
4. Outcome focused
5. Co-produced: Patient/Citizen are partner with commissioners and providers
6. Quality

Key Values
(beliefs which underpin the design)

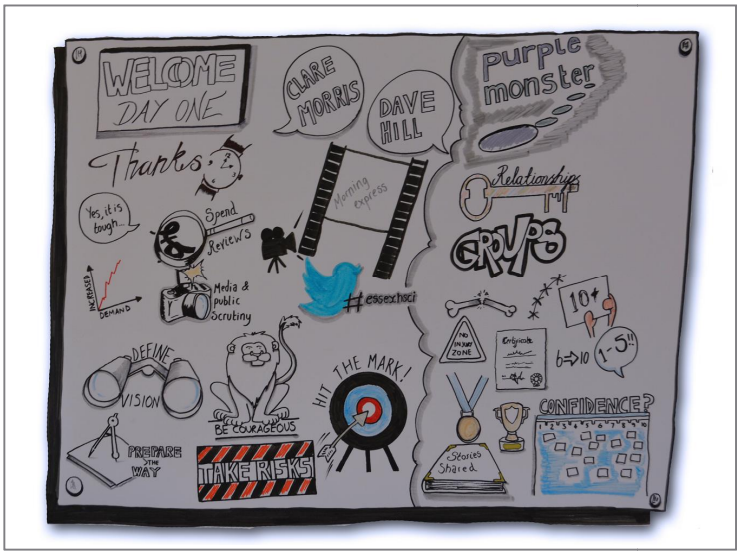
1. Affordable and cost effective
2. Sustainable and long-term
3. Innovative but informed by an evidence base
4. Shared risk and benefit
5. Effectively manage demand
6. Honest, fair and accountable
7. Continuous learning
8. In line with individuals

Appendix C: Workshop Artworks

Design Artworks

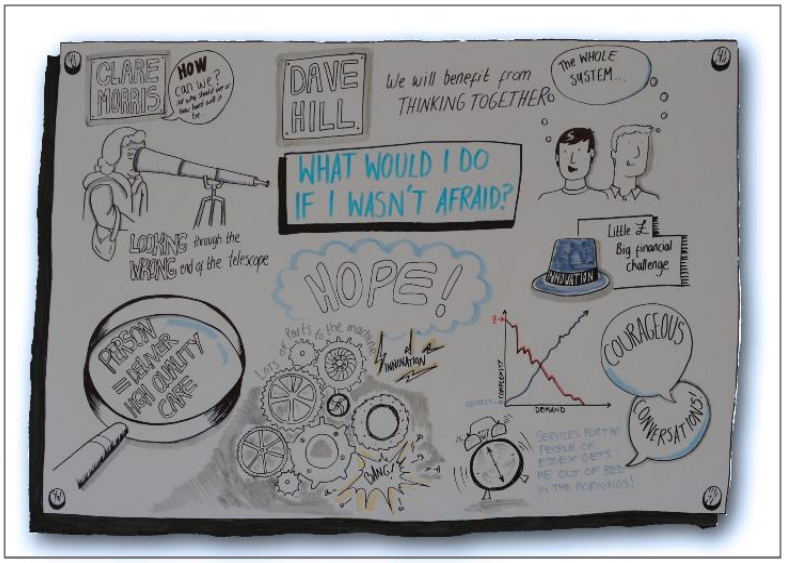
There was a visual presenter artist capturing discussions in each pod and representing these in the central plenary across both days of the workshop. This section showcase these artworks as shown below:

Day 1 - Welcome

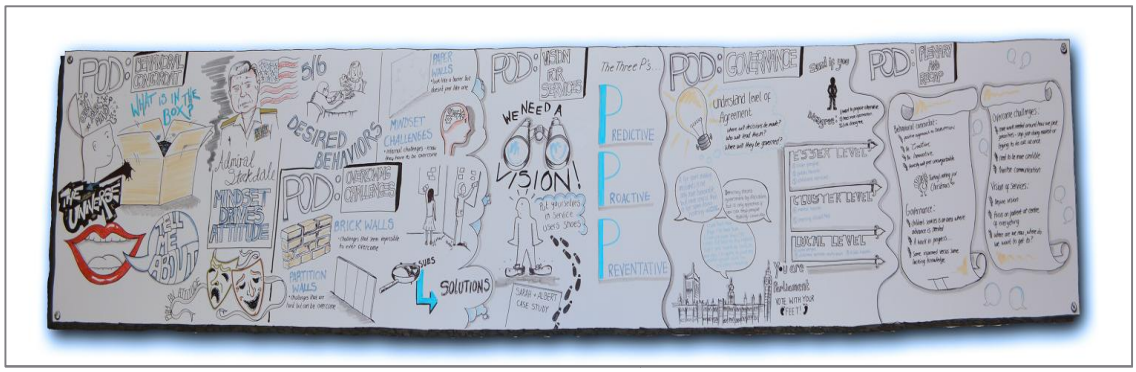


Day 1 – Derek Myers

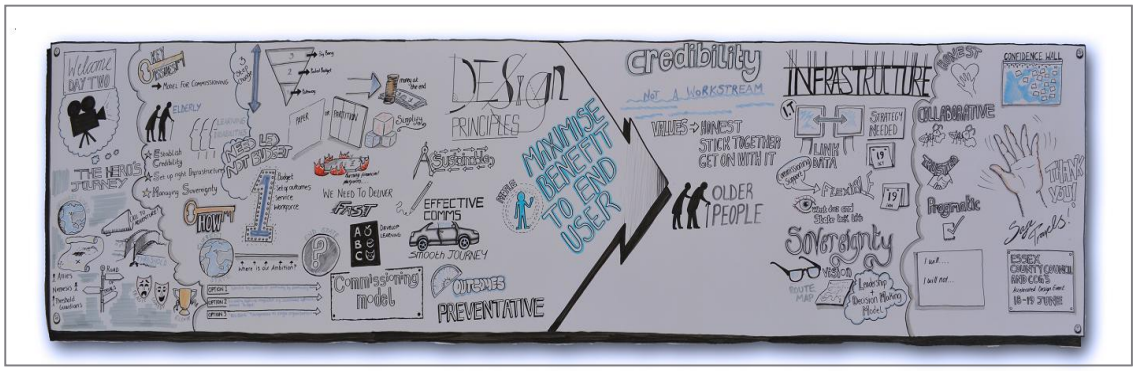
Day 1 – Clare Morris and Dave Hill outputs



Day 1 – Pod outputs



Day 2 – Live Scribing



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