City of Westminster

# Westminster Health & Wellbeing Board

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| **Date:** | September 2018 |
| **Classification:** | General Release |
| **Title:** | Update on integration plans in Westminster |
| **Report of:** | Managing Directors, NHS Central and West London CCG |
| **Wards Involved:** | All |
| **Policy Context:** | City for all; North West London STP |
| **Financial Summary:** | As set out in this cover sheet and the attached presentation |
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## 1. Executive Summary

1.1 This paper provides an update on the local health system's delivery of the Primary Care Strategy discussed at the Health and Wellbeing Board in July and the Integrated Care Strategies discussed at the Board in November 2017. In summary, both documents set out the three year journey the health system is going on in order to deliver the Five Year Forward View – the NHS's key policy document, published in 2014.

1.2 Since the last board discussions on this item, a great deal of progress has been made which is summarised for the Board in this cover paper and the attached presentation entitled "MCP in Westminster". In particular, CLCCG has approved a draft pre-procurement business case as part of an MCP programme which is focussed on delivering an MCP from April 2020; West London continues to look at ways to expand the Integrated Care Team provided by an alliance of local providers as the basis for further broadening the scope into a MCP in 2020/21.

## 2. Key Matters for the Board

2.1 The Board is asked to note this update and the attached presentation in line with the Board's statutory duties to promote the integration of health and care in the area.

2.2 The Board is asked to note, in particular, the financial and quality/performance context in which the care system needs to deliver the Five Year Forward View agenda and the implications this local context will have as the system moves towards the delivery of the MCP from 2020. Specifically, there is a requirement for the system to improve care and reduce over-spending against the national formula in the here and now and this work needs to take place regardless of the MCP programme: the MCP programme is being pursued as a way of maximising the amount of money available to focus on frontline care.

## 3. Background

3.1 The Westminster care system has been on a journey to deliver better integration of services in the community for some time. Since the CCGs' creation in 2012, so far this has taken a number of forms, including:

- The development of a strategic vision for integrated services provided through hubs and networks in the community
- The commissioning of additional services in community settings – through the Out of Hospital Programme from 2012, and now through the Partnership in Practice contract from 2018 in the Central London area
- The Shaping a Healthier Future acute reconfiguration programme (since 2011)
- The Whole Systems Integrated Care (WSIC) programme, which became one of 14 national pioneer sites in 2014
- The joint CLCCG/Central London Healthcare (CLH) Primary Care Strategy, published in 2017 – which set out the basis for the CCG's 3 year commissioning programme
- The Integrated Care Strategies approved by both CCGs and presented jointly with lead council officers to the Board in November 2017.

3.2 Since the adoption of both CCGs' Integrated Care Strategies, both CCGs have been working with partners. In CLCCG this has involved working with partners through the Westminster Partnership Board to develop plans and thinking.

3.3 CLCCG updates the board as follows:

- There have been regular, board-level conversations on local system issues at the Westminster Partnership Board since November 2017 – with a focus on how the local care system moves forward with integrated care (at what scale, pace, in which areas and how)

- Commissioning intentions were published to all current providers of care in Westminster early in the 2018/19 financial year. These commissioning intentions set out the system challenges and provided early notice for all contract holders/receivers of funding that the contracts CLCCG currently has in place will not continue in their current form into 2019/20. This notice was shared with the Council as well as with NHS health providers.
- Model of care development sessions have taken place – delivered mainly through workshops, and clinically led by local GPs – in which the clinical community has been galvanised to begin to articulate what it wants to deliver for patients and how the system needs to change to deliver local improvements. The model of care sessions have focussed on children and young people, working age adults with a focus on mental health and older people and frailty.
- Active engagement with both existing and potential providers of care in Westminster has taken place. This has included the first of a series of planned open engagement events, which was well attended by a range of providers from the Westminster system and beyond; and some kick start support commissioned by the CCG to facilitate the coming together of existing local providers to consider the implications of what both CCGs have set out in their plans.

## 4. The planning context

4.1 As the attached presentation entitled “MCP in Westminster” makes clear, the local health system is planning in a challenging environment. There are quality/performance and financial issues with which the care system in this area needs to grapple. These issues are endemic across the whole patient pathway and are not the sole responsibility of one organisation to sort out: all partners need to work together as a system. In part, these reflect national issues such as the requirement to invest more in prevention than ill health and coping with the effects of ill health. But there are also broader local issues in Westminster which the system cannot shy away from tackling now – including health inequalities, obesity in children and young people, the negative experiences of some of the users of our services, the low rates of access to some specialist services for people who are vulnerable or have life long conditions etc. It is this set of circumstances that has led national, regional and local policy to conclude that a new approach to the commissioning and delivery of care is required.

4.2 In Westminster in particular this includes:

- A number of areas where performance is either not where it should be, is on a declining trajectory or it risks falling into a declining trajectory. These areas are set out in the attached presentation and include key areas for delivery across all health systems in the country. In Westminster there are improvements which need to be made in services for people with long term conditions, older people, people with disabilities, issues in the way services are experienced or accessed and the way health promotion is prioritised or health issues are identified. These issues are particularly pertinent in

Westminster because the health system is currently significantly over-capitated: West and Central London CCGs are currently the first and second highest capitated health systems in the country. This means that, according to the national formula, the Westminster health system has traditionally received more income than other areas – i.e. it is over-spending. As this income falls to the levels anticipated through the national formula, it will be especially challenging for the good performance achieved so far, or the falling performance set out in the attached presentation, to be maintained or corrected.

- As noted above, the financial position of the health and care system is not positive – nor is it expected to improve. Both CCGs have programmes in place to deliver MCPs. In CLCCG, the draft pre-procurement MCP business case was approved on 11 July 2018. As part of preparing the business case, the CCG modelled 10 year financial scenarios affecting the potential income and expenditure in health in its area. These scenarios were assumptions based, and incorporated planning considerations currently known, but the scenarios point to a risk that unless acute growth can be contained over the planning period there will be little or no investment for anything other than secondary care, and this is an issue of which all system partners need to be cognisant.

4.3 In providing this briefing, CLCCG recognises the nervousness of local providers operating in Westminster in increasingly financially challenging times. There is widespread recognition that the financial position locally is worsening at a challenging pace and this is causing anxiety for all partners, particularly those involved in the delivery of community and mental health services. The CCG does take its statutory responsibilities to develop and publish system plans seriously, and has now done this. The CCG is also taking a medium term view so that the whole system can work to improve care and financial sustainability now: the CCG is looking to ensure that there is a managed approach to risk.

4.4 Although the focus of this paper is on structural improvements to the way care is commissioned to ultimately support improvements in delivery, this is because the nature of the issues requires a new structural approach and this is what has informed national policy. These plans are based squarely on consistent feedback from patients, clinicians, staff and an international and increasingly national evidence base which has informed NHS plans nationally and these plans locally. The CCGs both have draft communication and engagement strategies in place which they are currently looking to finalise with local organisations. The focus of the CCG's work on improving services will be on co-production as the way of harnessing improvements in care based on expertise by experience.

## 5. Options and choices

5.1 As the attached presentation makes clear, the Westminster system has had important options and choices to consider. Hitherto CLCCG has decided to pursue an integration strategy based on the strengthening of community services

and the registered list in primary care through the MCP model. The alternative choices at this stage are summarised in the attached presentation and have been discounted. For completeness they are set out here as follows:

- Option 1: Continue as is / status quo – i.e. continue to work to deliver incremental improvements in outcomes and finances
- Option 2: Trying to achieve greater, non-contractual alignment – i.e. build on the above through some focussed pilot/network/alliance-type model
- Option 3: Delivering on the new care models agenda as per the 5YFV – i.e. continue with the CCG's previous preference to work towards an MCP.

5.2 There is currently a difference of approach between Central and West London CCGs on the option for developing an MCP. West London CCG continues to work with the Alliance programme, building on the My Care My Way work on older people and frailty, which expanded in 2018/19. This has been a long standing, successful programme and is beginning to show improvements in older people's emergency admissions to hospital and is being further strengthened in terms of its links with other services including primary care. In Central London CCG, the position is different. In summary terms, the CCG's evaluation is that the first two of the above options would be unlikely to generate the required innovation, scale, pace or focus on prevention, culture change, patient outcomes and improvements in patient pathways given the local context.

## 6. CLCCG's MCP and draft MCP pre-procurement business case

6.1 The CLCCG governing body considered a draft MCP pre-procurement business case on 11 July 2018. This business case is in five parts and describes in further detail the proposal previously considered by the Health and Wellbeing Board, Partnership Board and CCG Board and discussed with partners since – i.e. the delivery of a partially integrated MCP. The CCG has proposed this approach as the main vehicle for driving improving health and wellbeing outcomes and system-wide financial sustainability.

6.2 In line with national and regional policy to use commissioning to support the better integration of care, Central London CCG has previously agreed to build on progress in developing a whole-systems approach alongside local networks that enable at-scale primary care to transform physical and mental health services in the community. In November 2017, the CCG decided that this needs to be supported by new care models and a new business model – and, for the reasons described in the integrated care commissioning plan, that the Multispecialty Community Provider (MCP) model is the CCG's preferred approach.

6.3 The draft business case sets out additional work done to define the approach the CCG plans to take, following further engagement on the proposed models of care; consideration of commercial and contractual options; further analysis of the long-term financial challenge; initial market engagement; and assessment of the work and resources required to implement this programme.

6.4 The business case summarises options, opportunities, and risks for commissioning an MCP.

6.5 The business case is in five parts, as follows:

6.6 The ***strategic case*** sets out the national and regional policy context for the work; progress to date towards the integration of out-of-hospital care, especially in primary care; why commissioning an MCP is the proposed next step; and how this fits the needs of the population served.

6.7 In progressing towards an MCP, CLCCG is at the forefront of national efforts to transform the commissioning and delivery of out-of-hospital care. It contrasts with the current approach of multiple contracts and different points of accountability, which creates fragmentation and inefficiency across organisational and contractual boundaries. The result of this is that local people's experience of care and outcomes are not as good as they should be. There is also much work to do on addressing local inequalities. Increasing financial constraints, combined with growth in demand for acute care and prescription medicines, mean that other services will be under unprecedented pressure unless a change in approach is delivered. This is particularly the case for physical and mental community health services, as these have previously been over-funded in comparison with other areas.

6.8 To continue to deliver these services as well as possible and keep within future budgets, there is a need for a bold programme of integrating front-line care to a degree not so far achieved. Without change, the reduction in funding to the Westminster health and care system as a whole and the growing cost of hospital services will severely limit the out-of-hospital care that the people of Westminster are able to access.

6.9 In the context of essential change and the proposal to commission an MCP to drive the integration of out-of-hospital care, the ***economic case*** draws on the objectives and critical success factors in a two-stage evaluation. This considers whether the proposed MCP approach remains the preferred commissioning option available to the CCG, in the context of the options and choices open to the CCG at this stage.

6.10 The first part of the evaluation considers the extent to which the proposed approach supports quality objectives within the constraints of the CCG's fixed resources and financial challenges; it is not a financial evaluation – because the quantum of resource available does not vary across options. It also considers the balance between the need to improve quality and control spending against the need to frame an attractive proposition for provider organisations that can be implemented and managed effectively. The second part of the evaluation assesses a range of different design features that shape the way the MCP will be commissioned and operated.

6.11 From this evaluation, the conclusion of the integrated care commissioning plan is confirmed: that a partially integrated MCP remains the preferred option for taking forward the significant changes necessary to achieve greater integration of out-of-hospital services.

6.12 In the ***commercial case***, the scope of services envisaged – currently more than a third of CLCCG's overall budget – is described; along with models of care that will seek innovative and creative solutions from the market. This summary of *'what'* care and services is followed by consideration of *'how'* they can translate into requirements that support a viable procurement process and the development of a well-structured contract. Initial engagement with the market is also outlined.

6.13 The approach described in the economic and commercial cases is dependent upon an MCP that is affordable for the CCG, attractive to the market, and sustainable in the long term. The ***financial case*** must therefore be considered within the totality of the CCG's short- and long-term financial planning.

6.14 With or without commissioning an MCP, the health service has to make significant savings to services (both in and out of scope) to achieve financial balance in 2018/19, 2019/20 (before the start of an MCP), and beyond. Before a final affordability envelope on which the procurement of an MCP will be based can be set, work is needed to complete a robust two-year plan as well as long-term forecasts for acute care and prescribing over the course of a potential MCP contract.

6.15 Setting an MCP affordability envelope will require judgements to be made about the risk of the CCG's financial plans not being delivered, and what will happen if they are not. Whilst these plans need to be developed, the reality is that an affordable health system (whether it is an MCP or not) does require a balance between de-commissioning of services and transformation of local pathways. The MCP has hitherto been the CCG's preferred approach to meeting local system quality and financial challenges, because it is the approach which is most focussed on patients, prevention, improved pathways and provides an opportunity for the system to drive out inefficiency as a way of meeting the financial challenge. In short, it provides the best opportunity to help the system move away from taking a "salami slicing" cuts based approach and maximises value in terms of focussing as much of the money and resource as possible on patient care, and helping to turn the money in patient care into wider resident wellbeing and prevention focus. All of this currently takes place on top of working with providers to drive out their own efficiency savings, known as CIPs.

6.16 The degree of change envisaged cannot be achieved without significant planning and an investment of time and resources from the CCG. This is considered in the ***management case***, which defines four principal phases of activity from the current position to the launch of a wide-ranging MCP that has capacity to adapt to further changes during the contract term.

6.17 The wider CCG planning tasks and preparations for MCP commissioning need to be progressed quickly if the procurement timeline described is going to be met. Expertise not readily accessible from within the CCG will be required throughout each of the phases. The timescales for the phases are tight and contain some

unknowns. The mitigation for this is detailed planning, efficient governance, and effective risk and issue management.

6.18 The Westminster system is on a long and challenging journey and the business case described in this paper and the presentation circulated alongside it set out the work required ahead. However, it also recognises how much the Westminster system has to build on, the work it has done and the alternative, less palatable challenges that lie ahead if we do not commit to a coherent programme of work which will drive better patient care, better use of the resources we have and more integrated services which support the increasing expectations of our residents and patients.

## 7. WLCCG's next steps to developing the MCP

WLCCG's governing body is in the process of agreeing a timeline to allow further work on developing local primary care networks, and the current alliance of providers enabling substantial steps towards the CCG's Integrated Care Strategy. The timeline indicates a decision in September 2019 on the approach to an MCP allowing for development work in the preceeding year. Specifically for 2019/20 this will include:

- Further work on delivering benefits of current integration in the ICT
- Identifying and incorporating a wider scope of services into the ICT – widening the focus on from older adults
- Developing the current Alliance agreement into a legally binding contract between Alliance partners
- Undertaking transformation work within services likely to form part of the MCP, to otpimise benefits of integration and future MCP success.

## 8. Legal Implications

7.1 The legal implications of this programme are not the focus of this briefing paper.

## 9. Financial Implications

9.1 These are as set out in the attached presentation.

**If you have any queries about this Report or wish to inspect any of the Background Papers please contact:**

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**BACKGROUND PAPERS:**

Integration Strategies presented to the Board in November 2017

Central London Primary Care Strategy presented to the Board in July 2017