NHS
Central London
Clinical Commissioning Group

Appendix 1: Delivering better outcomes for people in Central London

Our plan for accountable care 2017-2020

November 2017

Draft for discussion

Version 1.0
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NHS
Central London
Clinical Commissioning Group

Contents

Please see page 53 for a disclaimer covering the information in this document.

Section 1: The purpose of this document

1. The purpose of this document

A commissioning plan for better outcomes for local people

NHS Central London CCG is delighted to present this plan for improving the health and wellbeing of local people. It has been developed with input from colleagues in Westminster City Council and aligns with its City for All strategy.

Improving outcomes with local people

This plan sets out how we can support local people to improve their outcomes. We have a clear vision for how we want to work across services and organisations to better support residents. We will achieve this through a more singular commissioning perspective, uniting our requests of care professionals delivering services in Westminster around a common set of outcomes that matter most to residents. We will bring our services together much more clearly and at a much greater pace. We will be tackling areas of local inequality, prioritising the prevention of ill health and building a new system based on the principles of accountable care. As we work further with colleagues in Westminster City Council, we intend this to develop into a shared plan that encompasses both health and social care.

Our plan for 2017-2020

This is an ambitious plan for changing the way local care is commissioned and delivered. Our aim is that all of the services we offer are more aligned to focussing on people's expectations. To achieve this, we will be shifting away from the commissioning of individual services and focussing on the wider needs of our population. This plan describes how we intend to deliver on our ambition, based on a shared understanding of the nature of the problems we face and the way we intend to work in future.

Our approach

Our approach is based on:

- tackling the root causes of inequalities that affect health and wellbeing;
- focussing on the way that local people want to live their lives and experience services where they need them;
- prioritising the prevention of ill health, as well as providing high-quality services when these are needed;
- supporting, through our commissioning, better coordination of care;
- moving much more of the focus of support into the community, closer to people's homes;
- improving local networks of care, with the right level of expertise available in the community; and
- looking to the future – including embracing new technologies and digital developments and continually adapting our services and the way people can access them.

This plan describes the system that we wish to create and how we will work with all local partners to deliver it. The CCG is committed to providing system leadership and working increasingly in partnership to deliver the outcomes that matter to local people.

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Section 2: Summary

2. Summary

Plan on a page

This plan is based on five key points, which are summarised here.

1. Residents have consistently told us what they want their care services to look and feel like.

- "I am cared for as a whole person rather than a series of conditions, with continuity of care if this is important to me."
- "A range of people provide my care but they all work together, communicate effectively, and have clear roles that I understand. Together, they provide me with seamless care."
- "More of my care needs can be delivered closer to my home, without the need to visit the hospital."
- "I can access care easily and in the way most convenient for me, either in person or by using technology."

2. However, there remains a range of health and wellbeing issues that must be tackled. Health inequalities in Westminster are marked and persistent.

- Some aspects of care have improved over the past ten years, including immunisation and the management of common conditions.
- Specific issues that must be addressed include the needs of the growing number of older people, childhood obesity, and the burden of mental illness.
- Health and wellbeing is still characterised by deep inequality, including in life expectancy, early death, quality of life and the welfare of socially excluded groups.

3. How care is organised has already changed to improve health and wellbeing and deliver better experiences of care.

This has been through the development of the primary care village system and more joint working in the community.

4. But there are still problems with how care is organised.

- Even though many people need support from a range of care services, these services are mostly commissioned and delivered separately.
- This means that care is not always experienced as 'joined up'.
- It also means missed opportunities to deliver the right care in the right place at the right time.
- This impacts on people and their health and wellbeing as well as the efficiency and financial sustainability of the whole care system.

5. Further change is needed and the outcomes to which we aspire can be delivered through a 'One system, One budget, Better outcomes' approach.

- This is also known as 'accountable care', which means organising care so that it delivers the integrated and person-centred services necessary to improve health and wellbeing. It means:
  - a culture that overcomes artificial boundaries between organisations and teams;
  - all care professionals working towards a single outcomes framework, co-designed with local people, and incentivised to achieve the outcomes that matter most; and
  - organisations working under a single budget, with investment distributed to best meet people's needs.

If necessary, this will be delivered through a new contracting framework that will support providers to deliver this approach by ensuring that money flows and organisational structures help rather than hinder local professionals to deliver the best care possible.

2. Summary

The high-level timeline for this work

2017

May 2017 – the CCG and CLH published their draft primary care strategy, which set out the ambition to develop primary care homes as the delivery vehicles for a local Multispeciality Community Provider partnership

July 2017 – the Health and Wellbeing Board endorsed this direction of travel

August to September 2017 – the CCG developed a first draft of this plan, with input from Westminster City Council

October 2017 – the CCG's governing body further discussed its approach to this work

We're up to here

2018

November 2017 – the CCG's governing body authorises the programme to progress to gateway 2 (see the programme plan)

Integrated Support and Assurance Process

January 2018 – the MCP outcomes framework, scope, and system design principles are finalised following a process of co-design with partners through the Westminster Partnership Board for Health and Care and other stakeholders

June 2018 – business case approved

August and September 2018 – PQQ issued and responses evaluated; ITT issued

November and December 2018 – ITT responses received and evaluated; preferred bidder announced

2019

December 2018 to February 2019 – commissioner due diligence

March 2019 – approval of the contract award

March 2019 – contract award and signature → MCP mobilisation

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Section 3: The case for change

3. The case for change – from the population perspective

Health and wellbeing inequalities in Westminster are marked

Some aspects of health and wellbeing in Westminster have improved over the past ten years. Recent advances include improvements in childhood immunisation and the identification and management of common conditions like asthma.

However, health and wellbeing in the borough is still characterised by inequality. This includes:

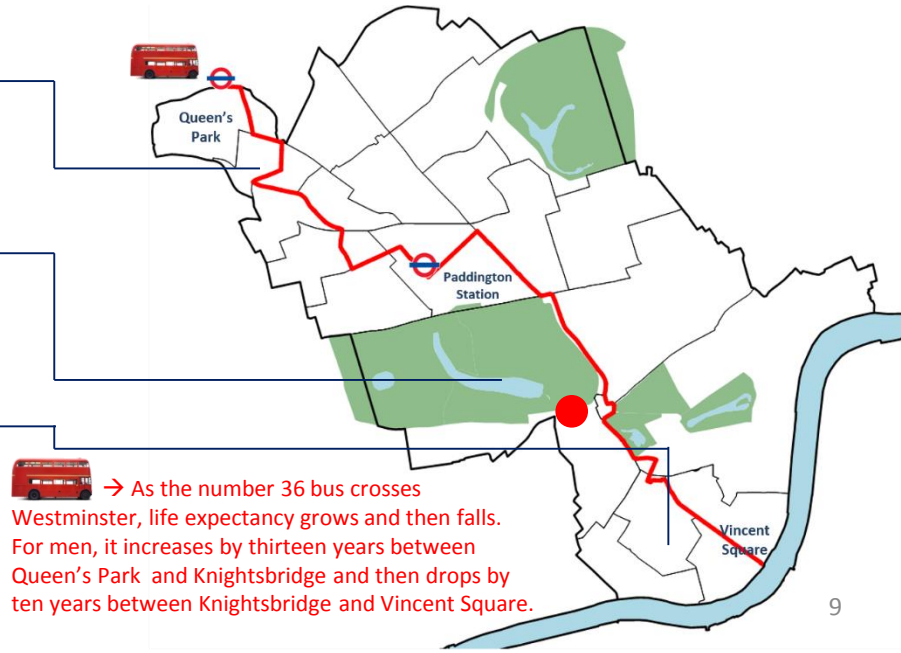
- **life expectancy** – people in the most deprived parts of the borough have shorter lives: 17 years shorter for men and 10 years shorter for women than those in the wealthiest wards;
- **early deaths** – approximately 213 per year, including from cancer, cardiovascular disease, and chronic obstructive pulmonary disease (and not including deaths from accidents and injuries);
- **quality of life** – there is a significant burden of disability on quality of life in Westminster, including from mental disorders, substance misuse, musculoskeletal disorders, and falls; and
- **the welfare of socially excluded groups** – difficulties in accessing and navigating the local care system can be profound for people who are homeless, some people with mental health conditions, and some older people.

The snapshots below show some of the disparities in health and wellbeing across the borough:

Harrow Road			
Life expectancy: Men – 76 Women – 85	People in bad or very bad health: 8%	People with a long-term limiting illness: 18%	Ranking in the GLA well-being index: 466/625

Knightsbridge and Belgravia			
Life expectancy: Men – 89 Women – 92	People in bad or very bad health: 2%	People with a long-term limiting illness: 6%	Ranking in the GLA well-being index: 1/625

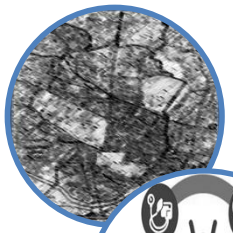
Tachbrook			
Life expectancy: Men – 83 Women – 84	People in bad or very bad health: 6%	People with a long-term limiting illness: 15%	Ranking in the GLA well-being index: 135/625



→ As the number 36 bus crosses Westminster, life expectancy grows and then falls. For men, it increases by thirteen years between Queen's Park and Knightsbridge and then drops by ten years between Knightsbridge and Vincent Square.

3. The case for change – from the individual perspective

There are also health and wellbeing issues that need to be tackled



By 2030 there will be a 15% increase in the number of **people aged over 85**, who have a variety of needs relating to frailty, dementia, and long-term conditions

Up to 30% of people with **long-term conditions** remain undiagnosed

22% of children in Westminster are **overweight** by the time they start school and 39% are overweight by year 6

Westminster has the one of the highest rates of **serious mental illness** in the country

Westminster has 27% of London's **rough sleepers** and high numbers of **homeless people** and **socially excluded adults**

Dementia in Westminster is higher than the national average, with only 11% of people with dementia dying at home

3. The case for change – from the system perspective

The way the care system is organised can disincentivise joined up care for people

Fragmentation	People often need care from a range of providers, such as GPs, social care, community services, mental health teams, voluntary organisations, and hospitals. These services are mostly commissioned and delivered separately, which means: missed opportunities for the right care in the right place at the right time through integrated care teams, uneven quality of care, and ultimately some poor outcomes.
Misaligned incentives	Commissioners' fragmented approach to contracting means that local care providers face different sets of incentives and constraints. Consequently, each part of the system works best to look after its own service users and staff without needing to fully understand or assess the impact on other parts of the care system.
Duplication of efforts	Record systems that don't join up mean that care providers often don't know a person's full story, such as medical history, test results, lifestyle, and home situation. This can mean that people receive multiple requests for the same information and the system duplicates effort, impacting on resources.
A confusing system	Our local care system can be accessed in many ways, through both health and social care. With these numerous entry points, people and care professionals are often unclear about how to obtain the best care and how to coordinate care to achieve the best possible health and wellbeing outcomes.
Workforce challenges	With fragmentation, duplication, and various operational constraints comes a workforce challenge. Based on current ways of working, we cannot staff or resource all the services we need to provide, leading to gaps in provision and lower quality or unsustainable staffing costs.
Financial sustainability	All of the issues above drive inherent inefficiencies and spending on care that does not contribute to the health and wellbeing of local people – and at the same time threatens the long-term sustainability of the local care system.

3. The case for change – from the workforce perspective

Westminster is not yet making best use of its skilled workforce

Westminster needs a care workforce with the skills and capacity to deliver care in the right place at the right time.

We have not yet achieved this. The themes in the boxes below show some of the current workforce challenges in Westminster, many of which are common across health and social care.

- recruitment
- vacancies
- availability of local housing
- a retirement bubble
- morale
- turnover
- costs of temporary staff
- skills gaps

These issues all impact on the quality of care delivered in Westminster and, in turn, the health and wellbeing of local people.

We want every care professional working in Westminster to be able to say:

"I am part of a team built around each person's individual needs"	"I understand the professional network around me"	"I know who to else to contact for my patient or client"	"I have time to focus on prevention as well as cure"
"I am able to flex my skills and experience to meet people's needs"	"I can work with others to be creative about how I deliver the best care"	"I have access to the data about my patients and clients required to do my job"	"I work in premises that support the delivery of good care"

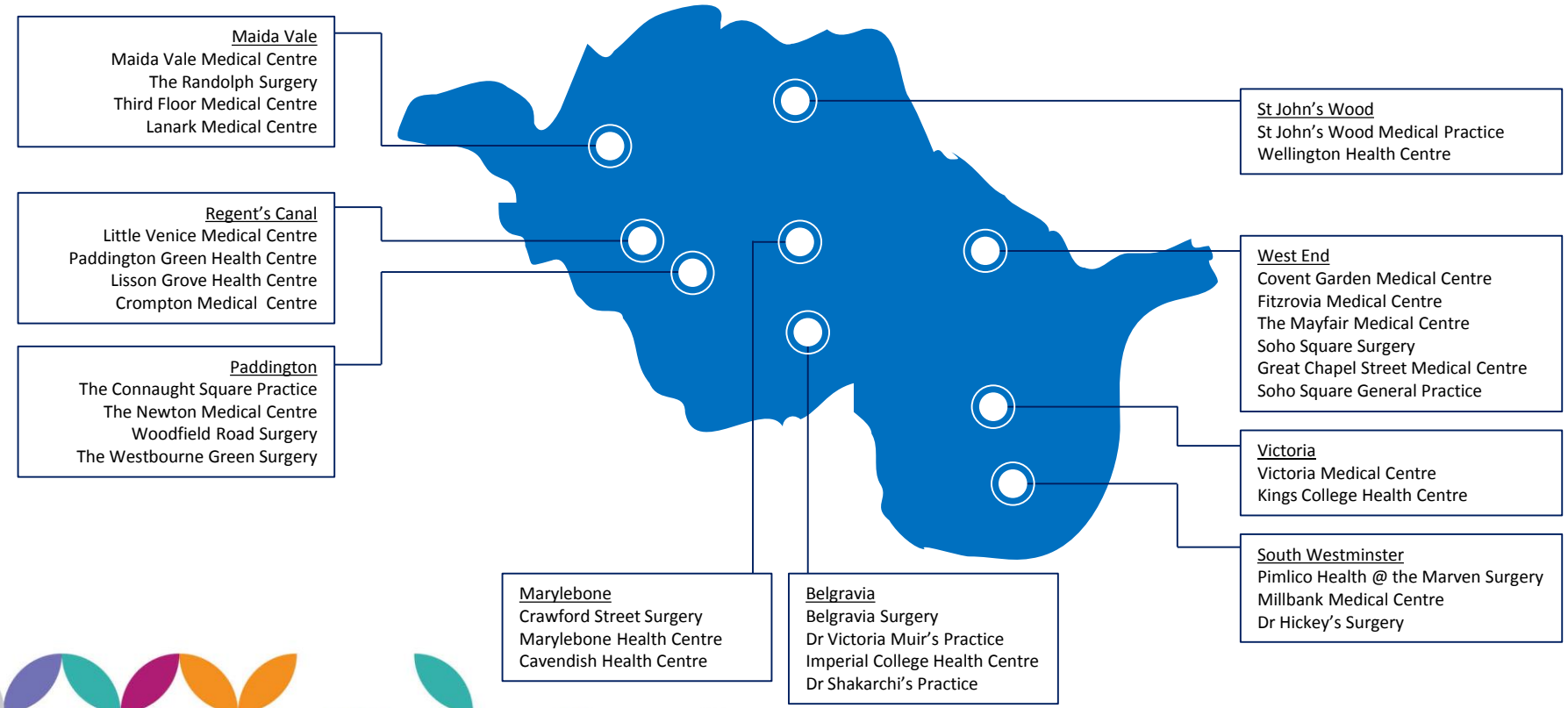
3. The case for change – progress to date

We have already started to change how care is organised to improve health and wellbeing and to deliver better experiences of care

The CCG and Westminster City Council are already working together to join up services more effectively.

There have so far been two key stages:

- the formation of nine villages, shown on the map below – groups of general practices working together to share expertise and each with a care navigator to oversee community referrals and to help support people after they leave hospital; and
- the current development of primary care homes – larger groups of practices working more formally together and with community services, social care, and the voluntary sector to develop a single integrated offer for care delivered outside of hospital.



3. The case for change – accountable care in theory

We now need to go further and faster to deliver the improvements required

Accountable care is based on the principle of '**One** system, **One** budget, **Better** outcomes'.

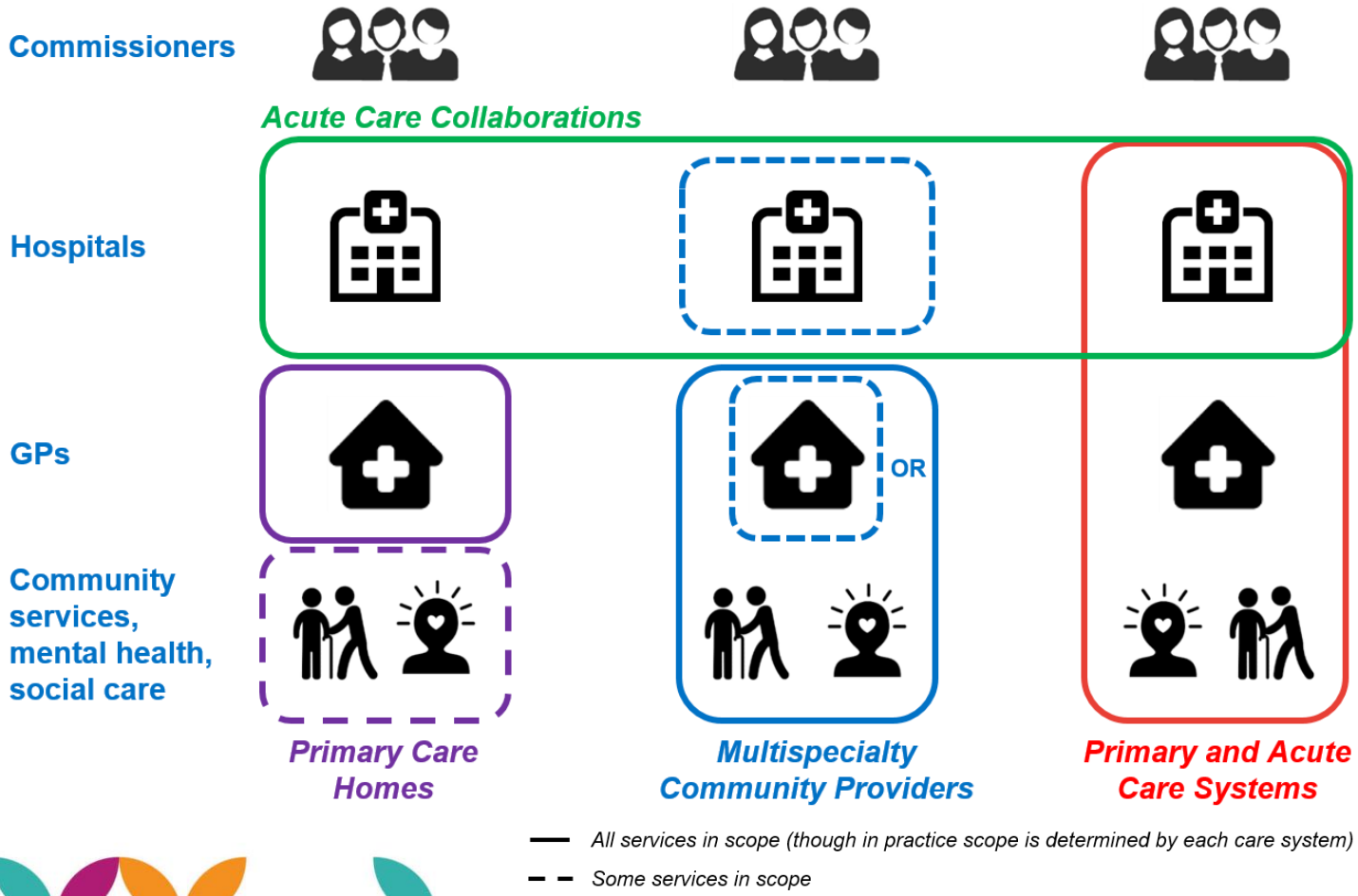
One system, **One** budget, **Better** outcomes

One system	**One** budget	**Better** outcomes
→ a one-system and one-team culture designed to overcome the artificial barriers between care organisations in the current system and to enable the sharing of expertise across all local organisations for the benefit of our whole population	→ organisations working together under a single capitated budget (potentially from multiple commissioners) and distributing investment across the system according to how it best meets people's needs	→ teams and organisations delivering care in Westminster working towards a single outcomes framework, co-designed with local people, and incentivised to support people to achieve the outcomes that matter most

3. The case for change – accountable care in practice

The *Five Year Forward View* sets out options for implementing accountable care

The NHS's *Five Year Forward View* describes a range of new care models, two of which in particular reflect the principles of accountable care. These are Primary and Acute Care Systems and Multispeciality Community Providers. The next page explains why a Multispeciality Community Provider, which is focussed on care delivered outside of hospital, is the form of accountable care most suited to Central London.



3. The case for change – focussing on care provided in the community

A Multispeciality Community Provider (MCP) will improve local outcomes

A Multispeciality Community Provider, which is focussed on care delivered in the community, is the form of accountable care most suited to Central London.

Our focus is on care delivered in the community because:

- this is where care is most fragmented and the benefits of integration for local people are greatest;
- this is where many types of care can be wrapped around primary care and tailored to each community's specific needs;
- this is where holistic care can focus on the long-term support of people in their own surroundings;
- this is where care can best encourage prevention, self-care, and the wider wellbeing agenda; and
- the flow of local people into hospital care involves a much wider area and must therefore be brought into an integrated system with a larger group of partners.

An MCP is multispecialty, community-based provider of a new integrated care model, potentially implemented through a new contract that formalises the new '**One** system, **One** budget, **Better** outcomes' approach.

It will deliver a wide scope of out-of-hospital care, based on a close partnership of organisations working under a single budget and delivering locally devised outcomes. It will operate through the primary care homes.

→ One issue that must be resolved through this work is the impact of the non-coterminous boundaries of Central London CCG and Westminster City Council, due to the Queen's Park Paddington (QPP) area sitting with West London CCG. The CCG and WCC will work with their partners to ensure that the benefits of accountable care are enjoyed by all of the people in Westminster.

3. The case for change – the accountable care model

We have a three-stage journey to an accountable care system

As our primary care strategy set out, accountable care through an MCP is an extension of the transformation of local primary care already under way:

DONE ✓

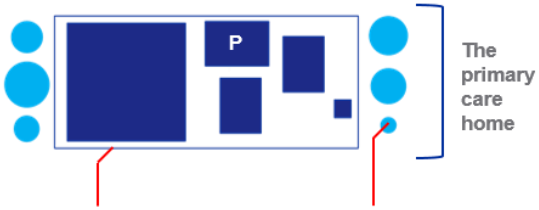
Stage 1: embedding effective village working

Primary care through the villages

- practices work together effectively in local groups
- MDT working is established
- working across organisations is established, including social care and the third sector

IMPLEMENTATION UNDER WAY ✓

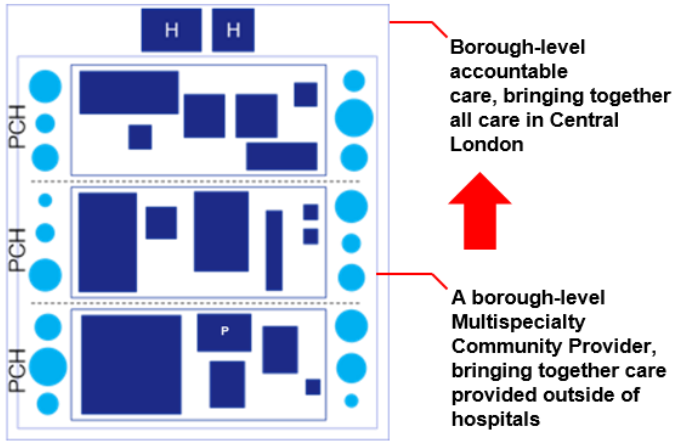
Stage 2: forming primary care homes



- practices are working in larger established units
- this way of working is more formal
- the sharing of skills and experience for the benefit of people receiving care is routine
- defined roles and responsibilities mean that who does what, and how, is clear
- primary care homes are capable of providing services at scale

PLANNING UNDER WAY ✓

Stages 3: forming an MCP and accountable care



Note: these diagrams shows an illustrative number of practices within a primary care home and number of primary care homes

- principles of joint working are well established
- there is clarity about local need and local resources and agreements are in place which facilitate local flexibility
- integration of services around people across health and social care

Section 4: Focusing on outcomes that matter

4. Focusing on outcomes that matter

The approach set out in this plan supports the delivery of local priorities

The CCG's **Sustainability and Transformation Plan**

click here

→ *three core aims*

- Improving health and wellbeing
- Improving care and quality
- Improving productivity and closing the financial gap

→ *five new delivery areas*

- Radically upgrading prevention and wellbeing – supporting everybody to play their part in staying healthy
- Eliminating unwarranted variation and improving the management of long-term conditions – everyone having the same high-quality care wherever they live and every patient with a long-term condition having the chance to become an expert in living with their condition
- Achieving better outcomes and experiences for older people – caring for older people with dignity and respect and never caring for someone in hospital if they can be cared for in their own bed
- Improving outcomes for children and adults with mental health needs – no health without mental health
- Ensuring that there are high quality and sustainable acute services – high-quality specialist services when people need them

Westminster City Council's **A City for All** plan

click here

→ *three new priorities*

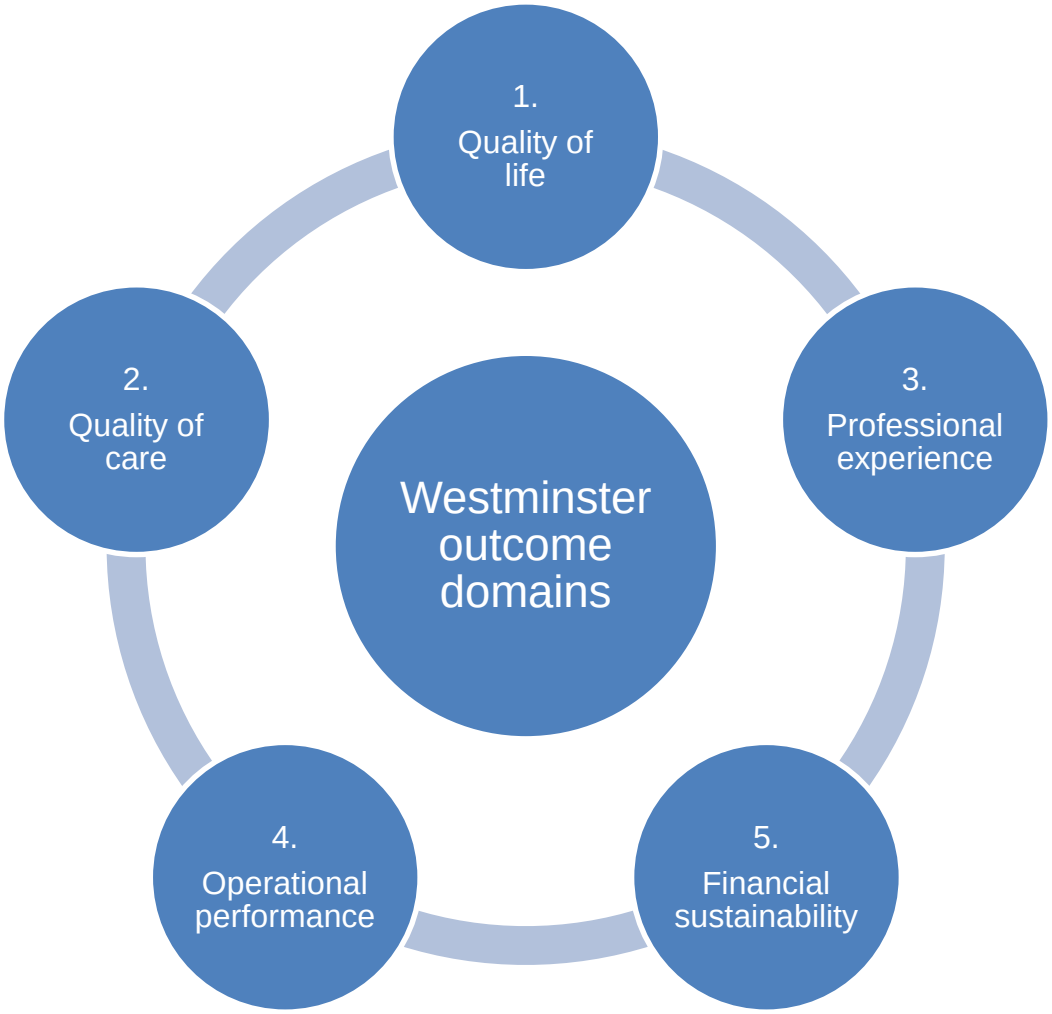
- Civic leadership and responsibility at the heart of all we do – ensuring that the council acts as a custodian of the city
- Opportunity and fairness across the city – including through housing and education and by supporting the most vulnerable people in the city
- Setting the standards for a world-class city – promoting the good practice of businesses that operate responsibly and tackling negative impacts of the sharing economy and anti-social behaviour on residents and business

→ *five new programmes*

- Civic leadership – giving everybody a stake in the future of our great city
- Building homes and celebrating communities – providing good quality and truly affordable housing
- Greener city – cleaner air and widely prized open spaces that are the envy of the world
- World-class Westminster – giving everyone in our community a stake in making Westminster a world-class city
- Smart Council – providing the best customer experience for our residents

4. Focusing on outcomes that matter

A key part of delivering the new approach is basing it on outcomes that matter



The objective of implementing accountable care in Westminster is to improve local people's health and wellbeing outcomes.

This work will, through a process of co-design, finalise the outcomes that we are aiming for and how they will be measured.

Outcomes are the benefits people gain from receiving care. This is in contrast to receiving a service, which should be considered an output. A course of physiotherapy is an output, whereas the fact that the person who received the treatment can now walk without pain, play with her grandchildren, and start swimming again are the outcomes.

As well as these outcomes for people, it is important also to think of outcomes from the point of view of those who deliver care, as well as the wider system, in terms of operational efficiency and financial sustainability. This is because these underpin the ability of a care system to continue to deliver the best outcomes for local people.

There has already been a lot of work done on outcomes. The North West London CCGs, along with other stakeholders, have devised an outcomes framework based on what people have said they want from their care. This is shown opposite.

It is also based on an integration of existing frameworks from across health care, social care, and public health – an important basis for the integrated system we are seeking to create.

4. Focusing on outcomes that matter

The local care system will start with “what matters to you?” rather than “what’s the matter with you?”

An ‘I statement’ is a useful way of setting out people’s expectations of what receiving care will help them to do or feel.

Each of the domains on the previous page is built up from these statements, gathered from engagement with local people.

The statements below set out some of what local people have said they want from their care. These will be finalised through a co-design process with local stakeholders.

Outcome	Outcome domain
• I can achieve my personal goals	Quality of life
• I can look after my mental and physical health	
• I can maintain my mobility and independence	
• I can take care of myself, rather than relying on others	
• I can meet and talk to other people	
• I have the opportunity to enjoy life	
• I can live at home	
• I feel safe	Quality of care
• I feel in control and well-informed	
• I feel understood and accepted	
• I feel respected for my own experience and knowledge	
• I feel that people are there when and where I need them	
• I know who to contact when I am concerned	
• I am supported effectively	

Outcome	Outcome domain
• I am supported by people who work well together	Professional experience
• I am supported by people who enjoy their work	
Additional example care professional outcomes: • I feel that I get the support and resources I need to do my job well • I feel my views are taken into account in decisions • I feel that the outcomes that matter to me are taken account of in my work	
• I receive support that is financially sustainable	Financial sustainability
• I am supported by people who respect my time	Operational performance
• I am not admitted into secondary care unnecessarily	

4. Focusing on outcomes that matter

We are increasingly measuring outcomes so that we know what difference services are making to people

The 'I statements' frame the local ambitions for the care system. A set of accompanying metrics shows whether the system is achieving these ambitions.

The metrics to be used in the outcomes framework will be co-designed with a range of stakeholders, including providers and people who use local services.

Some potential metrics for the quality of life and quality of care domains are shown below. It might be necessary to devise new metrics that relate to specific local issues.

Over time, payments and financial arrangements will increasingly align to the delivery of outcomes.

	Metric	Data source
Quality of life	Health- and social care-related quality of life in people over 65 with long-term conditions	NHSOF (2) / ASCOF 1A
	Proportion of physically active people over age 55, 65, 75 years	PHOF (2.13) / Sport England: active people survey
	Self-reported wellbeing	PHOF (2.23)
	Permanent admissions to residential and care homes, per 100,000 population (both over 65 and 18-65)	ASCOF (2A)
	Zarit Burden Interview (ZBI) score (on the burden of care for carers)	ZBI 22 item survey
	Percentage of caregivers who agree they have the support and resources to continue caregiving for at least six more months	New data source?
	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	HES, CCGOF (2.6), NHSOF (2.3i)

	Metric	Data source
Quality of care	Proportion of people with a care plan who were involved in putting it together	GP patient experience survey
	The difference between the number of people with a care plan and the number who say that they have a care plan	GP records; GP patient experience survey
	Proportion of people who use services who feel safe	ASCOF (4A)
	Delayed transfers of care from hospital	ASCOF (2C)
	Proportion of people and carers who report that the care they receive is delivered in a place that is convenient / accessible to them	New data source?
	Survey question: Have you or any members of your family had any experience where you have had to repeat your story to different health and care professionals?	New data source?

NHSOF – NHS Outcomes Framework • ASCOF – Adult Social Care Outcomes Framework
PHOF – Public Health Outcomes Framework • HES – Hospital Episode Statistics
CCGOF – CCG Outcomes Framework

4. Focusing on outcomes that matter

The CCG is working with partners across the city to achieve the improvements we need to see

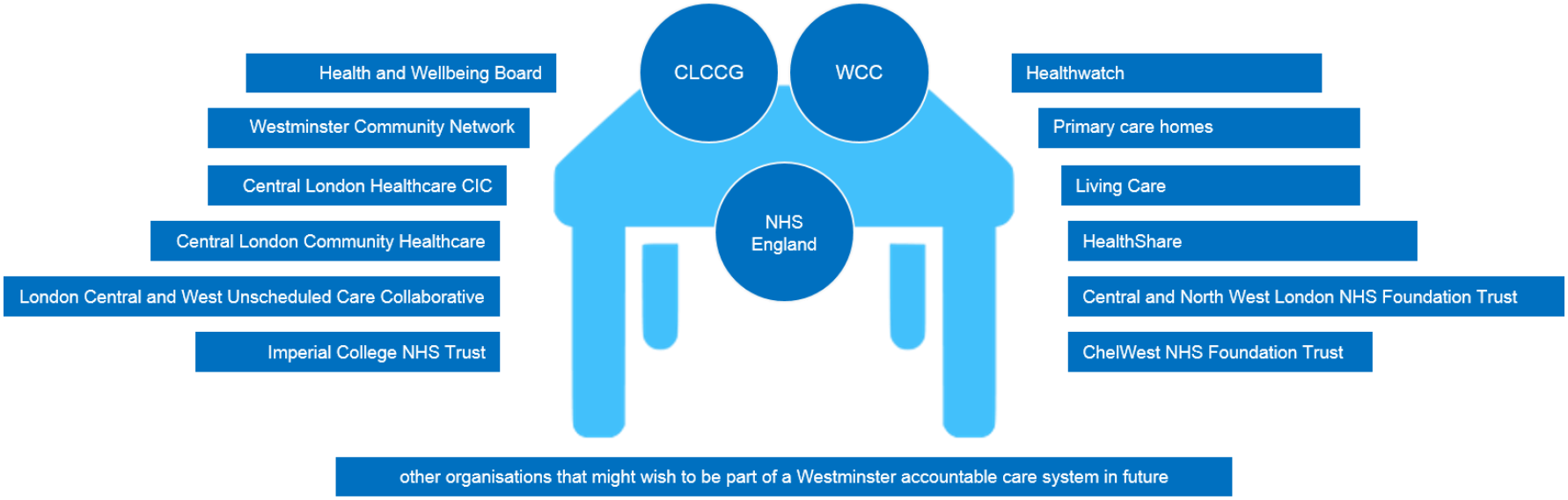
Achieving the right health and wellbeing outcomes for people in Westminster requires all care organisations – both commissioners and providers – to work together and with local people. Only in this way can we be sure that resources being spent in the city are maximising outcomes and delivering value for money.

Central London CCG and Westminster City Council will lead the process of bringing the right organisations together, along with representatives of local patients and service users. All parties can then drive progress on achieving the vision for care in Westminster.

This will be mainly through the **Westminster Partnership Board for Health and Care**.

Its main purpose is to co-design aspects of the commissioning approach with all relevant stakeholders, from across Westminster and beyond, and to drive rapid progress in both design and implementation.

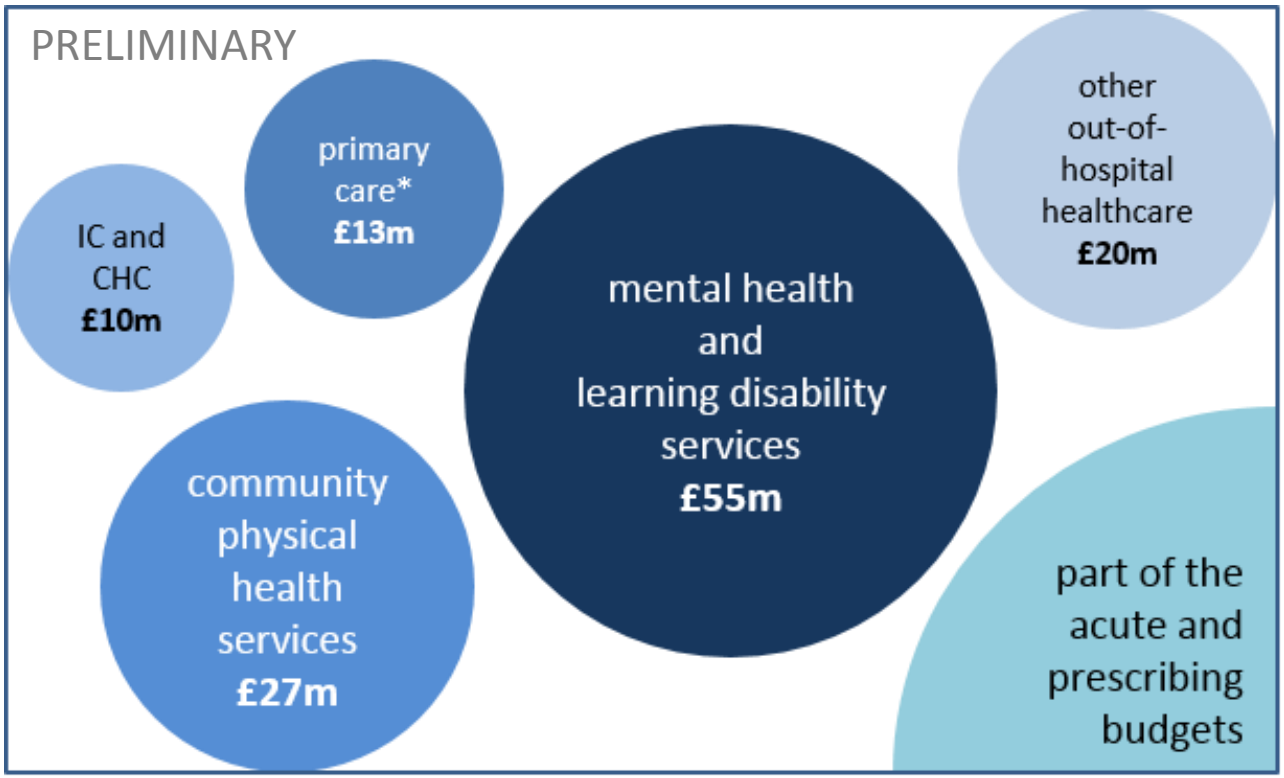
The range of organisations and stakeholders involved includes the following:



4. Focusing on outcomes that matter

Accountable care will bring together an ambitious scope of services and budgets

The initial scope for this programme of work is set out below. Its focus is on the services, contracts, and budgets that support people in the community.



* excluding contracts for core primary care services (GMS, PMS, APMS)

Source: Central London CCG 2017/2018 budget lines

Note: this preliminary financial analysis uses CLCCG budgets so does not include healthcare for the QPP non-coterminous area of Westminster

Section 5: The model of care we're looking to deliver

5. The model of care we're looking to deliver

How care is delivered in Westminster will reflect the needs of local people and communities

The future accountable care model will not involve commissioners specifying in great detail the services they wish to be provided. Instead, commissioners will work with residents to devise an outcomes framework and then fund the system to meet these outcomes. Providers will decide how best to organise and deliver services to meet the outcomes.

However, the commissioners are clear on the key **design principles** that they expect the local system to reflect. These are informed by what residents have told us they want and are listed on the left. Some more specific **core requirements** of the system are shown on the right.

These will be worked up in more detail in a co-design process with a range of local stakeholders.

- ✓ **Resident-focussed** – we expect all our residents to be supported by a single care team, using a single assessment and support process, supported by a single care plan if necessary
- ✓ **Community-focussed** – the care system will by default provide support in the community and make use of hospital or other bedded care only when necessary
- ✓ **Geographically relevant** – the approach to care must recognise the unique geography of Westminster and provide tailored solutions for people living in the north, centre, and south of the borough
- ✓ **Collaborative** – local approaches to care must be co-designed with local people and a wide range of local interest groups
- ✓ **Preventative** – the care model will focus on prevention and self-help, giving residents power over their own choices, health, and wellbeing

A **workforce** that is in the right place, with the right capacity and has the right skills

Access to **technology and data** that supports the delivery of joined up care

Time to focus on **prevention** as well as cure

Estates that are fit for purpose and support new ways of providing care in the community

Networks and structures that enable **collaborative working** centred around local people

Local structures that support **clinical leadership** of care networks

Digital **technology** that supports new ways of providing care

Processes that allow more of practitioners' **time** to be spent on caring

Freedom and support to **innovate** with how care is delivered

A **career path** for care professionals that mixes variety and specialisation, supported by appropriate professional development

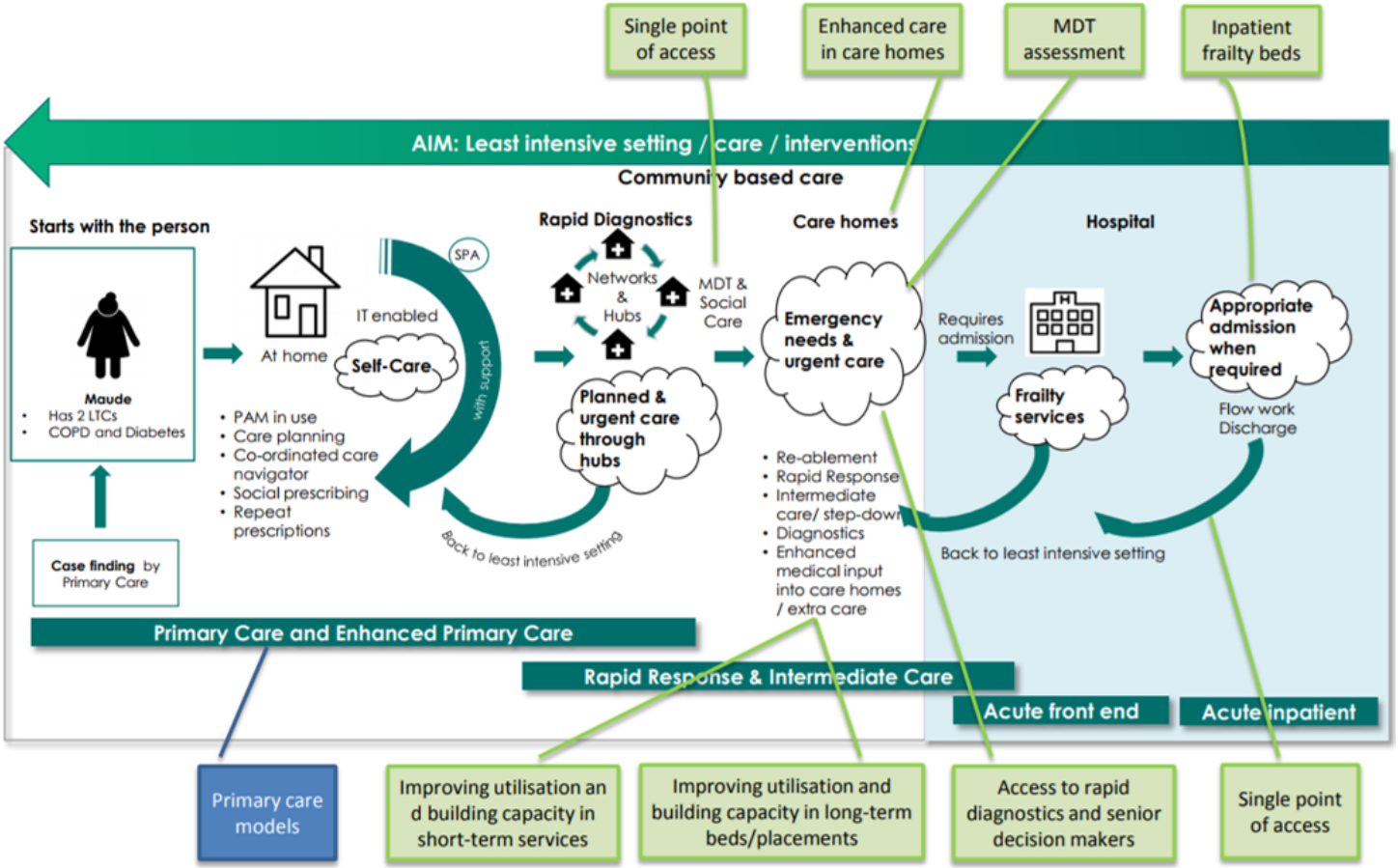
5. The model of care we're looking to deliver

Care must support a better quality of life and deliver better value for money

Our intention is to maximise people's quality of life by supporting them to stay well and delivering more of their care closer to home.

The diagram below shows how this will be achieved for an older person requiring the coordination of her care through a range of health and social care services.

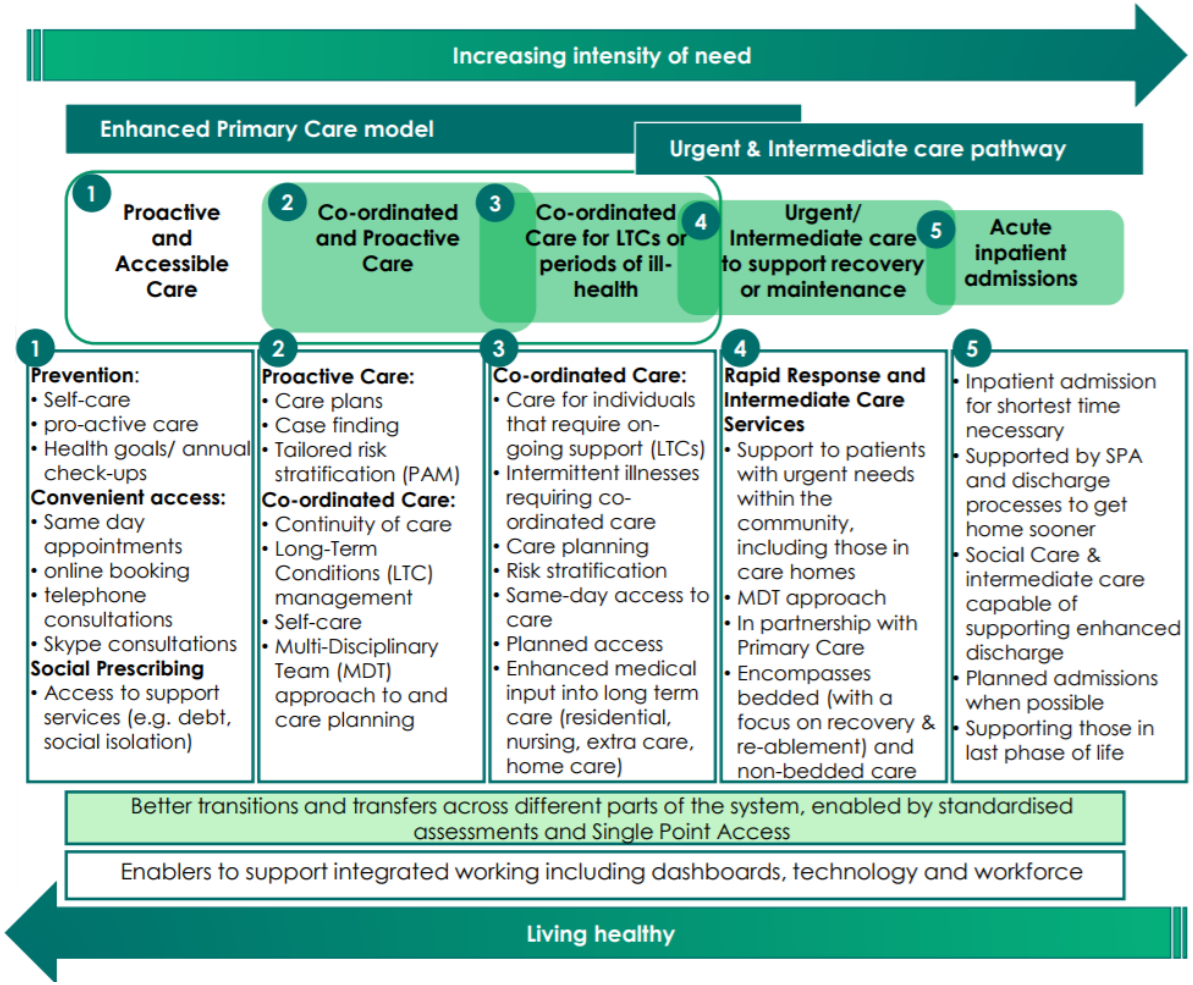
We also need to develop and integrate the support that **keeps all cohorts of people healthy and well** and therefore needing primary care less often. This includes housing, employment, and a variety of other forms of social support



Source: NWL Local Services strategy

5. The model of care we're looking to deliver

Achieving this ambition requires changes across the system



Source: NWL Local Services strategy

This is part of a broader social care model that integrates with primary and secondary care to support people in their communities:

Section 6: Implementing the change – from 2018/19

6. Implementing the change – from 2018/19

Enhancing services for people in the community – the Partnership in Practice contract

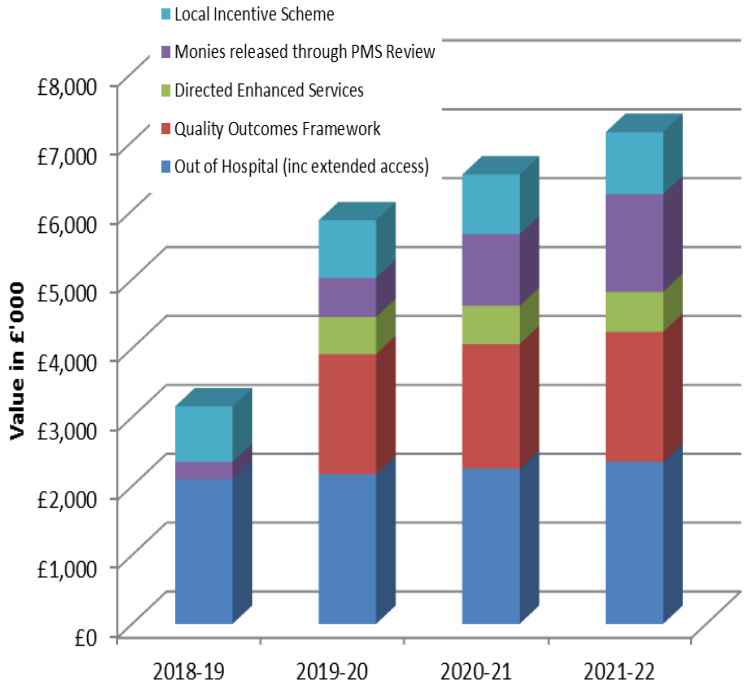
Beginning 1 April 2018:

- The CCG's non-core primary care commissioning will be brought together into single contracts
- These contracts will begin with a specific scope but include opportunities to draw in other commissioning arrangements and funding streams
- To reduce variability in outcomes, the contract will be held by new at-scale providers of primary care services

This contract will support more of a system leadership role for primary care:

- Increasing collaboration across health and care teams, as well as collaboration in primary care
- Increasing the flexibility of primary care to direct funding across services in a way that best enhances care, rather than according to the requirements of multiple contract
- Encouraging new and innovative approaches within and across practices, alongside other community health and care teams
- Supporting the formation of primary care at-scale models, including primary care homes, as the basis for more of a system leadership role for primary care
- Reducing the level of administration of contracts required within primary care – and therefore boosting the money that can flow direct to care

Funding for the new Partnership in Practice contract is expected to increase each year from 2018/19 to 2021/22, as shown in the chart below:



This contract will support the system to transition from the current model of commissioning to the future approach based on principles of accountable care.

6. Implementing the change – from 2018/19

The beginning of the shift of planned care pathways into primary care

What?

- The co-design of pathways around specific conditions with local people and clinicians so that they reflect national best practice and deliver care closer to people's homes, rather than in outpatient clinics within hospitals
- The CCG's hubs programme is a critical part of this shift of care as it will ensure that there is enough clinical space to deliver this care within the community. The South Westminster hub is in operation and there are plans for hubs in the central and north localities are under development

Why?

- To improve service quality and outcomes
- To prevent the need for people to attend hospital clinics for diagnosis and treatment of some simple conditions
- To improve the integration of the pathways into primary care and with the whole-systems approach
- To ensure integrated and seamless care for people receiving care along the pathway
- To pursue the objectives of accountable care in terms of providing more care closer to people's homes and removing current duplication between services and therefore improving efficiency

The pathways currently in development are:

Ophthalmology – a self-referral approach for people with minor eye conditions and cataracts to high-street optometrists

Gynaecology/Urology – consultant triage, with care planning and advice; the continence services will be maintained as a community service delivered as close to home as possible

Neurology – with a focus on pathways that should be delivered in a community setting, such as Parkinson's Disease

Gastroenterology – a more streamlined pathway

Cardiology – consultant triage, with care planning and advice; GP education to support keeping people in primary care wherever possible

Diabetes – education within primary care so that people can be cared for as close to home as possible; the development of a community-led diabetes service that will be rolled out in 2018/19

Cancer – support for primary care to increase participation in cancer screening at a local level

6. **Implementing the change – from 2018/19**

A new model to support frail elderly people in Westminster

What?

- The invitation to primary care homes to devise a new integrated model of care for frail elderly people on their practices' registered lists, focussed on bringing together all relevant care services to deliver seamless offer
- Commissioners are keen that this model involve the secondment of appropriate staff from a range of community-based teams into the primary care homes in order to reduce current organisational barriers to collaboration and assist joint assessment, support, and review. Other approaches should include more proactive care management of risk through up-scaled MDT working

Why?

- To improve quality of life and quality of care for one of Westminster's most vulnerable groups of people – especially the small but increasing number of people frail elderly people who are living alone
- Key outcomes should include more time spent at home, a reduction in avoidable admissions, a reduction in delayed transfers of care, and a better diagnosis rate against dementia prevalence
- To reduce unplanned admissions into hospital by frail elderly people, thereby bringing more of their care closer to home and achieving more efficient use of resources (a key priority of the NWL Sustainability and Transformation Plan)
- To demonstrate proof of concept of designing care around groups of people with similar care needs, which will be a core organising principle of how accountable care will be delivered across Westminster

The key principles of a Westminster frailty model should be:

- dignity, respect, and privacy
- a whole-system model where all parts of the system link from self-care, through primary care and social care, to services that should be provided in hospitals to enable people to return home to live healthy and independent lives
- improved communication and co-operation between health and social care in the community and the community and the hospital
- a focus on health inequalities, with everybody in the community receiving the best possible care and no one disadvantaged in access or experience due to their postcode
- consistent and rigorous assessment of need and an appropriate and prompt response in an appropriate location, in or near to the person's home wherever possible
- routine healthcare taking place as close to home as possible

6. Implementing the change

We are also now establishing the programme to deliver long-term change

The key information about this programme of work is summarised below.

➢ Programme objective

- To launch accountable care working in 2019

➢ Programme domains

- **Commissioning and contracting** – developing and implementing a joint CCG and WCC commissioning strategy and contractual approach
- **Primary care provider development** – establishing the primary care home model
- **System leadership** – supporting providers to respond to the challenge of accountable care
- **System enablers** – preparatory work on the improvement of estates, digital, and workforce infrastructure that will support accountable care

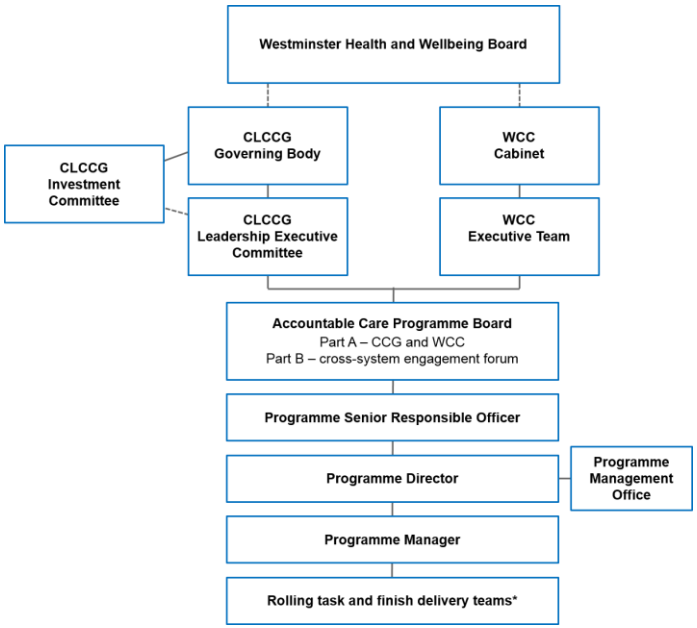
➢ Success criteria

A system that supports the people of Westminster to achieve better health and wellbeing outcomes	An integrated health and care system with a "can do" and "it's my job" approach	Services designed around personalisation, prevention and population health improvement
A system that lives within its financial means	A demonstrable shift of investment and resources towards prevention	Greater workforce satisfaction and new, accessible career paths
A stronger role for primary care as the leader of the system	A reduction in transfers of accountability for patient care	Improved use of resources, particularly estates and digital technologies
A step-change in self-management and self-care	People using health and social care services are kept safe from harm	A system that does not waste patient or staff time

6. Implementing the change

We are also now establishing the programme to deliver long-term change (cont.)

➢ Programme structure



* For the delivery of specific tasks or products, such as the development of the capitated budget and finalisation of the outcomes framework

➢ Key constraints and assumptions

Constraints

- a current lack of alignment between commissioner projects and programmes where this is necessary for programme success;
- evolving guidance from NHS England on accountable care contract forms and procurement rules;
- the requirements of the Integrated Support and Assurance Process (ISAP);
- limited system resources for implementation and opportunity cost where existing resources are transferred;
- limited at-scale provider development within primary care to date;
- limited collaboration between potential accountable care partners to date; and
- challenging timelines in which to design the commissioning approach and for providers to construct a viable partnership capable of delivering accountable care.

Assumptions

- system-wide appetite to make accountable care work;
- the full business case developed by the commissioners will confirm the strategic, economic, commercial, management, and financial cases for accountable care;
- the system will make available sufficient resources for the design and implementation of accountable care;
- the programme will have access to all relevant legal and other technical advice required;
- local plans can be tailored in line with emerging NHS England guidance and more detailed technical guidance does not contradict or undermine local ambitions;
- national workarounds required for issues identified by earlier accountable care programmes will be devised by NHS England in time to inform this programme.

Section 7: Implementing the change – from 2019/20

7. Implementing the change – from 2019/20

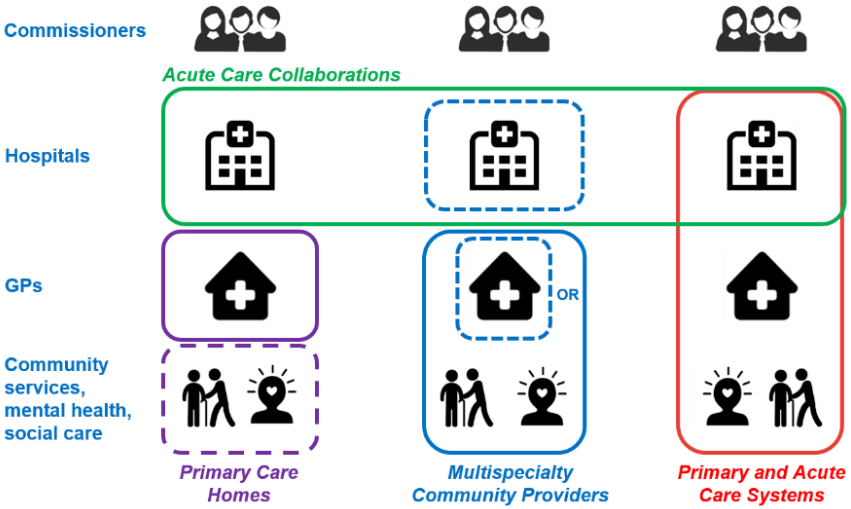
Accountable care in Westminster

The changes described above will help to improve local health and wellbeing by better joining up a range of primary care services.

On top of this, there needs to be a more formal and structured approach to ensuring that care is not hindered by boundaries between organisations or how money flows across the system.

This is the basis of the '**One** system, **One** budget, **Better** outcomes' – or accountable care – approach.

The NHS's *Five Year Forward View* describes a range of new care models, two of which in particular reflect the principles of accountable care. These are Primary and Acute Care Systems and Multispeciality Community Providers. The table opposite explains why a Multispeciality Community Provider, which is focussed on care delivered outside of hospital, is the form of accountable care most suited to Central London.



Advantages of delivering accountable care through a Multispeciality Community Provider

- ✓ It focuses on the care delivered outside of hospitals, which is where:
  - care is most fragmented and the benefits of integration for local people are greatest;
  - many types of care can be wrapped around primary care and tailored to each community's specific needs;
  - holistic care can focus on the long-term support of people in their own surroundings; and
  - care services can best promote prevention, self-care, and the wider wellbeing agenda
- ✓ An MCP is built around GPs' registered lists and therefore reflects the role of primary care as the best integrator of the wide range of services that local people need
- ✓ The prominence of general practice in the model means that GPs are in the driving seat of leading local change
- ✓ Implementing an MCP reflects the principles of our approach to date, which has been to focus on the development of primary care at scale and its integration with other care services

7. Implementing the change – from 2019/20

Scope: The MCP will be built around general practice

The CCG has identified a **Multispecialty Community Provider** as the preferred local approach to accountable care.

This is partly because an MCP is built around GPs' registered lists and therefore reflects the role of primary care as the best integrator of the wide range of services that local people need.

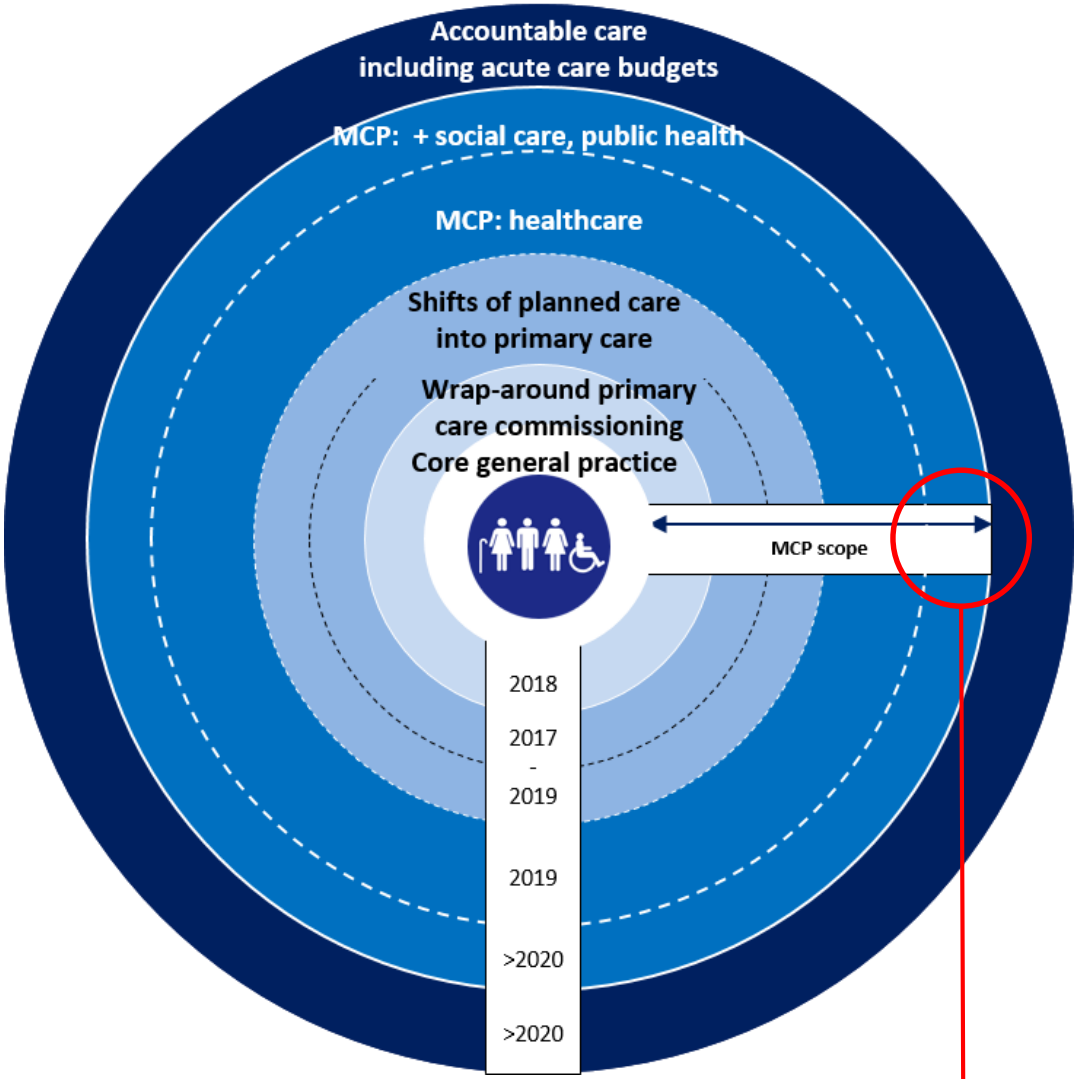
More specifically, many services will operate through the **primary care homes** now being developed.

These are groups of practices serving populations of around 30,000 to 50,000 people.

They will be the operational delivery units of the MCP.

Within general practice, they allow for the routine sharing of clinical skills and experience, specialisation that can drive up quality, and the provision of services at scale.

Beyond general practice, the primary care homes act as the cores around which other services organise themselves and deliver their services.



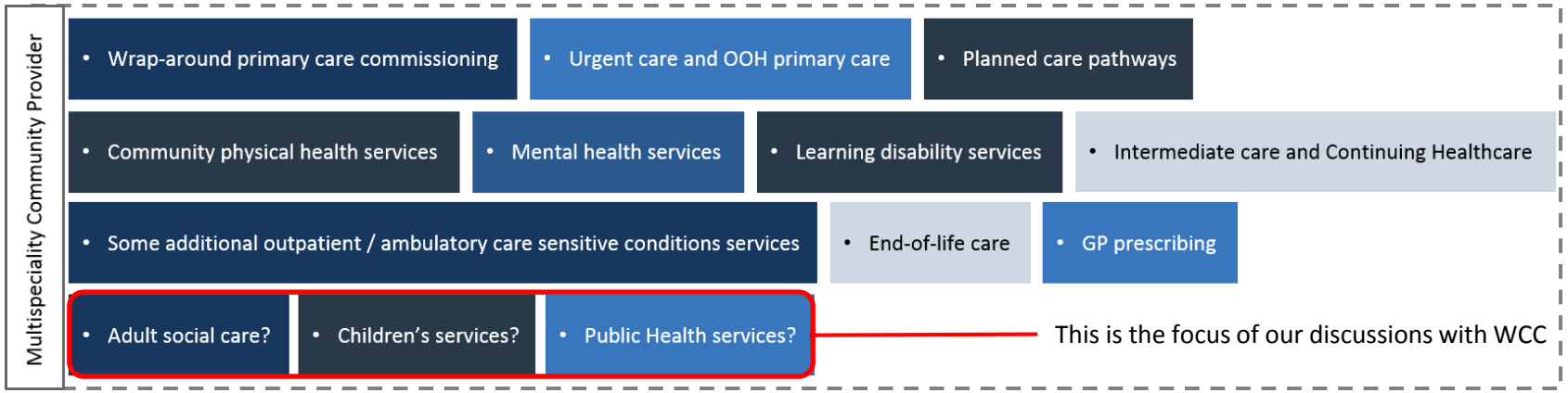
This is the focus of our discussions with WCC

7. Implementing the change – from 2019/20

Scope: The MCP needs to be broad enough to make a difference to people's care

The scope of an MCP needs to be large enough to improve local health and wellbeing outcomes by developing a truly integrated out-of-hospital service. A potential broad scope is shown in the diagram below.

This expands the detail on the previous page. It assumes that primary care core contracts are not included in the MCP (which makes it a partially integrated model rather than a fully integrated model, according to NHS England's definitions). The CCG will require the MCP to form integration agreements with the primary care homes, on behalf of their constituent practices, to ensure that the boundary between core general practice and the MCP does not impact negatively on how care is delivered.



An MCP will also assume various commissioner functions and funding necessary for it to achieve the health and wellbeing outcomes required. This could include service redesign, safeguarding, assessment, and medicines management.

Choice will remain as an important principle that the new accountable care approach will need to support. Our current thinking is that people who choose to be treated outside the local system should have their care paid for by the accountable care provider at the prevailing national tariff or, where there is no national tariff, at a locally agreed price.

7. Implementing the change – from 2019/20

Scope: The MCP will bring together multiple fragmented contracts and budgets

The high-level and preliminary healthcare budget for a local MCP, based on the scope set out above, is **c.£122m** per year.

Added to this will be portions of current spending on acute contracts, prescribing, and commissioning and programme costs.

These values are based on 2017/18 contract values.

This will form the basis for intensive work on the calculation of a capitated budget for the MCP, in addition to which there will be:

- incentive payments based on the achievement of defined health and wellbeing outcomes; and
- a risk-share / gain-share agreement.

The table below shows the values attached to the different categories of service:

Commissioner	Category	Approximate value, £m*	
		In scope	**Partly in scope**
Central London CCG	Services in scope	122	
	Acute budgets – partly in scope		113
	Prescribing – partly in scope		22
	Commissioning and programme costs – partly in scope		16
	Totals	**£122m**	**£151m**

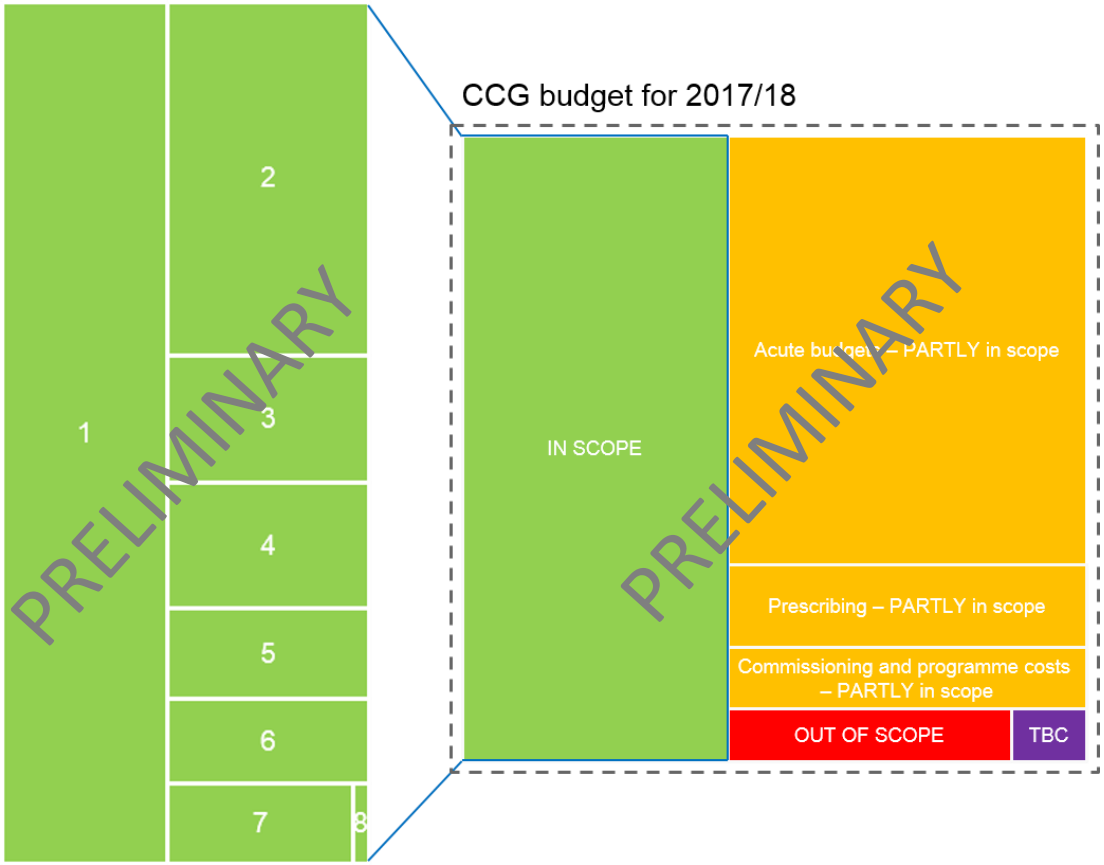
PRELIMINARY

* based on 2017/18 contract values

7. Implementing the change – from 2019/20

Scope: The MCP will bring together health budgets currently managed separately

The diagram below shows how CCG spending potentially fully within the scope of the MCP is made up of a range of budgets.



#	Service	£m†
1	Mental health and learning disabilities	55.5
2	Community physical health services	27.4
3	Adults*	9.9
4	Intermediate care and Continuing Healthcare	9.8
5	Urgent care and OOH primary care	7.0
6	Multiple**	6.5
7	Additional primary care commissioning	5.8
8	Children's services*	0.5
	Total	**122**

† Approximate value, £m (based on 2017/18 budget values)
* This mainly reflects healthcare contributions to the Better Care Fund and local section 75
** Budgets and contracts covering multiple service categories

PRELIMINARY

7. Implementing the change – from 2019/20

Integration: The MCP will provide the basis for integrating and transforming services over several years

NHS England guidance states that, if commissioners wish to avoid multiple formal procurements, the full scope of an MCP needs to be set out in the procurement process and accounted for in an MCP contract.

However, it is not feasible to expect the new MCP immediately to integrate and transform all services across its entire scope from the very start of the contract. The preferred approach is therefore to:

- mobilise the MCP in shadow form in April 2019 and then fully operationalise this in April 2020 for the healthcare services in scope, with a clear timetable of service integration and transformation based on local health and care needs; and
- subject to agreement with Westminster City Council, to bring social care services into the operational scope at a later date, as a scheduled variation advertised up front through the market engagement and procurement process.

The key advantages of this approach are:

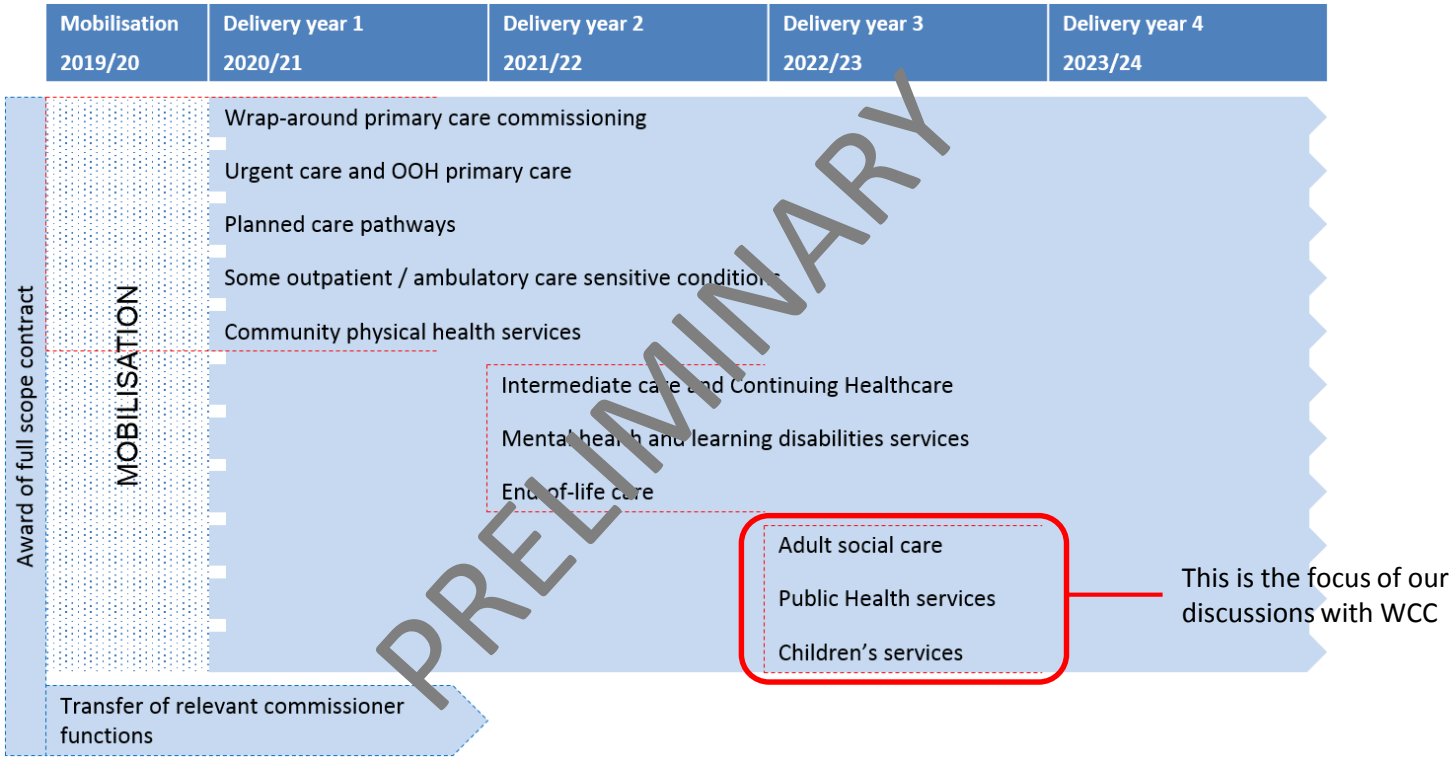
- ✓ the MCP has **near maximum reach to integrate and transform services** – and therefore to improve outcomes – from the earliest opportunity, beyond the alternative approach of incrementally folding contracts into the MCP's operational scope either as they expire or as pre-defined blocks of services relating to different population segments;
- ✓ **financial risks** associated with the mobilisation can be mitigated through the phased introduction of outcomes-based payments and the risk-share / gain-share model, as explained in this chapter;
- ✓ **operational risks** associated with the mobilisation can be mitigated through the extended shadow running period;
- ✓ it avoids the challenges of managing **rump contracts** outside of the MCP operational scope, in advance of their transfer to the MCP (although commissioners can require an integration agreement between the MCP and the providers of these services);
- ✓ it avoids an extended and complex **transfer of commissioning resources** to the MCP, in line with its growing operational scope;
- ✓ it avoids the potentially complex **unbundling of current contracts** required if services are folded into the MCP operational scope according to population segment; and
- ✓ finally, it makes a statement about the commissioners' intention to **move decisively**, rather than running a multi-year transition between system forms, providing that risks can be mitigated appropriately.

7. Implementing the change – from 2019/20

Integration: Care will be transformed in line with local needs

The chart below shows a preliminary view of a phased integration and transformation plan. Developing and verifying this requires:

- commissioner agreement on the vision for the end-state of the MCP and the local outcomes metrics it is designed to improve;
- detailed conversations with stakeholders on local transformational priorities;
- a clear understanding of operational interdependencies between services and their impact on phasing; and
- detailed contractual analysis covering expiry dates, notice options, and extension options.



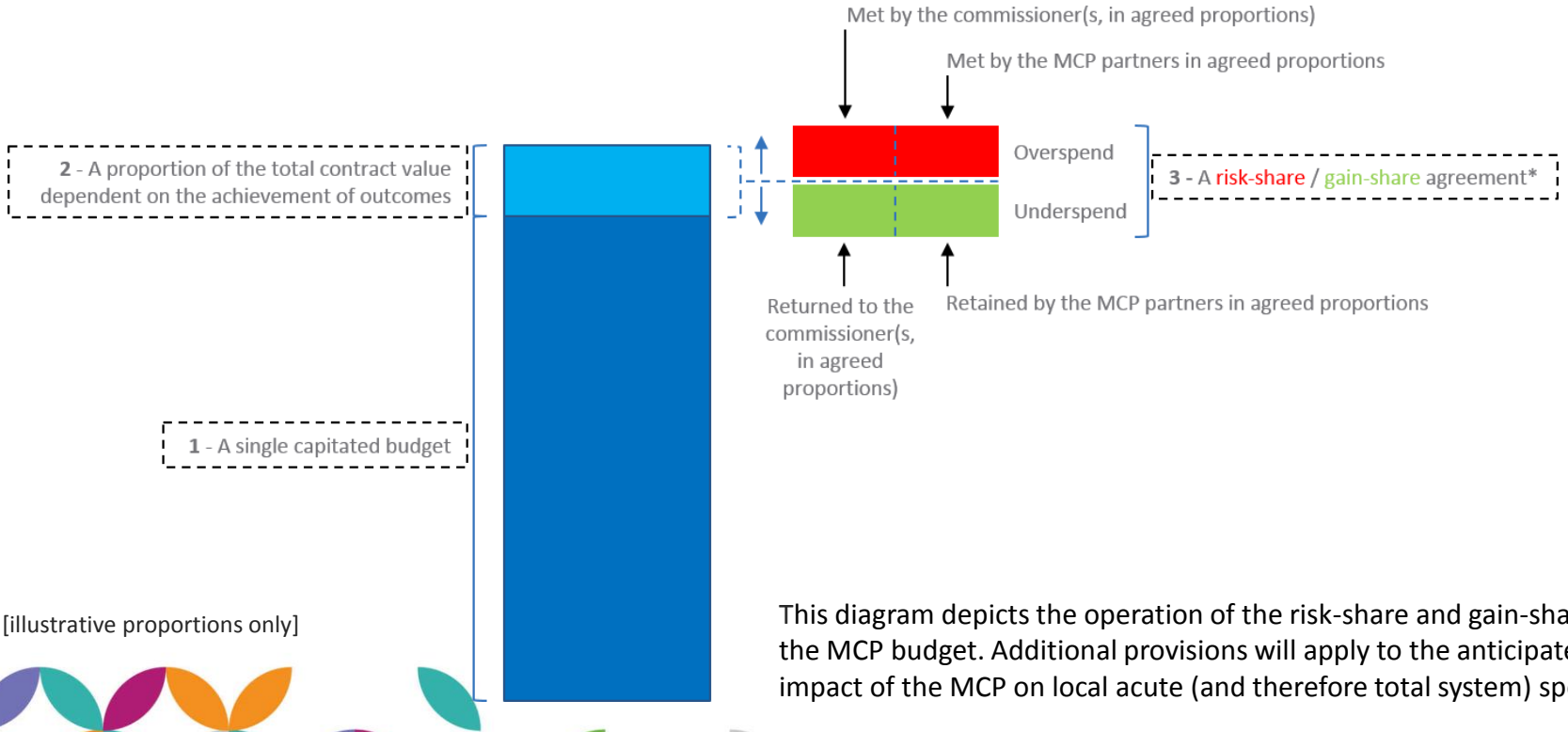
7. Implementing the change – from 2019/20

Financial strategy: The financial arrangements must work for all sides

The MCP financial strategy will:

- provide a fair, realistic, and affordable **whole-population capitated budget** for the delivery of better health and wellbeing outcomes;
- incentivise the achievement of the most important of these health and wellbeing **outcomes**; and
- apportion **risk and reward** across the system in a fair and sustainable way.

In order to do meet these objectives, the MCP budget will be formed in three main parts. These are shown in a simplified way in the diagram below. Each component is explained in more detail in this chapter.



This diagram depicts the operation of the risk-share and gain-share on the MCP budget. Additional provisions will apply to the anticipated impact of the MCP on local acute (and therefore total system) spending.

7. Implementing the change – from 2019/20

Financial strategy: A whole-population capitated budget will encourage accountability for all care

The MCP will receive a single capitated budget – a set amount of money based on the combined registered lists of local practices.

The capitated budget brings together a large number of individual budgets and has these advantages:

- **Accountability is for outcomes rather than activity:** The MCP will not be paid for undertaking any particular activity, which shifts the focus of payment arrangements from the delivery of services to whether outcomes are met.
- **Funds flow to where they are needed:** With one budget shared across the whole population and unconstrained by individual commissioner contracts, the MCP provider is able to direct money to where it can make the biggest contribution to improving outcomes, including for functions such as coordination, care plans, care navigators, shared management, and integrated information systems.
- **It also allows for greater flexibility:** The MCP will be able to personalise care according to what is best for an individual's outcomes, rather than having to follow service specifications used in the current payment model.
- **There is a greater incentive to keep people well through more preventive care:** The MCP is not penalised for reductions in activity caused by improved health and wellbeing and because people are able to look after themselves better at home. At the same time, the outcomes component of the capitated budget will reward the MCP for the achievement of population outcomes, so it has a reason to keep people well rather than just to provide care when it is needed.
- **The MCP can overcome current issues with shared investments:** A capitated budget across the MCP will allow it to invest in the direct costs of coordination, such as network management, information systems, and activities like care planning. These costs can be top sliced off the capitation with saving made in other areas. The current payment model, which fund providers separately for different services, means that agreeing these joint investments now is far more complicated.
- **The MCP is incentivised to manage overall costs:** The MCP is accountable for the end-to-end costs of care within its scope – ending the situation where individual providers can pass off activity and costs to other organisations.

7. Implementing the change – from 2019/20

Financial strategy: Capitated budgets are complex and need to stand the test of time

The initial value of the MCP accountable care budget will be calculated on the basis of current commissioner spend, using CCG current contract values, programme budgets, and running costs relevant to the services in scope.

From the initial analysis shown above, this preliminary value for healthcare services is **£122m** per year.

The capitated budget must be adjusted over the lifetime of the contract to take account of:

- pre-agreed growth rates in the size of the population;
- pre-agreed inflation rates and productivity improvement assumptions; and
- actual changes in the numbers of people assigned to particular population segments or risk-adjusted groups (if implemented – see below).

The early termination of the UnitingCare Partnership contract highlighted the importance of pre-agreeing these adjustments and then reviewing them at specified points during the contract.

Uncertainty

Commissioner budgets for the potential full length of the contract is not known. For the CCG, its allocation is predictable with any certainty only a few years in advance and the capitated budget will represent a large portion of the allocation. For this reason, the national accountable care contract is developing in a way that allows for flexibility. If either an adjustment to the capitated budget or the consequential contract variations cannot be agreed by both commissioners and the MCP, either party may terminate the contract.

Refinement

There are two ways in which the capitated budget can be refined to allow for greater insight into its composition:

→ development of accurate budgets for individual population segments, from providers' actual costs. In order to do this, providers will need to agree to the principle of open book accounting with their partners and commissioners; and

→ development of a risk-adjusted approach to capitation, where average price per person is adjusted for a series of risk factors to produce an individual or limited range of prices for each registered person. There are examples of this from elsewhere and previous work in North West London on Whole Systems Integrated Care provides a good starting point.

7. Implementing the change – from 2019/20

Financial strategy: The MCP will be incentivised to achieve certain outcomes

As chapter three described, the MCP outcomes framework will contain three categories of outcome:

1. Pay-for-performance outcomes – a small number of prioritised outcomes that the MCP will be paid for supporting people to achieve;
2. Local quality and assurance outcomes – applied contractually and able to support commissioners' assessment of overall MCP performance over a number of years; and
3. National operational standards and quality requirements – applied contractually, with relevant sanctions.

The financial strategy described here focuses on the pay-for-performance outcomes.

When developed in full it will be based on the following core principles:

- ✓ The proportion of income dependent on outcomes will be sufficiently **material** to the MCP to act as an incentive to transform services.
- ✓ At the same time, the outcomes and financial rewards will be **realistically attainable** and any value placed at considerable risk will not place the MCP in a rapidly deteriorating or unsustainable financial position. This can be done by, for example, using historic date to calibrate outcomes targets and rewards so that the MCP has a 95% likelihood of achieving ≥90% of the assigned reward by outcome, though with the maximum reward always reserved for a statistically significant improvement in an outcome.
- ✓ For **new outcomes**, where historical data is not available, the MCP will be incentivised to develop a sampling and data capture methodology and then form a baseline from which targets and rewards can be set.
- ✓ The outcomes and rewards set at the outcome will be **durable** – though they can be set annually where new performance data becomes available, in order to give the MCP sufficient operational and financial planning certainty as a rule they should not be reviewed annually but instead every three years. The reward proportions set for given outcomes should not change once set.
- ✓ There will be **clear business rules** associated with the management of outcomes measurement and payment.

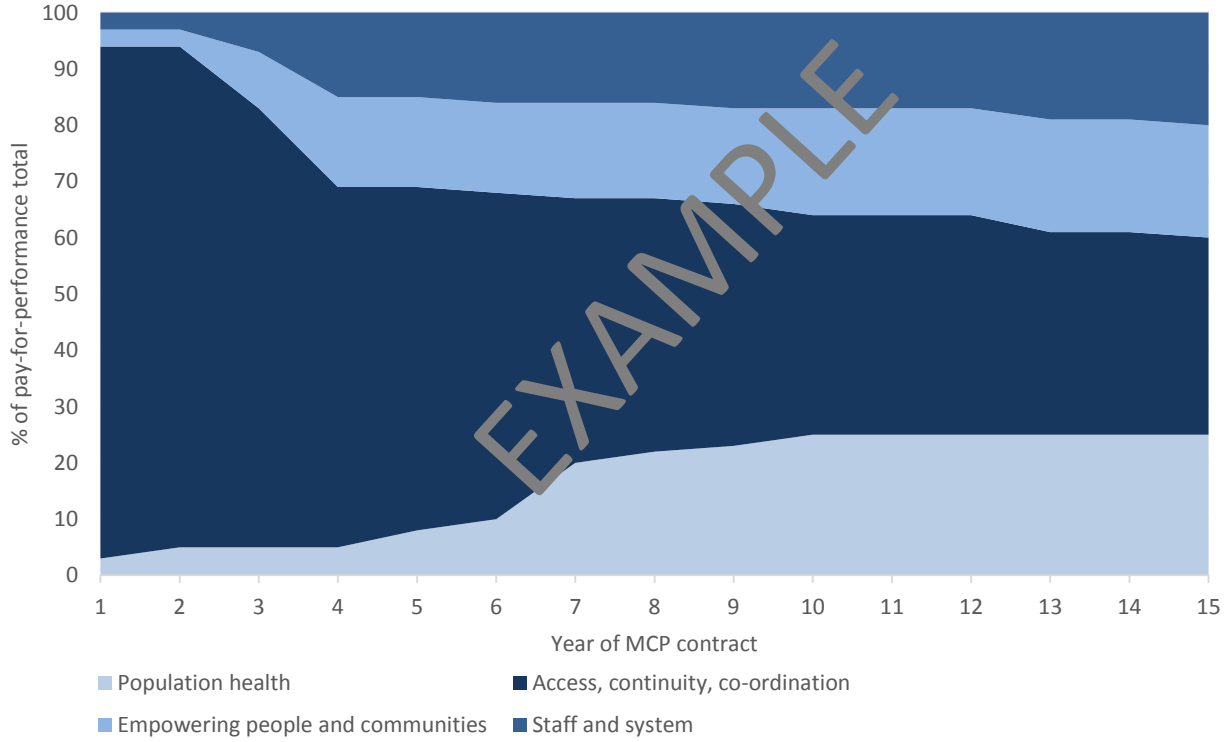
7. Implementing the change – from 2019/20

Financial strategy: How outcomes are incentivised will change over time

The balance of how different types of outcomes are incentivised will change over the lifetime of the MCP contract.

How this could work is shown in the diagram below. In Westminster, this will be determined primarily by:

- the prioritisation of particular local health and care needs with the local community;
- the MCP transformation programme and therefore its ability to impact on given outcomes; and
- the likely lag times between the MCP's interventions and the impact on an outcome measure.



For an example of a proposed MCP outcomes incentivisation model, open this link.

7. Implementing the change – from 2019/20

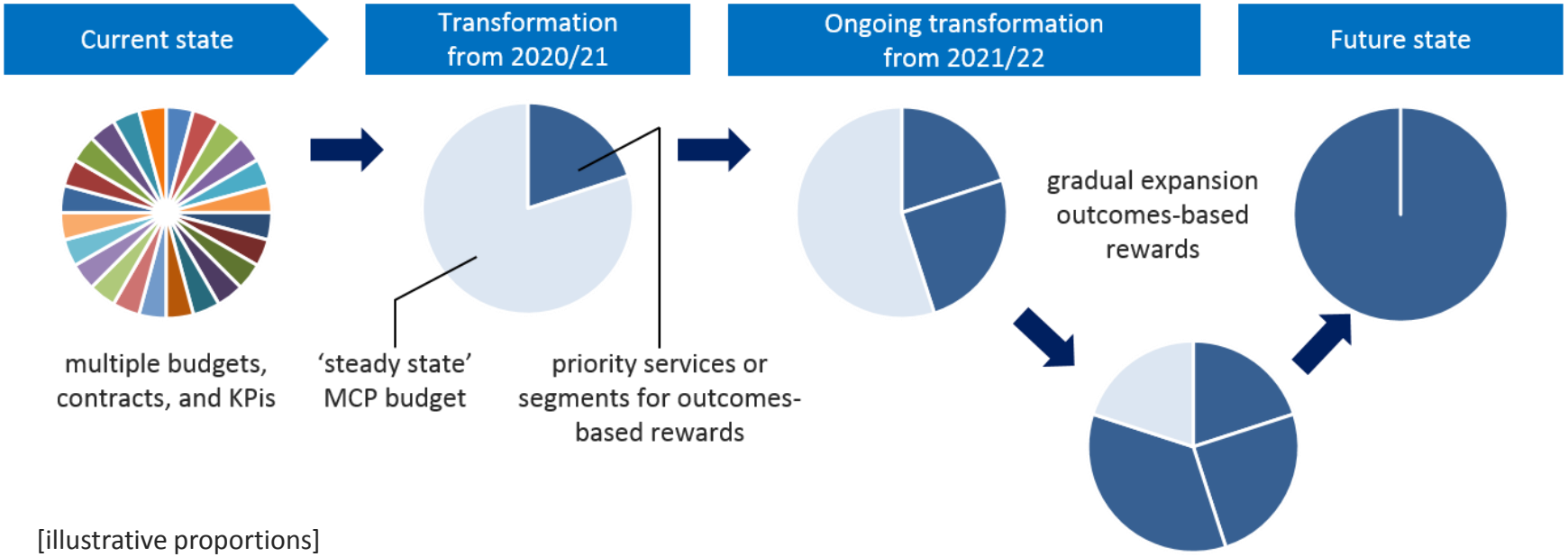
Financial strategy: The number of outcomes that are incentivised will grow over time

As a means of setting clear transformational priorities and mitigating the MCP mobilisation risk, the proportion of the MCP budget subject to outcomes incentive payments will grow over time.

So too will the proportion of the MCP budget subject to a risk-share / gain-share agreement, as explained below.

For outcomes, incentivisation will start with prioritised services or population segments and expand incrementally until the full scope of the MCP contract is measured by outcomes.

This means that the value of the 100% shown in the chart on the previous page will increase year by year.



[illustrative proportions]

7. Implementing the change – from 2019/20

Financial strategy: risk and reward will be distributed across the system

A key objective for the MCP financial strategy is to transfer to providers operational risks that they have better control over than commissioners, such as reducing hospital admissions or avoiding delayed discharges.

In order to do this, there must be strengthened incentives for providers to manage those risks more effectively.

This is achieved by sharing between commissioners and the MCP the risks and rewards of making improvements to services through a risk-share / gain-share mechanism, such that:

- any deficit will be met by commissioners and the MCP in agreed proportions; and
- financial benefits are shared as new ways of working generate efficiencies and better preventive care and supported self-management lead to reductions in demand for some types of care.

Deficits and benefits will be apparent in two ways – relative to the anticipated impact of the MCP on local acute spending and on the MCP budget itself.

The introduction of the risk-share/gain-share agreement will need to be carefully calibrated so as not to expose the MCP to excessive risk as it takes on new accountabilities and devises new ways of working.

This will likely mean that the mechanism is introduced incrementally, so that the MCP initially takes on upside risk (i.e. keeps a share of any savings generated) before taking on downside risk (i.e. also needs to fund a share of system overspend by generating additional savings).

The level of both upside and downside can increase over time (with the upside risk for the CCG probably capped at its surplus target, as surpluses cannot be carried over from year to year).

This reflects the incremental approach to introducing pay-for-performance outcomes discussed above.

7. Implementing the change – from 2019/20

Contracting: The extent of our ambition requires a contractual underpinning for the MCP

The MCP must be commissioned in a way that organises care professionals and money flows behind the achievement of better outcomes.

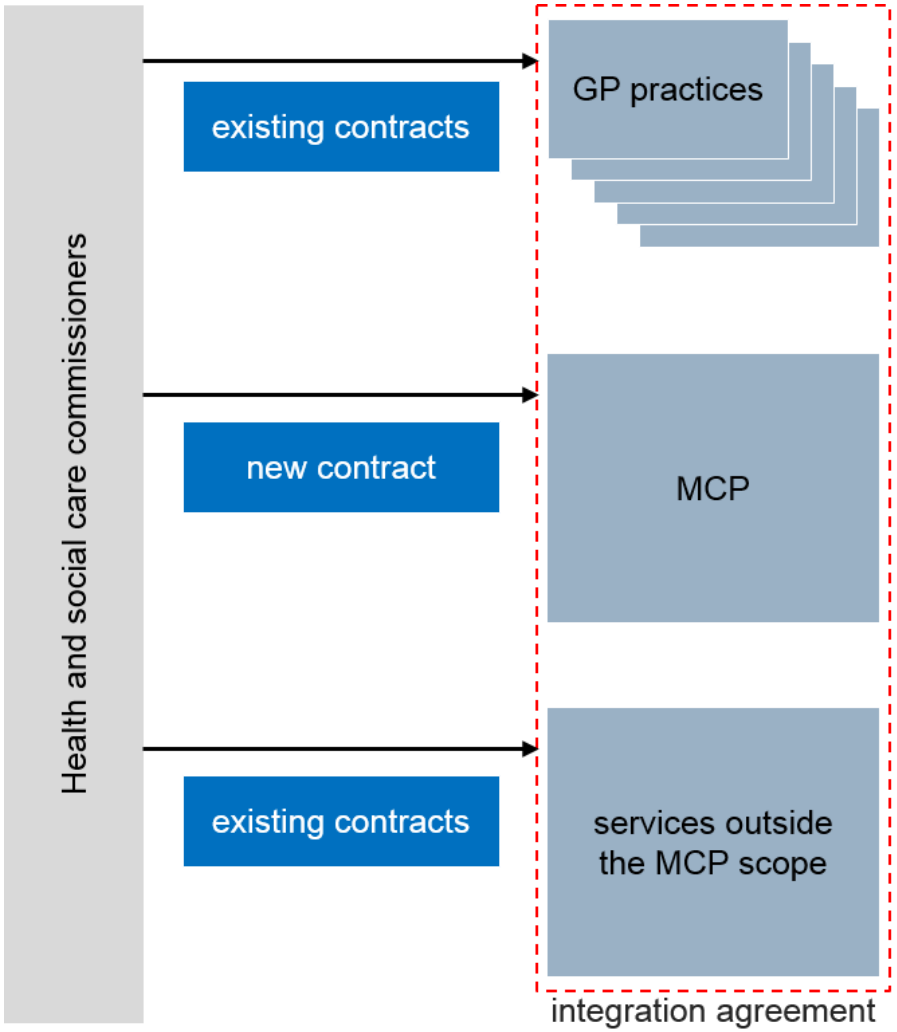
Commissioning an MCP is about enabling the integration of care services required to improve health and wellbeing, rather than a particular contracting form.

In fact, a 'virtual MCP' does not require a new contract. Rather, it involves a new alliance agreement between all relevant commissioners and providers. This overlies existing contracts and establishes a shared vision and commitment to managing resources, governance and gain/risk sharing arrangements, and agreements about operational delivery.

This approach is the least disruptive. However, the persistence of existing contracts means that it relies largely on goodwill. It also adds an extra layer to already complicated contractual arrangements. It is the weakest form of MCP in terms of its rights to create and manage integrated provision and to deploy resources flexibly across a care system. Organisational structures and money flows still hinder rather than help care professionals do the right thing.

The CCG therefore needs to commission an MCP through a contract that supports care professionals to do the right thing.

This will be through a **partially integrated MCP contract**, shown in the diagram opposite and explained on the next page.



7. Our approach to improving health and wellbeing – changes from 2019/20

Contracting: The partially integrated MCP contract works best for Westminster

There are two types of MCP contract: for a fully integrated model and for a partially integrated model.

The main difference is the treatment of GPs' existing GMS and PMS contracts: the fully integrated model includes them all and the partially integrated model does not.

The CCG's preference is for the partially integrated model, which does not require GPs to volunteer to suspend their current core contracts and effectively merge them into the single MCP contract. This is because:

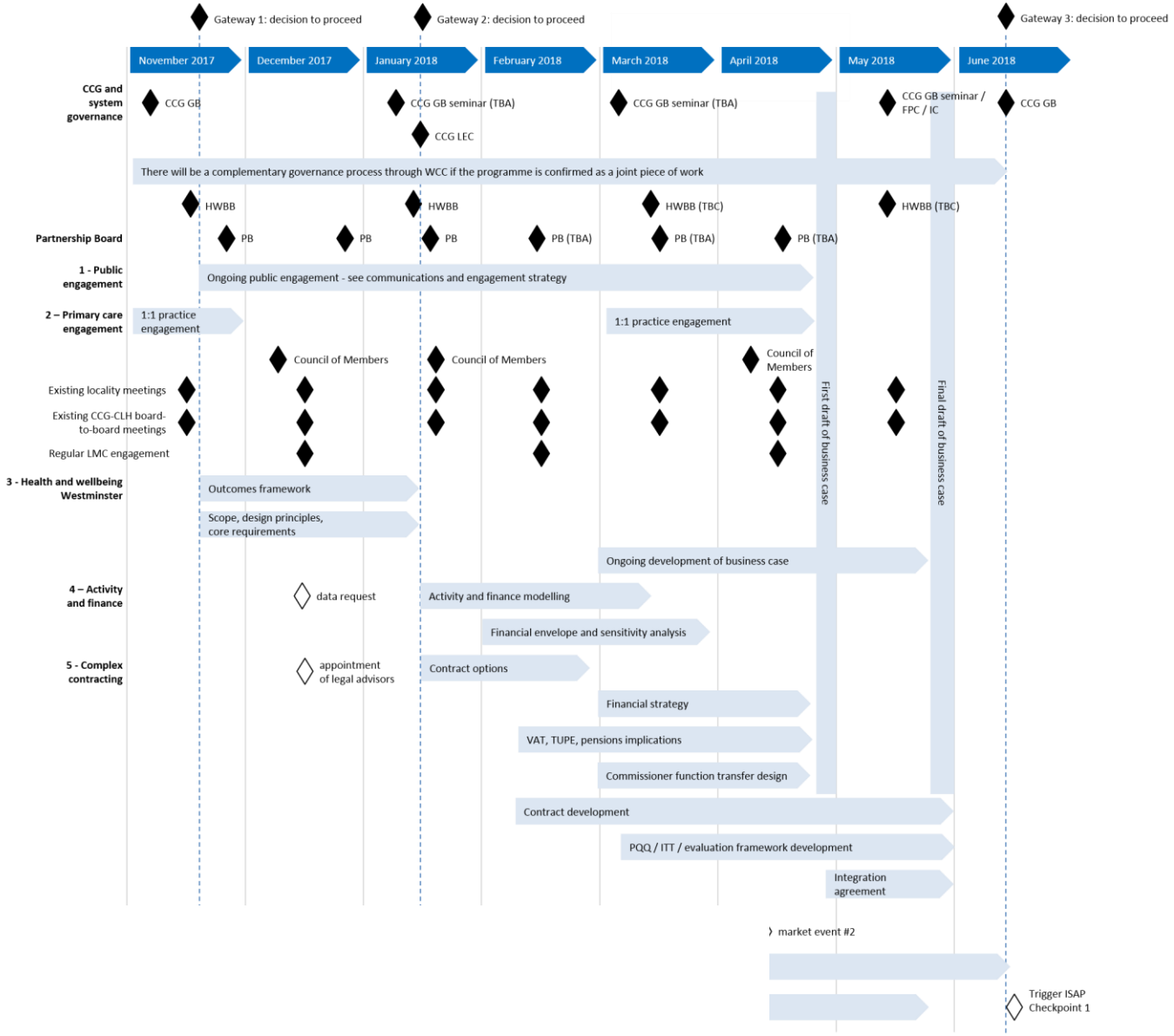
- the conditions around the temporary suspension and reactivation of core contracts set out in NHS England guidance are not yet sufficiently well understood or tested for local GPs to be likely to support a fully integrated model; and
- there are already very high expectations on general practice to lead the development of primary care homes and deliver the new wrap-around contract, which means that over the next twelve months energy is best dedicated to these tasks rather than a debate about core contracts.

Although narrower than a fully integrated model, a partially integrated MCP still brings significant local benefits:

✓ The healthcare scope remains very wide-ranging, across extended primary care, community services, mental health and learning disabilities, and some services currently delivered by acute trusts – which means a proportionately large remit to integrate services and allocate investment efficiently
✓ An integration agreement between general practice, the MCP provider, and other providers will support integration beyond the formal MCP scope – and commissioners will facilitate this to ensure that it allow is suitably ambitious for what the whole system working together can deliver for local people
✓ The procurement process will still quality for the Integrated Support and Assurance Process (ISAP) – meaning assistance from NHS England and NHS Improvement and a level of internal and external assurance commensurate with the risk of the contract
✓ GPs retain their current core contracts, which means that time and energy is not diverted from delivering the overall vision of the MCP into a debate about existing core contracts

7. Our approach to improving health and wellbeing – changes from 2019/20

Our programme plan for the next eight months



Disclaimer

This paper sets out a potential approach to commissioning a Multispeciality Community Provider (MCP) for consideration by the Central London CCG Governing Body. It represents the work done to date and is supported by a cover paper that sets out the further work required to bring about a formal decision of the Governing Body in 2018. Until the CCG has made the formal decision to proceed to commissioning a MCP, the CCG reserves the right to withdraw this draft commissioning plan. The CCG recognises this is a document in the public domain and that potential bidders may start to consider how to respond to this; however, the CCG accepts no liability for costs associated with this in the eventuality the Governing Body does not approve the commissioning plan and any subsequent procurement activity.

The CCG also reserves the right to continue to work on its commissioning plans in its entirety and individual sections of the plan remains draft and subject to change and/or removal. Any information provided by Central London CCG about the requirement and potential procurement process to be followed is indicative only, and subject to change/confirmation. No supplier selection or supplier preference is implied.