

8/9/2026

To: Lynn Millar, NHS Shropshire, Telford and Wrekin ICB & Steve Ellis, Deputy Director of Operational Service Development, Shropshire Community Health NHS Trust

Re: Neighbourhood Health Outcomes Framework and Associated Delivery Documentation

Dear Lynn and Steve,

Thank you for sharing the Neighbourhood Health Outcomes Framework documentation and the associated material issued in support of its implementation across Shropshire, Telford and Wrekin.

The Local Medical Committee welcomes the ambition to improve outcomes for frailty, ageing well, cardiovascular risk management and health inequalities through stronger neighbourhood working. General Practice has consistently supported integrated care, multidisciplinary working and proactive population health approaches where these improve patient outcomes and make best use of collective system resources.

Having reviewed the documentation, including the Introduction to the Neighbourhood Outcomes Framework, the Strategic Commissioning Framework, the Letter to PCN Clinical Directors, the Funding Breakdown and the proposed MDT structures, the LMC wishes to highlight a number of areas where further clarification and assurance would be helpful.

1. Alignment Between Strategic Messages and Operational Requirements

A recurring theme throughout the documentation is the reassurance that the Framework is not intended to create additional workload or reporting requirements for General Practice.

However, when considered alongside the operational requirements contained within the Strategic Commissioning Framework and subsequent supporting documents, there appears to be a significant disconnect between that reassurance and the practical expectations placed upon neighbourhood teams.

The framework expects neighbourhoods to undertake population risk stratification, maintain and validate registers, proactively manage high-risk cohorts, undertake comprehensive reviews, support medicines optimisation, coordinate care plans and participate in regular multidisciplinary team working. The Letter to PCN Clinical Directors further requires neighbourhoods to establish Integrated Neighbourhood Team infrastructure and deliver measurable improvements in outcomes, activity and utilisation.

Whilst these activities may formally sit within a neighbourhood model, many depend heavily upon primary care records, clinical leadership, prescribing oversight, continuity of care and established practice-patient relationships.

The LMC therefore remains concerned that the documentation does not clearly explain how these expectations can be delivered without increasing demands upon practices and Primary Care Networks.

2. The Central Role of General Practice in the Proposed Model

The supporting documentation repeatedly emphasises partnership working and system-wide delivery. However, the detailed operating models identify General Practice and PCNs as key contributors to successful delivery.

The proposed Frailty MDT identifies a GP Frailty Clinical Lead as providing medical oversight, diagnosis, escalation decisions and continuity of care. The proposed CVRM MDT identifies a GP Clinical Lead responsible for clinical leadership, multimorbidity management, prescribing decisions

and escalation. Likewise, pharmacists, care coordinators, social prescribing staff and other primary care-related roles feature prominently throughout the proposed structures.

This appears to place General Practice at the centre of delivery whilst at the same time maintaining that no additional work is being created.

The LMC believes greater clarity is required regarding the expected commitment from practices, how GP leadership capacity will be funded and how participation requirements will be accommodated alongside existing contractual responsibilities.

3. Accountability, Governance and Risk

The documents establish SCHAT as the Lead Provider, Anchor Organisation and Delivery Integrator. At the same time, successful delivery depends upon contributions from community services, general practice, local authorities, social care, mental health services and the voluntary sector.

Whilst collaborative governance is welcome, the practical implications of shared accountability remain unclear.

In particular, the LMC would welcome clarification regarding:

- clinical accountability for decisions made through multidisciplinary teams;
- responsibility for delivery where multiple organisations contribute to care plans;
- responsibility for achievement of outcome measures;
- governance arrangements where partners disagree on priorities or resource allocation.

Without such clarity there is a risk of uncertainty regarding where accountability ultimately sits, particularly where outcome targets are not achieved.

4. Financial Transparency and Resource Flow

The Funding Breakdown identifies a core programme allocation of approximately £2.4 million across Shropshire, Telford and Wrekin, equating to approximately £4.33 per weighted head of population.

At the same time, neighbourhoods are expected to establish MDT infrastructure, provide care coordination, support population health management, deliver proactive interventions, maintain governance structures, demonstrate outcomes and support system transformation.

The LMC is concerned that the documentation does not yet sufficiently demonstrate how available funding translates into sustainable frontline workforce capacity.

It remains unclear:

- what proportion of funding will reach neighbourhood delivery teams;
- what proportion will support programme administration and management;
- what resources will flow directly into primary care;
- how recurrent workforce commitments will be sustained.

A clearer understanding of funding flows would help reassure practices that responsibility is matched by resource.

5. Additionality and Potential Duplication

The Letter to PCN Clinical Directors makes clear that new investment should not duplicate existing commissioned activity and must demonstrate genuine additionality.

The principle is understood and supported.

However, many elements of the proposed model overlap significantly with existing activity already delivered through:

- PCN Enhanced Services;
- anticipatory care initiatives;
- Structured Medication Reviews;
- frailty management programmes;
- long-term condition management;
- multidisciplinary working arrangements;
- population health management initiatives.

The documentation does not yet clearly explain how neighbourhood programmes will avoid creating parallel structures, duplicate reporting or overlapping requirements.

The LMC is concerned that neighbourhood teams may find themselves spending considerable time evidencing additionality whilst carrying out work that resembles existing commissioned activity.

6. Workforce Assumptions and Deliverability

The proposed MDT structures rely upon consistent participation from a broad range of professional groups including GPs, pharmacists, therapists, specialist nurses, community nurses, social workers, analysts and coordinators.

The LMC is concerned that the workforce assumptions underpinning the model may prove challenging to achieve in practice given current recruitment and retention pressures across the NHS.

The documentation would benefit from greater detail regarding:

- workforce funding;
- contingency arrangements;
- recruitment assumptions;
- sustainability planning should required workforce not be available.

7. Proposal Development Requirements

The submission requirements set out in the Letter to PCN Clinical Directors are substantial.

Neighbourhoods are expected to provide detailed information regarding population need, inequalities, governance, safeguarding, workforce, information governance, finance, partner contributions, outcomes and sustainability, alongside evidence of genuine co-production with multiple partner organisations.

Whilst the LMC supports robust planning, there is concern regarding the burden of developing these submissions and the capacity required within neighbourhoods to undertake this work.

Clarification regarding support available for proposal development would be welcomed.

Overall Observation

When all documents are considered collectively, a common theme emerges.

The narrative throughout the programme is that neighbourhood delivery will be collaborative, locally owned and not intended to create additional workload for General Practice. However, the operational detail contained within the framework, supporting guidance and MDT structures repeatedly relies upon General Practice leadership, workforce, clinical oversight, prescribing support, data quality, continuity of care and multidisciplinary participation.

The LMC's principal concern is therefore not the ambition of neighbourhood working itself. Rather, it is the apparent gap between the strategic assurances provided and the practical requirements set out within the accompanying documentation.

We would welcome further discussion regarding workload implications, accountability arrangements, funding flows, workforce assumptions and governance structures before neighbourhood implementation arrangements are finalised.

We look forward to continuing constructive engagement with the ICB and SCHT in developing models that improve outcomes whilst remaining realistic, sustainable and appropriately resourced.

Yours sincerely,

Dr Julian Povey

Chair of Shropshire and Telford LMC

Dr Nicola West

Vice Chair of Shropshire and Telford LMC

Dr Damien Thompson

Secretary of Shropshire & Telford LMC