NHS
West London
Clinical Commissioning Group

Progress developing the Multispecialty Community Provider (MCP) in support of the CCG's integrated care strategy

18 September 2018

The objectives of today's session

1. To recap for members the rationale for, and components of, WLCCG's integrated care strategy
2. To discuss the progress made on our MCP programme since July
3. To agree the next steps for MCP development and discuss programme risks

1. To recap for members the rationale for, and components of, WLCCG's integrated care strategy
2. To discuss work since July and next steps on key areas
3. To agree the next steps for MCP development and discuss programme risks

Integrated care – why it matters

- There are three key reasons why the CCG is working with its partners to better integrate local care services:

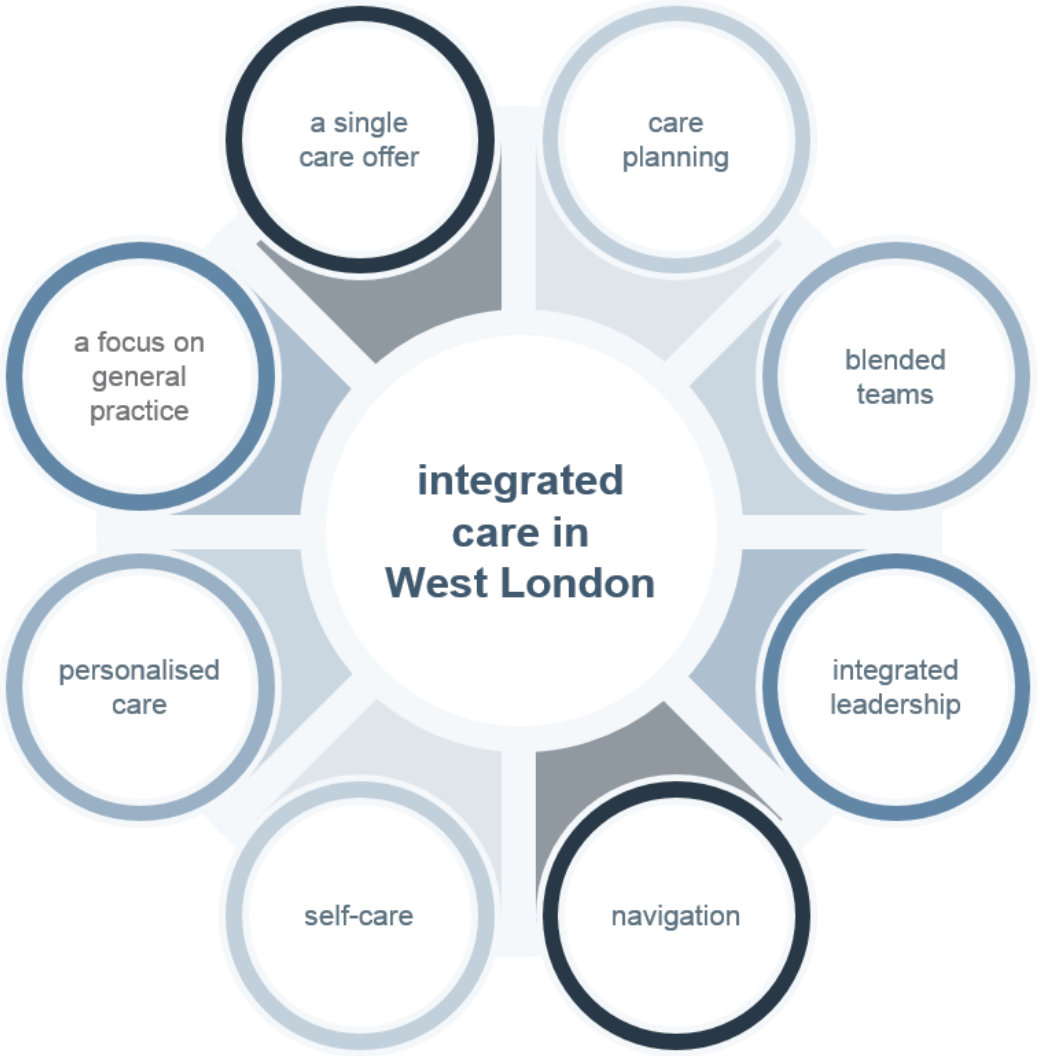
to improve health and wellbeing **outcomes** in West London;

to improve residents' **experience** of receiving care and

to support the long-term **financial sustainability** of the local care system.

Work so far has already made a difference to local people's lives

- **Over the past five years, West London CCG and its partners have worked hard to integrate out-of-hospital care services.**
- ***My Care, My Way*** and ***Community Living Well*** have focused on people for whom the positive impact of effective integration is greatest – older people and people with long-term mental health needs.
- The new model of care in **North Kensington** has brought together the partners necessary to respond to the additional needs arising from the fire at Grenfell Tower.
- Now, the ***Integrated Care Team*** is extending the scope of the local integrated care offer, based on features of these three models.
- It is doing this by bringing more services into the integrated care offer, focussed on delivery of a set of shared outcomes.
- It is also focussing on where financial efficiencies can be generated, such as through a single management team and co-location.



Feedback has been positive, but not without challenges

What our GPs and My Care, My Way *team say:*

"I have been the patient's GP for the past fifteen years but I found out more about them in the session at the St Charles Integrated Care Centre today than I have in the fifteen years of looking after them – this is really positive for patients."

What our patients say after their first My Care, My Way *appointment:*

"I am grateful to my GP who has assisted my during my many years of working life. Now I am ninety years old and have been in hospital, my GP has introduced me to My Care, My Way. I did not know that I can get help to make my life better, easier and safer. Many thanks for providing support to improve my health."

"Thank you so so so much. **I could never have gone back to work without your help.**"

Employment Services client

"Being with others who have a shared experience of depression is helpful because people there have lower expectations of me, they are less judgemental and we do help each other, sharing our experience of depression when it comes up. The groups don't make demands of me and that helps when I'm depressed – I also have problems with personal obligation. **Coming out to the meet-ups does reduce my isolation**, and keeps me active and I can help others."

Peer Support attendee

What users of Community Living Well *have said about the service*

"**I had a great and positive experience**. The experience with Robin was life-changing. I was treated respectfully and the sessions were very fruitful. I received support with CVs, interview coaching and covering letters. After several months, I finally got a job and started working again after five years of unemployment!

I feel that I bonded well with Robin, and consider him to be a life-long friend and mentor. I am grateful to have received great support, which helped me overcome depression and embark on a new career as an animal/aquatic technician in major institutions."

Employment Services client

"When I'm at the groups they help take away my anxiety (not all – but partly). **It's a fantastic service.** The mix of talks and activities is varied and relevant. When I'm depressed I need to be with others to help me laugh again, during the conversations with others this does happen and the sharing of experience really helps and to know that there are people around who care and who recognise me."

Peer Support attendee

"I wasn't new to counselling when I had group sessions with the Mother Tongue Counselling Service, but it was still a new experience to me. I was looking for someone who listens to what I have to say and respond without being pushy, and that's what I got. The facilitator brought in interesting topics of discussion, paid attention to us individually and showed us our options. I was able to make changes and have some conversations with my family which I had always been avoiding. We were always reminded of the choice of self-referral, if need be. The handouts, booklets and emails which were distributed, especially after the Grenfell Tower tragedy, have been extremely handy and helpful. **Will definitely recommend the service to a friend!**"

Talking Therapies, Mother Tongue Counselling Service attendee

But we do need to continue this work to further improve outcomes

- **Care services do support local people to achieve some very good outcomes:**

Higher average life expectancy at birth for men and women than the London and England averages

Many fewer adults over 65 needing their long-term care needs met by admission to residential and nursing care homes than the London average

A higher proportion of people aged ≥65 at home 91 days after hospital discharge into reablement/ rehabilitation services than the London and England averages

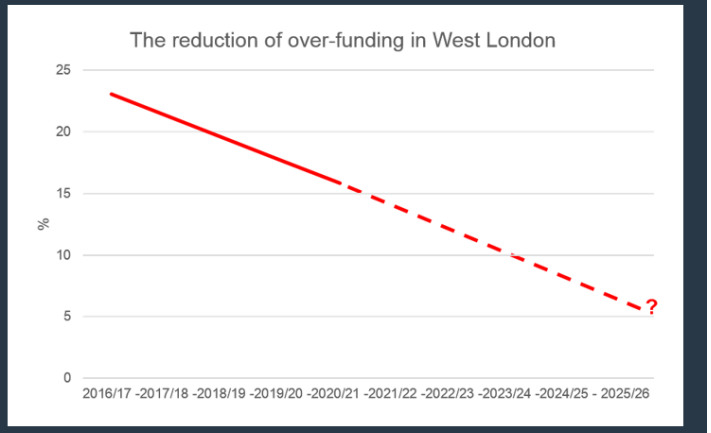
A higher proportion of carers who find it easy to find information about support than the London, inner London, and England averages

The recent evaluation of ***My Care, My Way***, conducted by Buckinghamshire New University in January 2018, showed a trend of reduced use by *MCMW* patients of all types of unplanned care, including A&E attendance and non-elective admissions, as well as shorter average hospital stays

- **But improvements are still required across a range of outcomes:**
- None of these outcomes can be delivered by a single organisation or service, which supports the case for pressing on with the integration of care for all people in West London.

There is also a major challenge of long-term financial sustainability

Our resources are going down in real terms:



… this equates to:

a reduction of

£15m

of purchasing power per year by 2020/21

… despite demand and population pressures:

growing demand and activity in hospitals and the community

27% more over 65s by 2028: **6,700 people**

66% more over 85s by 2028: **2,000 people**

- **The local care system is not financially sustainable if we continue to commission as we do now.**
- This is because the CCG has historically been over-funded relative to other areas – and this additional money is now being withdrawn, as shown in the graph opposite.
- This is despite significant increases in demand for care and an ageing population.
- By 2020/21, the CCG will have lost approximately £15m worth of purchasing power per year.
- We need to assume that this will continue beyond 2020/21. So money will continue to be very tight.
- Our options are to:
  - make cuts, service by service, in line with the resources available – this means decommissioning and a likely deterioration in quality, experience, and outcomes; or
  - our preferred option, which is to challenge ourselves to continue to redesign our system to create the system structure and efficiencies necessary for commissioners and providers to live within their means.

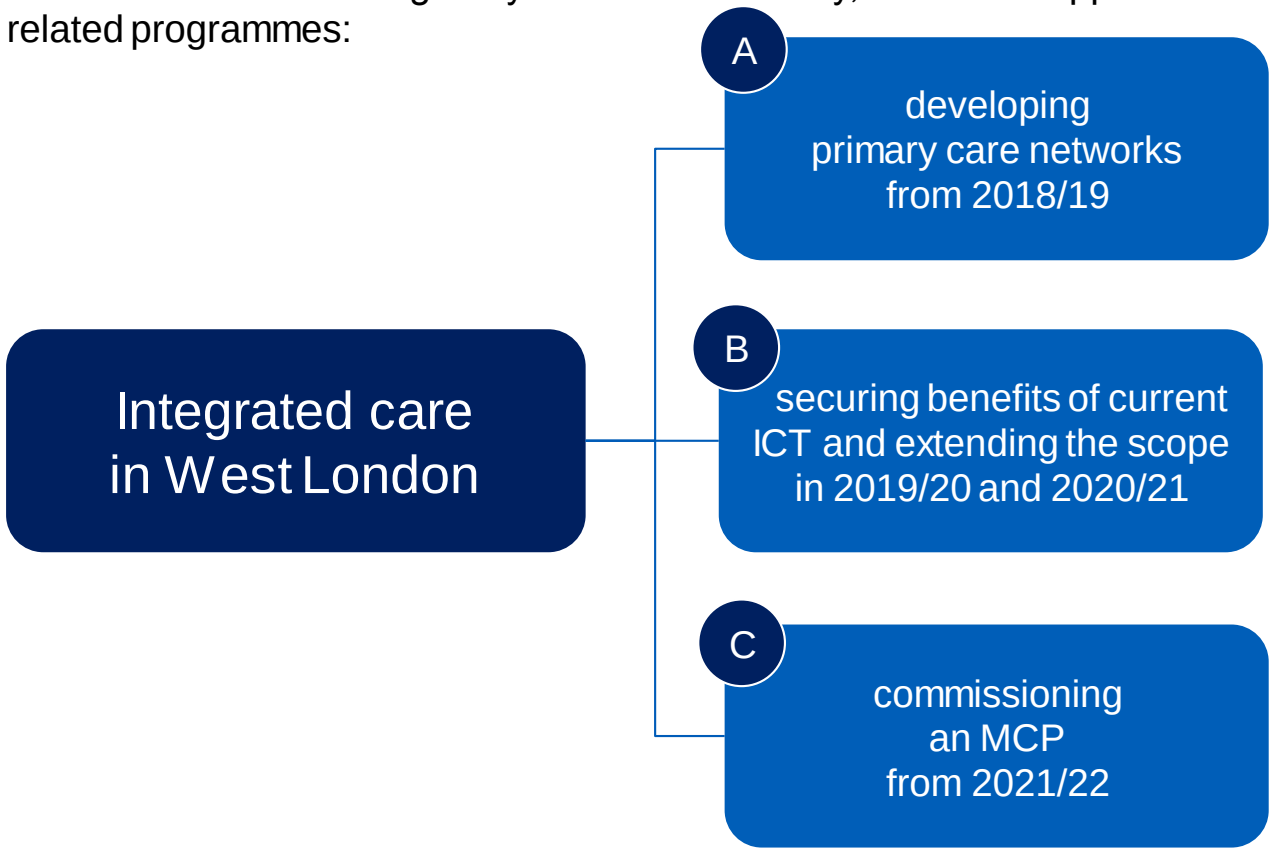
The Governing Body in July set expectations of our direction of travel for the MCP

- Approved the proposed outline commissioning timeline from 2018/19 to 2021/22;
- Approved the approach to developing the alliance;
- Considered and endorsed the approach to commissioning a Multi-speciality Community Provider as the initial working hypothesis from which more detailed Multi-speciality Community Provider design would be undertaken during July to September ahead of further discussion and decision making by the Governing Body;
- Noted that the Transformation Board approved the Multi-speciality Community Provider definition framework as a supplement to the CCG's integrated care strategy, which was approved by the Governing Body in November 2017;
- Noted the work to date on provider development; and
- Noted the programme risk register.

Do you recognise the point that we got to in July before we continue and share the work undertaken since?

The agreed integrated care strategy is designed to meet these challenges

- In line with the Governing Body's discussion in July, the CCG's approach to integrated care has three inter-related programmes:



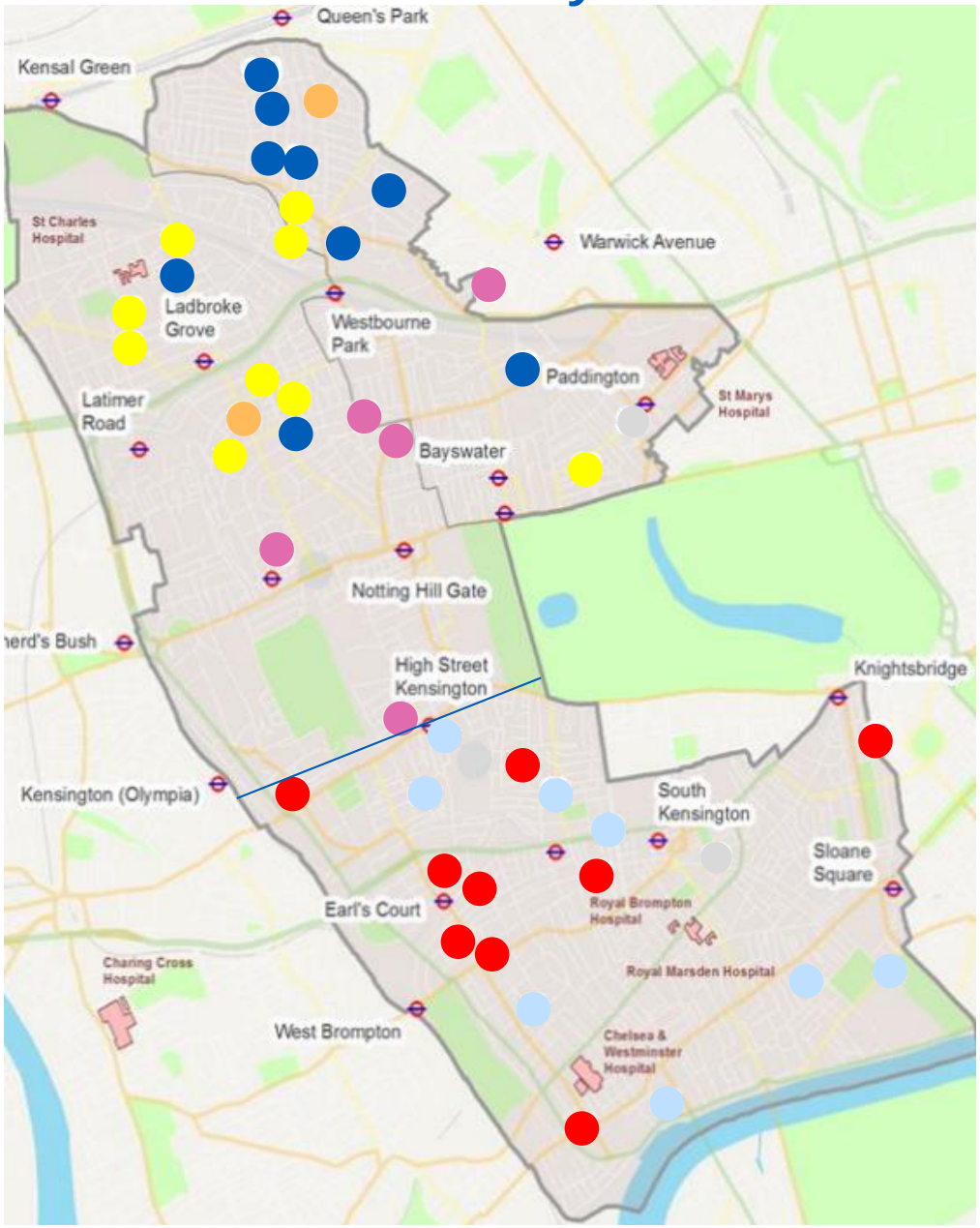
Over the last 2 months the oversight of these three interconnected programmes has been brought more formally together under the Integrated Care Delivery Group

Primary care networks can put GPs at the heart of integrated care

A Developing primary care networks across the patch

- Integrating care in West London has been most successful where primary care has played a central role.
- This must be replicated within the MCP's whole-population integrated care offer, which requires:
  - leadership from practice teams in designing and delivering integrated care models; and
  - a strong and coherent primary care voice in system-wide decision-making.
- Primary Care Networks (PCNs) will work with the GP federation to enable both of these functions.
- Initial PCN configurations and roles and responsibilities have now been confirmed through Stage 1 plans.
- PCNs are now working to the second stage of the local PCN development plan, focused on analysing local PCN population health needs and assessing the best use of PCN-wide workforces.
- We are working on how we will manage conflict.
- The priorities for the remainder of **2018/19** are to:
  - support full mobilisation of the ICT and define the primary care role in the 2019/20 alliance agreement;
  - achieve full population coverage of out-of-hospital services on a PCN basis;
  - submit further development proposals after identifying their year 1 local objective; and
  - support the GP federation to build on the outputs from the NWL GP provider maturity evaluation framework.
- The focus in **2019/20** and **2020/21** will include:
  - continuing to develop at-scale capabilities; and
  - defining and developing the role of at-scale primary care in the MCP and preparing for mobilisation.

Confirmed Primary Care Network configurations



Key:

North

- NeoHealth PCN (41k / 42k)
- North PCN (46k / 43k)
- Kensington and Chelsea PCN North (37k / 39k)

South

- Kensington and Chelsea PCN South PCN (58k / 49k)
- South PCN (54k / 46k)
- EoI yet to be received (6k / 7k)

(Raw / Weighted aggregated list sizes)

NHS
West London
Clinical Commissioning Group

The ICT will spread the benefits of integrated care prior to the MCP

B Securing benefits of current ICT and extending the scope in 2019/20 and 2020/21

- We have continued to develop the *MCMW* service, most recently securing feedback at practice-based 'Learning labs'. There have been significant additions to the integrated offer through the ICT, such as district nursing and the memory assessment service.
- Transformation is underway across twelve workstreams led by different members within the alliance, including development of a single management team, comprehensive case management and clinical decision-making.
- Beyond progress on individual workstreams, a more holistic view of alliance progress will be agreed through a stocktake. This will be an adapted version of the framework recently used by Hammersmith and Fulham Integrated Care Partnership. The stocktake will include self-assessment by alliance members and then moderation with a range of partners.
- The priorities for the remainder of **2018/19** are to implement the ICT phase 1 workstreams and to work with alliance partners to develop the 2019/20 programme and agreed legally-binding alliance contract.
- The focus in **2019/20** and **2020/21** will include:
  - implementing the 2019/20 programme
  - confirming and delivering the 20/21 scope and priorities; and
  - preparing for MCP launch during 2021/22.

An MCP will complete the local out-of-hospital integrated care offer

C Commissioning an MCP from 2021/22

- In July, the Governing Body agreed in principle that an MCP is the preferred vehicle for contracting a coherent out-of-hospital integrated care offer.
- It also agreed that the CCG programme team should begin work on answering design questions such as those listed below.
- The next section of this pack provides detail of work to date and further work needed on these areas.

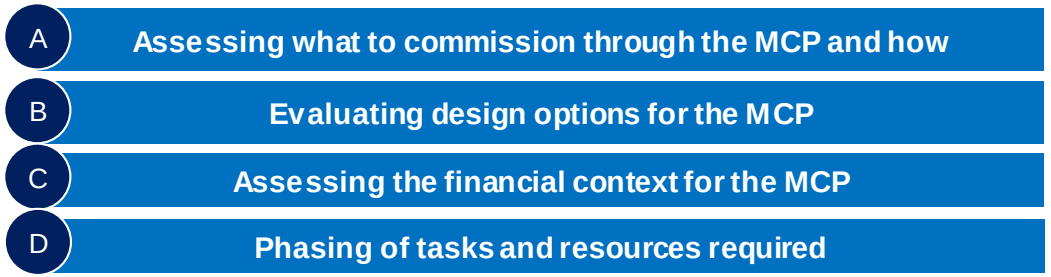
- **How can the CCG support providers to prepare for the MCP?**
- **What is the model of care for the MCP?**
- **Which services need to be included in the MCP to achieve the right outcomes?**
- **When and in what order should services be added to the MCP?**
- **How do we define and resource the preparatory work for an MCP?**
- **How should the CCG design a long-term contract and budget for the MCP?**

It is important we focus on delivering in 18/19 and 19/20 as well as planning for the MCP. Does this Board have any tactical suggestions we should consider on how to manage this?

1. To remind members of the rationale for, and components of, the integrated care strategy
2. To discuss work since July and next steps on key areas
3. To agree the next steps for MCP development and discuss programme risks

Work on designing the MCP in greater detail has now begun

- The Governing Body has agreed that it will take its decision on how to contract for the MCP in September 2019.
- To make sure that the CCG keeps open all appropriate options, the work done since July 2018 on designing the core features of the MCP has considered collaborative approaches as well as a competitive procurement, and how these approaches will align with the Public Contracts Regulations 2015.
- In line with its obligations under the Public Contracts Regulations (2015), the CCG will complete its design work over the next year in a way that enables the Governing Body to pursue the optimum route to securing an MCP.
- Whatever the approach selected for the MCP, the CCG and its partners will focus in 2019/20 and 2020/21 on delivering successful change – both clinical and financial – through the current ICT alliance.
- As well as informing our internal approach, the likely value of the MCP means that the NHSE assurance process will be triggered – this is called the Integrated Support and Assurance Process (ISAP). This requires certain questions to be answered and our work so far, and over the coming year, will support this
- **Some of this design work is commercial in confidence and will be discussed at private forums of the Governing Body over the next twelve months. The detail provided in this pack summarises progress and provides transparency whilst not including commercially sensitive information.**



A Assessing what to commission through the MCP and how

- The Governing Body agreed in July that the scope of the MCP needs to be large enough to improve outcomes and drive savings by delivering a truly integrated out-of-hospital service.
- Building on this discussion, the following principles were developed to assess which services should be considered for inclusion in – or exclusion from – MCP scope, including:

Including a service	(Permanently) excluding a service
Does the inclusion of a service or group of services within a single MCP contractual, financial, and outcomes framework support providers to: • integrate community and primary care; • integrate physical and mental health; • support patients to move to less intensive care settings where clinically appropriate; • form single care teams focused around individual service users; • across the dimensions above, improve patient outcome; • form a logical single management team that supports system efficiency; • be able to integrate in a way that removes duplication, and improves value for money (contributing to overall system efficiency); • flexibly use funding to focus on prevention and early intervention; • utilise simplified single assessment / referral mechanisms and data sharing (greater possibilities to invest in system infrastructure); and • make smarter use of the workforce, resulting in improved productivity and removing inefficiency.	Services would be permanently excluded from an MCP if there is a clear rationale for them continuing to be commissioned separately by the CCG. The CCG would require a rationale for a service operating outside of the MCP's contract mechanism, outcomes framework and performance measures, budget, and management. This could relate to: • bespoke contracts that cannot be novated; • permissions (i.e. inclusion of a service is beyond WLCCG's sole authority); or • insufficient contestability (e.g. regional ambulance services).

A Assessing what to commission through the MCP and how (continued)

- The following high-level categories are currently included and excluded from the MCP scope:

Included:*

- all services and budgets within the ICT and added over 2019/20 and 2020/21
- community physical and mental services
- CAMHS
- BCF- and s.75-funded services
- urgent care
- continuing care
- intermediate care
- voluntary sector services

* Analysis has been undertaken according to individual lines in the 2018/19 budget, at which level some exclusions apply to these broad categories.

Excluded:

- acute general inpatient services
- A&E attendances (with potential for gain share)
- inpatient mental health (with potential for gain share)
- prescribing
- London- and NWL-wide services (e.g. LAS, 111, wheelchairs)
- primary care core contracts
- running and programme costs

Note:

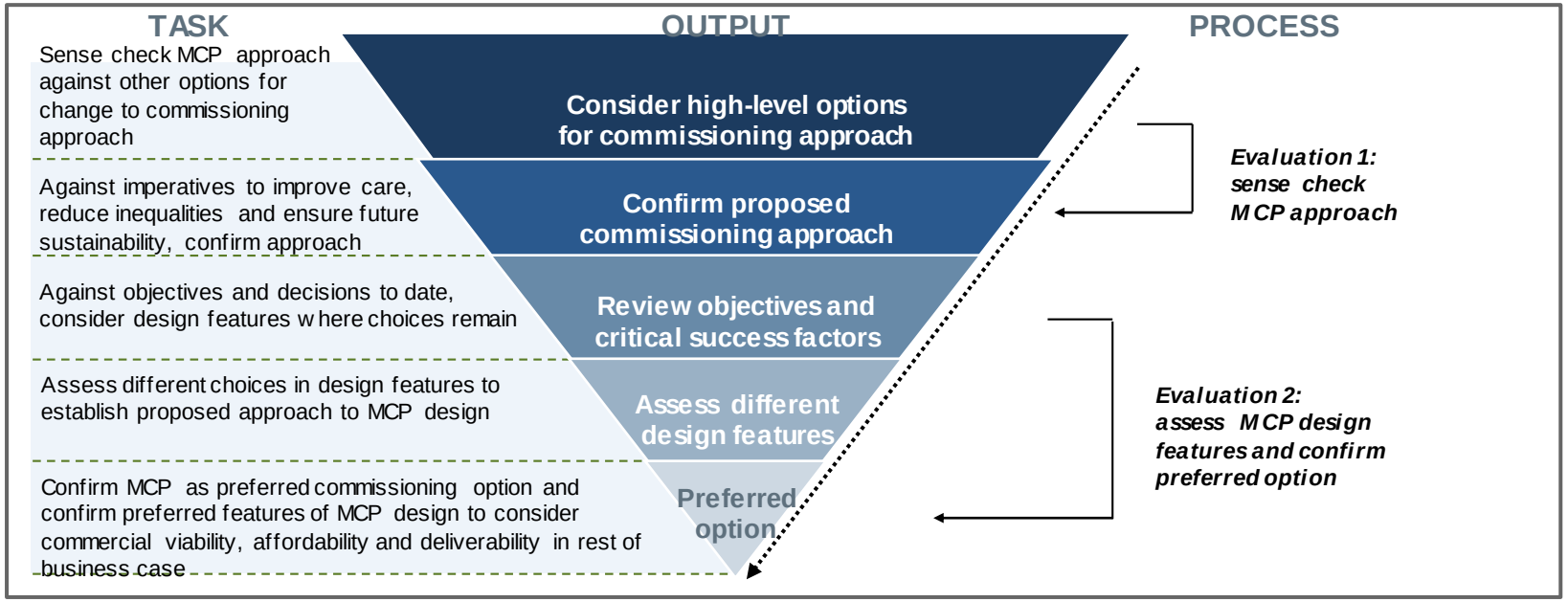
- hospital outpatient services and diagnostics will be explored with partners on a pathway basis
- the placing of non-core primary care services requires further discussion

- Ongoing work to refine the scope will include engagement with residents, current providers, neighbouring CCGs, and a full legal and contractual review.
- The scope listed above accounts for **28%** of the CCG's budgeted spend for 2018/19 at **£113m**.

Do the Board support the proposed scope above as a working assumption to now take forward more detailed work on the make up of the MCP?

B Evaluating design options for the MCP

- There remain options on how we commission an MCP. The work we have done since July demonstrates that much of the work required in the lead up to a formal decision on approach in September 2019 is the same regardless of the option we select in the future.
- As well as a systematic confirmation that an MCP is the best long-term means of achieving the CCG's system objectives, the CCG has evaluated options across the range of MCP design features.
- The options include, but are not limited to, a full open market procurement or enhanced system collaboration and could also reflect change during 2019 in timeline or work with other CCGs in NWL.



Our proposed approach will be influenced by work of neighbouring CCGs and across North West London. Are there additional considerations we should take into account at this stage?

B Evaluating design options for the MCP (continued)

- The CCG has evaluated MCP options for:
  - route to market (left open, as explained above);
  - delivery model;
  - contract form;
  - contract length;
  - contract flexibility;
  - payment approach (core payment);
  - payment approach (incentive payment);
  - risk sharing; and
  - transformation phasing.

The objective is to design an MCP that gives providers the tools and incentives to transform services.

The evaluation of the route to market was informed by consideration of how other care systems have approached similar programmes, including Dudley, South Warwickshire, the City of Manchester, and Lambeth.

Provisional core features of the MCP design are:

- an NHS standard contract, at least ahead of the national integrated care contract being available;
- a long-term contract that provides certainty to all parties and enabling investment & transformation;
- a flexible contract that permits planned changes in scope and rebasing of financial arrangements, plus appropriate exit arrangements;
- a core payment that is mainly block with activity-based provisions where appropriate;
- an incentive payments approach in which the emphasis on improvement in outcomes increases over time;
- risk sharing arrangements that operate between the CCG and MCP and between the MCP and other system providers; and
- transformation phasing that prioritises simultaneous changes across all groups of services and population cohorts.

Additional detail under each category is currently commercial in confidence and will be considered by private sessions of the Governing Body.

Do the Board support the proposed core features above as a working assumption to now take forward more detailed work on the make up of the MCP?

C Assessing the financial context for the MCP

The CCG's financial challenge must be addressed whether an MCP arrangement is entered into or not, whatever form the MCP takes, how it is brought about, and when.

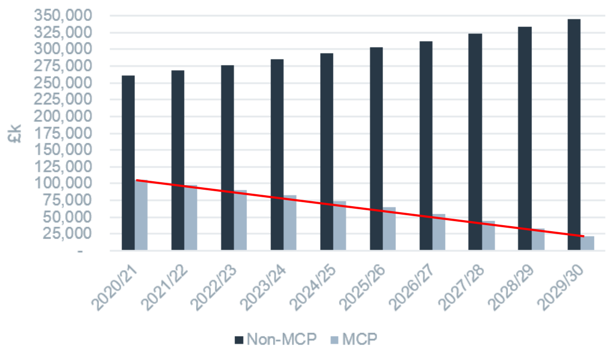
- **Estimating an affordability envelope for an MCP contract requires a longer-term view of finances than CCGs are otherwise required to produce.**
- A model and set of assumptions have been developed that allows this to be done.
- **It shows how investment in an MCP depends on a range of factors – particularly spend on acute care and prescribing, which are funded on an activity basis.**
- **This sets the financial context for the commissioning and delivery of the MCP.**
- The pre-existing building blocks for this work are:
  - the CCG's one-year budget for the current financial year, 2018/19; and
  - the North West London financial planning model, which spans the years 2018/19 to 2021/22.
- A financial planning model spanning 2018/19 to 2029/30 has been developed, in line with the assumptions of the North West London model:
  - no allocation growth, other than primary care co-commissioning;
  - equal primary care co-commissioning allocation and expenditure;
  - in all years, prescribing expenditure growth at 3-4%;
  - cross-subsidies phased out from 2019/20; and
  - outturn to budget in all years and therefore the achievement of all QIPP in current and next financial year.

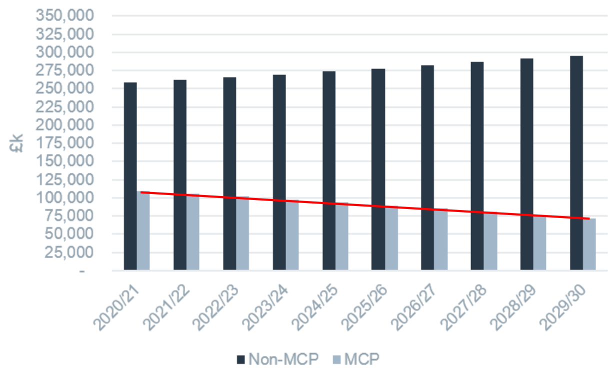
C Assessing the financial context for the MCP (continued)

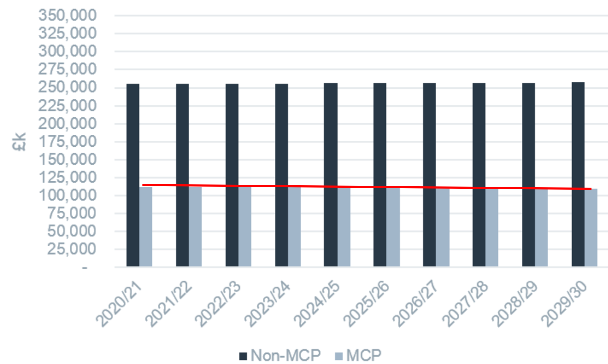
- Three scenarios have tested the impact of varying levels of growth in acute general hospital expenditure on the MCP affordability envelope. They are:

Scenario	Rationale
#1: 6% acute growth	This reflects a high-growth assumption and can be considered a potential worst case scenario
#2: 3% acute growth	This is mid-way between scenarios #1 and #3
#3: 0% acute growth	This reflects the assumptions of the North West London planning model

- The investment available in each scenario for services provisionally within the MCP scope, under current payment regimes, is shown in the three charts below:







NHS
West London
Clinical Commissioning Group

D Phasing of tasks and resources required

- Tasks and resources have been plotted over three phases to achieve an MCP in 2021/22:

	The end point of each phase	The essence of what we need to do
Phase 1: Confirming Approach	Enabling Governing Body decision on approach in September 2019	Define 'what' the MCP is and 'how' we get to it
Phase 2: Commissioning the MCP	Following commissioning process to contract award in Q3 2020/21	Implement the GB's decision on 'how' we get to an MCP
Phase 3: Mobilising Ways of Working	Following contract award preparing for MCP to commence through mobilising new ways of working across the system in Q3 2021/22	Make the MCP a reality

- The detailed programme plan for phase 1 is shown in the next section. The reminder of this section sets out an overview of the tasks, deliverables, and capabilities required to deliver phase 1.

D Phasing of tasks and resources required (continued)

- The MCP team has mapped out the principal and potential additional deliverables required to deliver phase 1 (up until September 2019 decision at GB):

Principal phase 1 deliverables
Stakeholder and market engagement plans – development and delivery
Confirmation of service scope / model of care requirements
Independent clinical review
Benefits realisation and evaluation framework
Quality and Equality Impact Assessments
Legal and specialist financial advice
Final version of business case
Financial plan for 2019/20
Commissioning intentions
Commissioning strategy and plan
Draft contract and supporting specifications
Prior Information Notice/Contract notice
Contingency plan

1. To remind members of the rationale for, and components of, the integrated care strategy
2. To discuss work since July and next steps on key areas
3. To agree the next steps for MCP development and discuss programme risks

To deliver our Integrated Care Strategy there is much to do – but not solely on the MCP

- The priorities for MCP development for the remainder of 2018/19 and the first half of 2019/20 are to complete the work required to support the Governing Body's decision on its approach to commissioning the MCP in September 2019:

Work programme up until September 2019 includes:

Integrated care in West London

- **A** developing primary care networks from 2018/19
  - Grow as new organisations to deliver agreed development plans, support mobilisation of ICT
- **B** securing benefits of current ICT and extending the scope in 2019/20 and 2020/21
  - Ensure benefits from current ICT, develop greater integration through Phase 1 workstreams, undertake stocktake of progress, design and agree legally binding alliance contract, agree widening scope of ICT,
- **C** commissioning an MCP from 2021/22
  - Engagement, MCP design (Model of Care, financial modelling, commissioning approach)

We want to keep the Governing Body updated throughout the year ahead of key decision in September 2019

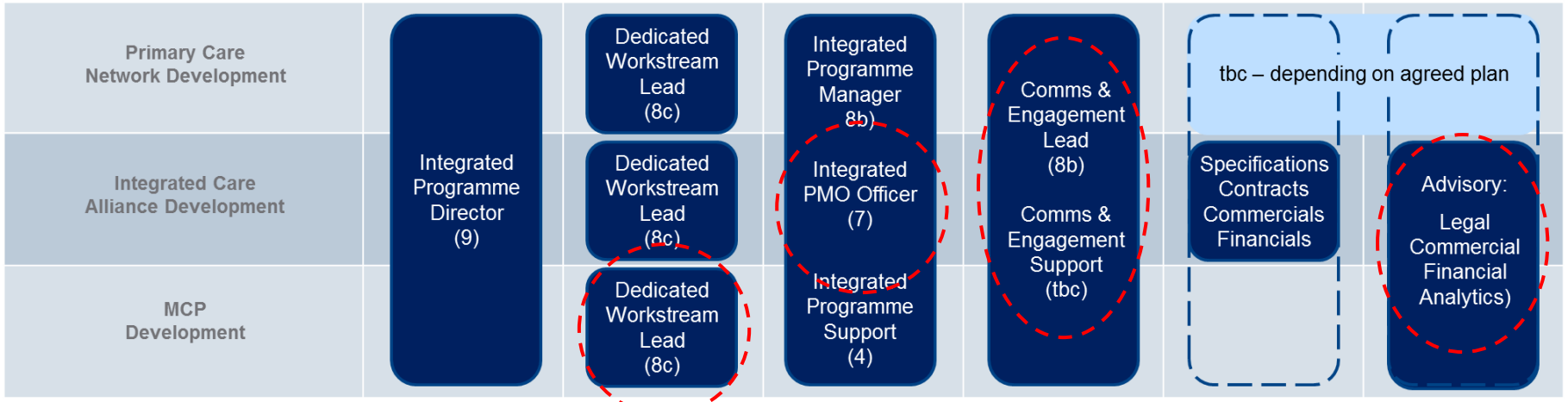
- Updates on the integrated care programme will be a standing item for Governing Body meetings at least until the decision on the CCG's MCP commissioning approach in made in September 2019
- The forward view of discussion and decisions that will act as gateways for progress is currently envisaged as follows:

	Decision points
November 2018	• Confirmation of MCP engagement plan prior to initiation (determined by the CCG Operations Group with delegated authority)
December 2018 or January 2019 (TBC)	• Review of draft alliance agreement for 2019/20 • Confirmation of progress and resource requirements for first half of 19/20
March 2019	• Confirmation of CCG approach to alliance agreement for 2019/20 • Confirmation of financial plan for 2019/20 to inform MCP development
Q1 2019/20 (TBC)	• Confirmation of remaining preparatory work required (with possible need for additional funding) to support September decision on MCP commissioning approach • Report back on next alliance stocktake
September 2019	• Decision on MCP commissioning approach • Confirmation of resource requirements for second half of 2019/20 and associated funding need

How do we evidence that reasonable progress is being made – is the approach described above sufficient to provide assurance?

For the rest of 18/19 the CCG needs to build out the team required to do this work

- The integrated care team budget includes an allocation of resource for future developments and it is proposed that budget is utilised for MCP development and ensuring the three workstreams are aligned on the same deliverables.



Note: the Programme Director will support delivery of the PCN workstream in the context of the wider programme, but accountability will remain with the Deputy Managing Director as the CCG's lead for primary care

= new role or capability required

- This structure is designed to ensure the most efficient use of both general and specialist resources across the three programmes. Colleagues across WLCCG have been asked to express interest in working within the team to also enable integration and development opportunities.
- Above our existing headcount the additional estimated cost of the resources required to deliver the known priority tasks for the remainder of 2018/19 across the three programmes is c.£200,000. This can be covered by funds already allocated to the integrated care programme.
- We are also planning for the team required after April 2019 and will provide an update in December/January

The risks of this work are considerable but manageable

- The MCP team has formed a comprehensive view of programme risks. The most significant categories of risk are summarised below.
- The full risk register is being managed by the integrated care delivery group, which will report to the Transformation Board and, in turn, to the Governing Body.

Risk category	Additional detail
Engagement	• Establishing a strong public narrative of the rationale and benefits of the change • Conducting a level of public engagement commensurate with requirements of the OSCs • Establishing the extent and nature of alignment with the Central London CCG MCP programme • Engaging with other commissioners and providers on the MCP scope to ensure alignment and viability • Establishing local authority appetite for inclusion of services and budgets • Engaging with developments in the national and NWL approaches to integrated care
Programme leadership and management	• Building a team with the right capabilities to deliver the programme plan • Managing CCG conflicts of interest appropriately
Finance	• Undertaking CCG-wide financial planning that supports a viable and sustainable MCP • Planning for foreseeable programme costs and provider costs related to the programme
Regulation, legal	• Ensuring adherence to NHSE Assurance requirements (ISAP) in case the process is required by NHS England and NHS Improvement • Ensuring that the CCG's decision-making and processes remain robust to any external challenge, particularly related to the Public Contract Regulations (2015)
Contracting	• Ensuring the correct management of contracts to enable the MCP launch date of 2021/22 • Supporting any transition of services between providers

The GB is asked to note key risks and approach to management

Any further questions?