NHS
Central London
Clinical Commissioning Group

MCP in Westminster

Update to Westminster Health and Wellbeing Board

September 2018

Objectives

- To set out the CCG's progress and thinking to date in respect of:
  - Integrating care and
  - Delivering on the Five Year Forward View by 2020
- To discuss priorities for the Westminster care system, and how these need to be delivered
- To recap on the system financial position, including 10 year planning scenarios
- To set out the options and choices considered so far, including:
  - Proceeding as is / status quo
  - Trying to achieve greater, non-contractual alignment
  - Delivering on the new care and business models agenda as per the Five Year Forward View
- To set out how the CCG plans to move forward with the delivery of an MCP
- To discuss and provide some responses to queries received so far
- To set out the timetable and process from here

Contents

1. Executive summary and logic model “on a page”

1. The Westminster system is facing 3 key challenges..

Challenges

The **quality challenge –** either because performance has been historically good, or because we are not transforming local services at the pace required/demonstrated elsewhere

The **system challenge –** because system-working as envisaged in the STP is not yet routine and this affects patients and patient care

The **financial challenge –** over-capitation has led to over-investment in community, mental health, primary care and social care services locally

2. ..current system plans for 18/19 and 19/20 plans are not sufficient to meet these challenges on their own..

Opportunities

We have 18/19 and 19/20 plans which include:

- Ambitious QIPP savings, mainly focussed on transactional schemes
- Community, mental health and primary care transformation

But these plans will not be sufficient to meet the challenges because:

- Large scale re-commissioning is required to rebalance the system
- The financial challenge increases each year at a greater rate than QIPP can realistically deliver
- The CCG wishes to protect frontline patient care by looking to generate efficiencies in complex pathways
- Transformation at the level required needs to be supported through a clear process

Therefore **the CCG’s plan has been developed to:**

- Deliver the most efficient approach to recommissioning non-acute services
- Create the basis for longer term planning and delivery in the community (e.g. in investment planning)
- Incentivise financial and clinical improvements through efficiency rather than reductions in services
- Stimulate improvement in services

3. ..but we are in year 2 of a 3 year programme to deliver:

Delivery

Delivery programme 1:

Primary care development

Delivery programme 2:

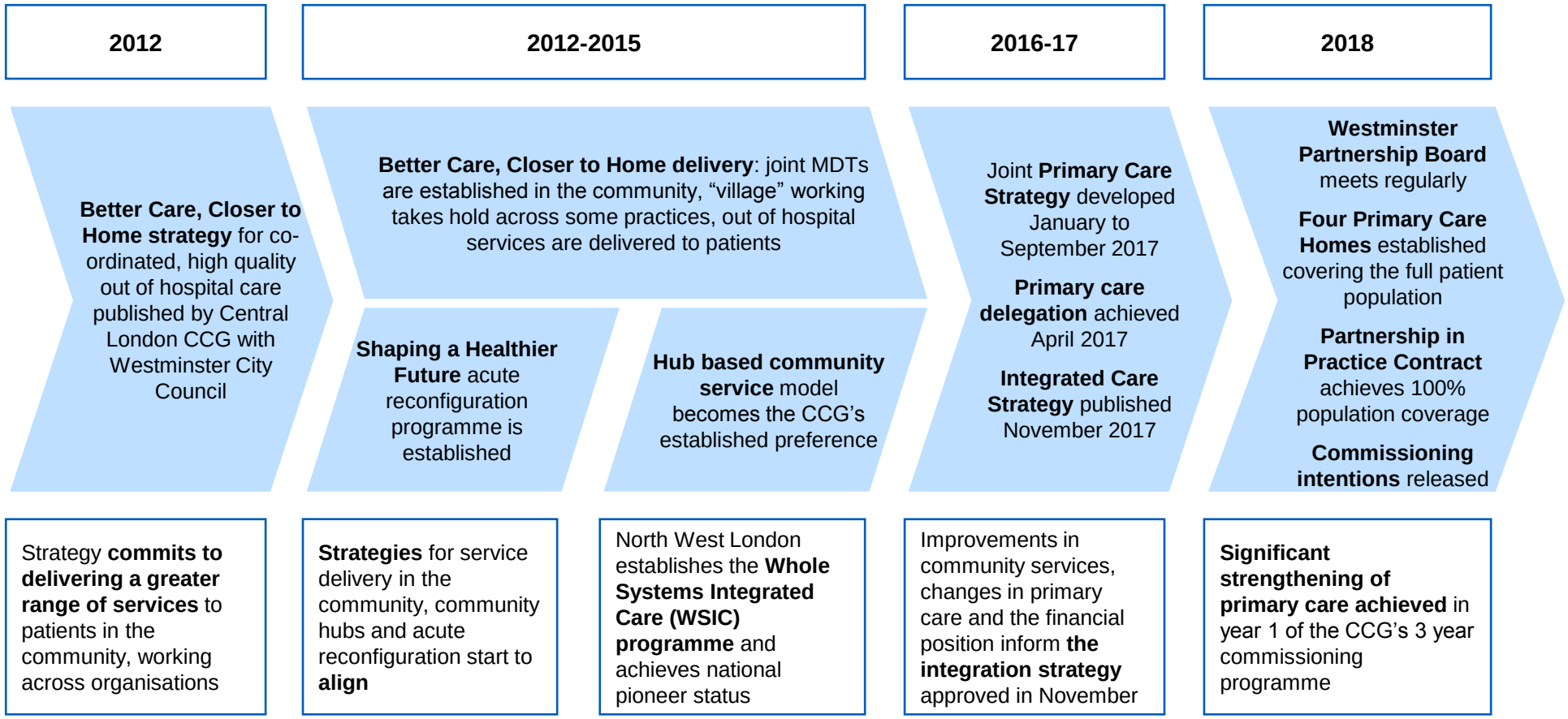
Community service transformation and model of care development

Delivery programme 3:

Integration and the MCP

2. Background and context

Westminster and North West London have a track record of improving services in the community through integrated care…



3. Planning for 2020

…but there is now recognition nationally, regionally and in this area that a new approach to care is required.

Our plans

The **Five Year Forward View** calls for the delivery of new care models

The **5YFV Into Action** focuses on delivering new care models through new business models

The **NWL STP** set out the vision for coordinated care

The **Primary Care and Integration Strategies** set out how this will be achieved in Westminster

The **Westminster Health and Wellbeing Strategy** focusses on the better coordination of care locally

This has been supported by our **transformation programmes and commissioning intentions**

Implications

A **new approach to care is required**

This is especially the case where the combination of quality/clinical, financial and system factors mean that re-commissioning is a requirement for the health and care system – the question is how best to deliver this.

4. System priorities 2018-20

The system has a number of priorities it needs to deliver on throughout 2018-20. These present a number of challenges to the CCG and partners. But they are also set against increasing expectations from patients about the way people want to receive their care.

Priorities	CCG and system requirements	Increasing expectations of care
1. Better coordination of care in the community	To deliver these priorities, the systems needs to put in place: • A clearer clinical vision –i.e. what do we want for our patients? • More closely defined models of care – i.e. how will our vision / set of expectations be delivered? • A greater focus on working with partners from across organisations and services – i.e. system leadership • Genuine co-production and engagement with patients, as experts in the types of care they want to receive and how • Commissioning arrangements, contracts and funding models which support rather than inhibit joined up systems of care • Risk-based commercial models which incentivise right care in the right place at the right time (removing disincentives) • Coherent programmes of work which balance the scale of the challenge with the resources available to deliver	Patients increasingly expect of the whole care system: • Networks and partnerships to be in place, spanning organisations and types of services • Easier and more convenient access to services • Accountability for the support that can be provided • New care models which are routine rather than happenstance (e.g. MDTs, care transitions, navigation, linked ICT) • Better health and wellbeing, fewer emergencies/urgent access • Better long term condition management support • Focus on health promotion and ill-health prevention
2. Improvements in care at greater scale and pace		
3. System sustainability		

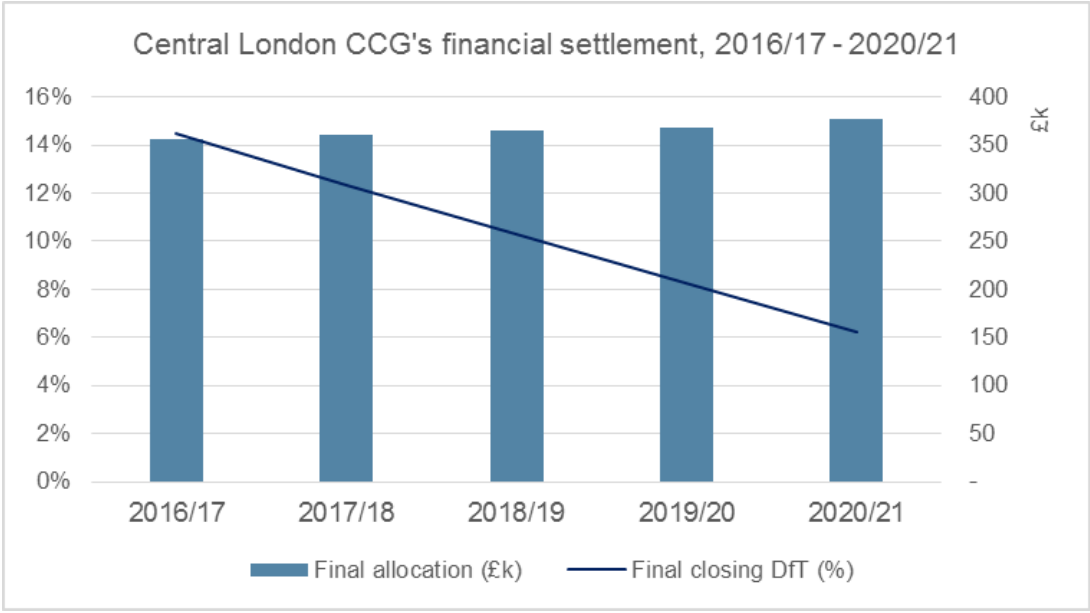
5. Westminster care system 10 year financial position

National, regional and local policy, and the CCG's priorities and action plans, need to be delivered in a highly pressurised financial environment

Financial context

- No growth funding is expected over the planning period
- The local health system (commissioners and providers) is facing cost pressures, with significant in-year and accumulated deficits or erosion of historic surpluses
- Local authority partners have significant challenges (and have had these for some time)
- Recently announced financial increases for the NHS are unlikely to create headroom for growth above cost pressures in Westminster

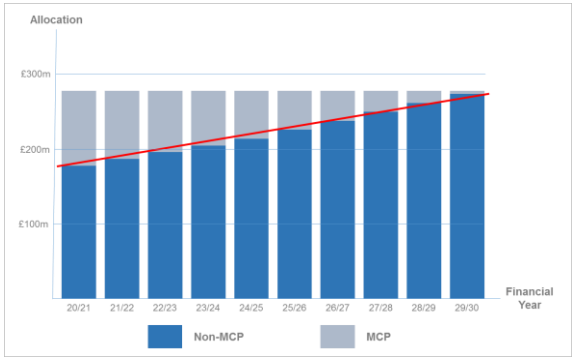
The CCG's financial settlement over the planning period



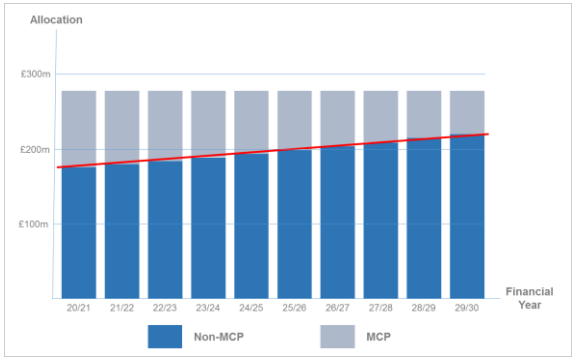
5. Westminster care system 10 year financial position

The CCG has modelled 3 potential financial scenarios for the Westminster health system in relation to the income expected over the next 10 years

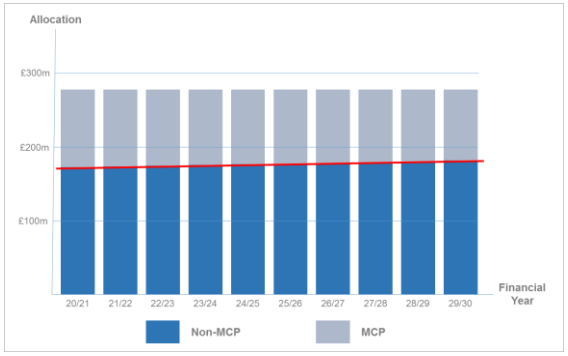
Scenario 1: 6% acute growth



Scenario 2: 3% acute growth



Scenario 3: Nil acute growth



6. Health outcomes / experiences of care

Health outcomes in Westminster have generally been good. In some respects this makes it increasingly challenging for local organisations to deliver year on year improvements in care, especially within a reducing financial envelope. Particular issues in Westminster trajectories are in: rising levels of obesity, self-care in diabetes, the number of older people experiencing a fall, experience of adult social care services, access to some mental health services , support to people with learning disabilities and support to people experiencing a healthcare emergency.

CCG Summary Dashboard

Please select CCG from the KLOE tab

Print to PDF

NHS Central London (Westminster) CCG

2016/17 Year End Rating: **Good**

Better Health		Period	CCG		Peers	England	Trend
R	102a % 10-11 classified overweight	2013/14 to 2015/16	40.1%	↑	11/11	196/207	
	103a Diabetes patients who achiev	2016-17	39.8%	↓	4/11	114/207	
	103b Attendance of structured edu	2016-17*	1.1%	↓	7/11	176/207	
R	104a Injuries from falls in people 6	17-18 Q2	1,240	↓	3/11	14/207	
R	105b Personal health budgets	17-18 Q3	10.06	↑	8/11	140/207	
R	106a Inequality Chronic - ACS & UC	17-18 Q2	1,165	↓	2/11	15/207	
R	107a AMR: appropriate prescribing	2017 12	0.671	↓	3/11	4/207	
R	107b AMR: Broad spectrum prescri	2017 12	11.0%	↑	10/11	182/207	
R	108a Quality of life of carers	2017	0.60	○	9/11	176/207	

Sustainability		Period	CCG		Peers	England	Trend
R	141b In-year financial performance	17-18 Q3	Amber	↔	BM/A	BM/A	
R	144a Utilisation of the NHS e-referr	2018 01	40.3%	↑	9/11	175/207	

Leadership		Period	CCG		Peers	England	Trend
R	162a Probity and corporate govern	17-18 Q3	Fully Compliant	↔	BM/A	BM/A	
	163a Staff engagement index	2016	3.82	↓	6/11	57/207	
	163b Progress against WRES	2016	0.17	○	9/11	176/207	
	164a Working relationship effective	16-17	62.65	↓	9/11	163/207	
	166a CCG compliance with standards of public and patient participation (not available)						
R	165a Quality of CCG leadership	17-18 Q3	Green	↔	BM/A	BM/A	

Key

- Worst quartile in England
- Best quartile in England
- Interquartile range

Note: There are no data for NHS Manchester CCG (14H) for the following indicators: 121a, 121b, 121c, 122d, 125b, 125c, 165a, 163b, 163h and 164a

* Patients diagnosed in 2015; #Patients diagnosed in 2014

Better Care		Period	CCG		Peers	England	Trend
R	121a High quality care - acute	17-18 Q3	61	↑	5/11	78/207	
R	121b High quality care - primary ca	17-18 Q3	66	↑	6/11	105/207	
R	121c High quality care - adult socia	17-18 Q3	55	↓	10/11	203/207	
R	122a Cancers diagnosed at early st	2016	43.2%	↑	11/11	205/207	
R	122b Cancer 62 days of referral to t	17-18 Q3	94.5%	↑	1/11	2/207	
	122c One-year survival from all can	2015	77.1%	↑	1/11	2/207	
	122d Cancer patient experience	2016	8.9	↑	1/11	12/207	
R	123a IAPT recovery rate	2017 12	57.1%	↓	1/11	22/207	
R	123b IAPT Access	2017 12	3.0%	↓	11/11	190/207	
R	123c EIP 2 week referral	2018 02	89.7%	↑	1/11	38/207	
	123d MH - CYP mental health (not available)						
R	123f MH - OAP	17-18 Q3	60	○			
	123e MH - Crisis care and liaison (not available)						
R	124a LD - reliance on specialist IP c	17-18 Q3	40	↔	1/11	36/207	
	124b LD - annual health check	2016-17	27.3%	↓	11/11	205/207	
	124c Completeness of the GP learn	2016-17	0.21%	○	11/11	207/207	
R	125d Maternal smoking at delivery	17-18 Q3	2.5%	↑	2/11	4/207	
	125a Neonatal mortality and stillbi	2015	4.8	○	9/11	108/207	
R	125b Experience of maternity servic	2017	85.9	○	4/11	44/207	
R	125c Choices in maternity services	2017	69.7	○	1/11	3/207	
R	126a Dementia diagnosis rate	2018 02	74.0%	↓	6/11	49/207	
	126b Dementia post diagnostic sup	2016-17	80.3%	↑	4/11	59/207	
R	127b Emergency admissions for UC	17-18 Q2	1,496	↓	3/11	12/207	
R	127c A&E admission, transfer, disc	2018 03	86.6%	↓	4/11	52/207	
R	127e Delayed transfers of care per	2018 02	10.0	↑	5/11	97/207	
R	127f Hospital bed use following em	17-18 Q2	383.2	↓	1/11	13/207	
	105c % of deaths with 3+ emergency admissions in last three months of life (not available)						
	128b Patient experience of GP servi	2017	79.3%	↓	11/11	187/207	
R	128c Primary care access	2018 01	100.0%	↔	1/11	1/207	
R	128d Primary care workforce	2017 09	0.82	↓	10/11	190/207	
R	129a 18 week RTT	2018 02	86.0%	↓	9/11	155/207	
	130a 7 DS - achievement of standards (not available)						
R	131a % NHS CHC assesments takin	17-18 Q3	35.5%	↓	7/11	157/207	
	132a Sepsis awareness (not available)						

Note: peer and England rankings are unavailable for indicator 123f because it is not currently produced as a rate

The CCG needs to work with local partners to develop a response to these issues which is proportionate and sufficiently ambitious.

7. Options and choices

There have been broadly three options for the CCG and partners to consider

Option	Evaluation against CCG priority			Commentary
	Coordination of care	Clinical improvement at scale and pace	System sustainability	
1. Continue as is / status quo – i.e. continue to work to deliver incremental improvements in outcomes and finances	Incremental			• The Westminster care system has amongst the highest savings targets in the country • It is also faced with reducing real-terms income
				
2. Trying to achieve greater, non-contractual alignment – i.e. build on the above through some focussed pilot/network/alliance model	Insufficient to meet the challenge here			• Performance challenges are endemic and linked (e.g. obesity linked to diabetes) • To some extent this approach has been tried through major cross-sector programmes of work (e.g. Like Minded, SaHF, STP)
				
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	Challenging to deliver, but with potential			• New care models are still in their infancy in the UK • But this option does bring evidence of focus, prevention, scale, scope, pace of change and potential for provider-led innovation • For these reasons and others, this option is national policy and the published strategy of the CCG
				

Impact key

 Excellent  Good  Satisfactory  Poor  Very poor

8. Preferred approach: MCP

For reasons discussed previously, the preferred model of MCP being described is a partially integrated MCP

Virtual MCP e.g. the Connected Care Partnership (Sandwell and West Birmingham)	**Preferred approach** Partially integrated MCP e.g. Dudley	Fully integrated model e.g. Yeovil fully integrated model
• In the **virtual MCP** model existing contracts stay in place and are supplemented by an alliance agreement • Alliance agreements are non-binding on groups of providers and tend to be additional to, rather than supplement, existing contracts and commissioning arrangements • Virtual MCPs tend to focus on smaller pilot areas or population groups (e.g. frailty) • As a result, virtual MCPs lack the scale required to make an impact on priorities set out in the 5YFV and local NWL plans – for example in prevention, coordination, moving from services to outcomes	• In the **partially integrated MCP** commissioners re-procure all services in scope under a single contract • This does not include core general practice contracts, which are nationally set – but there must be an integration agreement with GP practices • Partially integrated MCPs align the GP practice registered list with the commissioning of out of hospital services • As such, they can reinforce the link between clinical decision making and system delivery (i.e. clinical commissioning)	• In the **fully integrated MCP** commissioners re-procure all services in scope under a single contract – including core general practice • Individual GP practices are requested to move to a new contractual arrangement • Fully integrated MCPs tend to work in areas of the country where the long term sustainability of a small, usually rural District General Hospital (DGH) is in question

9. Why MCP?

1. **Aligning financial and quality incentives to shift settings of care –** While our spend on acute services is relatively low, this reflects the fact that we have a much lower % of older and more frail people than other areas. When this is taken into account, our acute activity and spend does not benchmark as favourably. An MCP will embed financial and quality incentives across all providers to better manage care requirements within primary and community settings.

2. **Driving integration to make productivity and efficiency savings within our over-capitated sectors –** Local benchmarking shows that Central London CCG spends significantly more on mental health and community services than regional or national benchmarks. Work undertaken to develop the models of care for the MCP has identified significant areas of inefficiency with these services, with patients being seen in multiple sectors as part of their pathway, or functions duplicated across providers and services. The MCP will have the ability to redesign the way that front-line staff work on a collective basis to reduce these areas of duplication and identify productivity and efficiency gains.

3. **Governance and structures which support quicker change** – Currently if commissioners which to change a service or price, we are required to negotiate with an individual provider or undertake a procurement exercise. This makes the pace of transformation slow and reduces our ability to deliver the savings required. An MCP will have collective decision-making processes and control over the flow of money. This will ensure that where changes are agreed by the MCP, these can be achieved quickly without the need for lengthy negotiation and/or commissioning processes.

Annual Spend Difference	Mental Health Care	Community Care	Acute Care
Between CLCCG and STP average	£19.4m	£8.5m	(£19.9m)
Between CLCCG and DCO / regional average	£20.5m	£14.6m	(£21.6m)
between CLCCG and National average	£24.4m	£11.9m	(£15.1m)

10. Delivery – risks and opportunities

Delivering an MCP in Westminster will not be a straightforward process and the CCG and partners need to be cognisant of the risks as well as the opportunities

Risks and opportunities include:

1. Establishing **models of care** in sufficient detail for them to be put in place by/with provider(s)
2. Supporting these through **the right commercial approach** – recognising that a lot of the financial and strategic planning being put in place will ultimately form the basis of negotiation
3. Provider **market development** and provider interest in working in Westminster
4. **Co-production, communication and engagement**
5. Capacity and capability required in the CCG, partners and wider health system

The CCG holds a detailed risks and mitigation strategy which is updated regularly.

10. Delivery – key lessons learnt from international experience

What are the key lessons learnt from experience elsewhere? What makes the difference?

These lessons learnt represent a challenge for all leaders and care system partners in Westminster:

1. **Find common cause** with partners
2. Develop a **shared narrative** and understanding of **why integrated care matters**
3. **Create a compelling case for change** – a vision based on benefits to people and populations, as well as clinical and financial issues
4. Build as much as possible **from the 'bottom-up'** – since no one best model of care exists
5. **Create alignment** at a political level to support and enable change
6. **Align financial and governance incentives**
7. Create an **understanding of the theory of integrated care** – why integrated care interventions should improve peoples' outcomes
8. **Message the vision** and its impact through effective communication, genuine co-production and engagement planning
9. Put in place **specific, measurable objectives** so that there is **transparency** in the progress being achieved
10. Ensure there is **continuous quality improvement**
11. Transformational change for the long-term requires **commitment**
12. A coherent **change management strategy** is required

There are contributions for everyone to make to the above

10. Delivery – MCP budget approach

MCP delivery will have financial and budgeting issues for the Westminster system and Westminster's partners. This will include a number of considerations – both prior to the launch of an MCP and after.

Before the launch of any MCP

- The CCG will be required to manage system finances for the intervening period until the launch and mobilisation of the MCP
- The CCG is establishing a 3 year financial savings programme to cover the two years leading up to the launch of the MCP and a further year for any slippage in implementation. These elements are required to put the MCP on a path to delivering financial sustainability
- This plan features the de-commissioning of services across both MCP and non MCP services – as is currently the case in the CCG's QIPP plans
- Given over benchmarked levels of mental health and community service investment in Westminster, these areas are likely to feature strongly in the CCG's ongoing financial planning
- The impacts of any changes in national policy both in the transition phase and post implementation will need to be managed, including any changes to tariffs
- Any changes will have impacts on local providers of care. This may bring to the fore challenges in terms of the sustainability of some local providers.

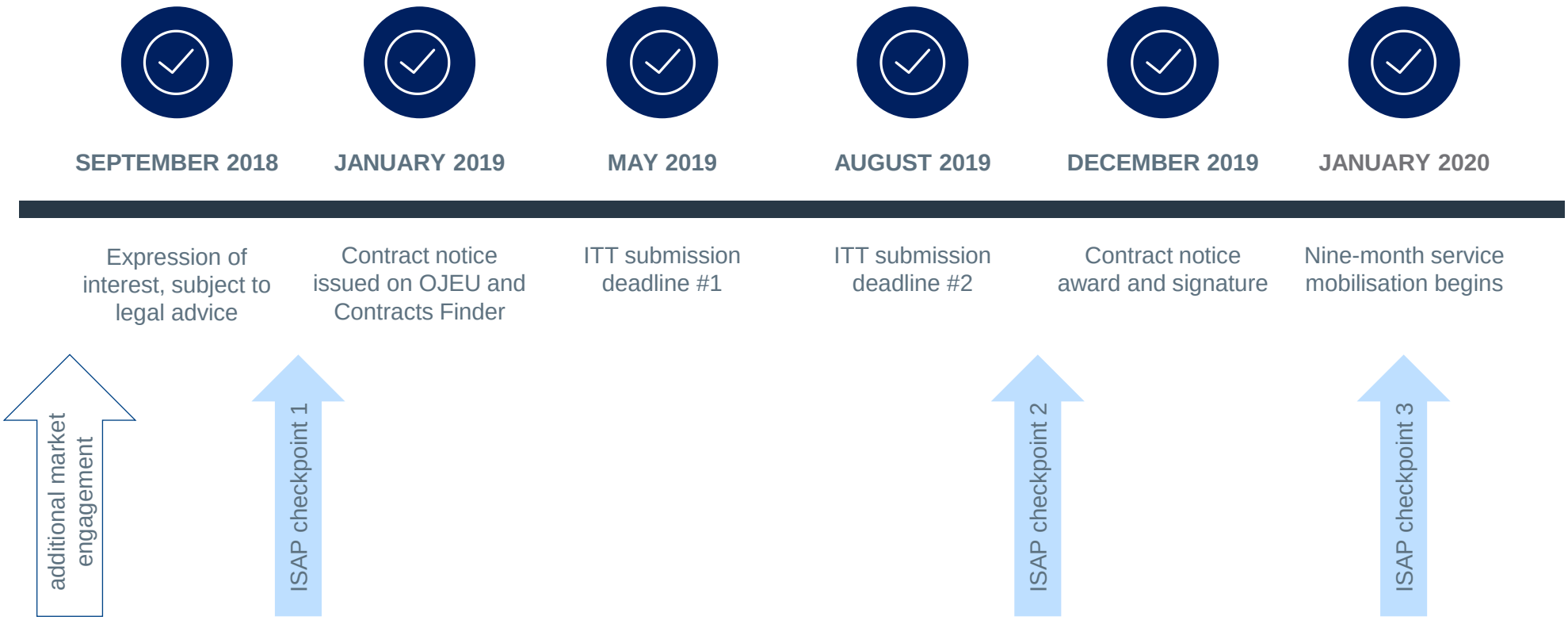
10. Delivery – MCP budget approach

Preparing for the launch of any MCP

- The financial outlook for the system may change, so setting a value for the MCP now is not possible
- Key considerations for setting the MCP financial framework include:
  - The CCG's overall appetite and ability to manage the remaining system risk i.e. MCP budgets in relation to non-MCP cost pressures such as acute spend against tariff and prescribing
  - Bidders' ability and capacity to manage the risk they would be being asked to take on
  - Further detail on the payment mechanism to be used
  - The commercial aspects of any gain/risk share arrangement
  - Being clear about any potential, additional services or funding sources that may be introduced to the contract over the contract period and how these would be treated (e.g. any local government services).

- The above aspects would be refined and honed through the competitive dialogue process and would be influenced by perceptions of the above in the wider market
- The CCG's preference would be for the MCP to focus on cost reductions through internal efficiency programmes, which would be made possible because of the alignment of complex arrangements, contracts and pathways. However, the MCP may also need to consider service retraction opportunities (i.e. service changes and reductions) alongside service transformation
- These factors would need to form part of the structured dialogue process.

11. Timeline and next steps



11. Timeline and next steps

The timescales include:

- **Further market engagement** between July and November/December 2018 – including three further open market information sharing/gathering events between July-September 2018 and an expression of interest process for potential providers beginning in September/October 2018
- **A formal decision** on whether or not to proceed to procurement in December 2018 – following engagement with regulators (through the ISAP process)
- If approved, **a formal procurement** process which would commence in January 2019 – with contract award to take place in September 2019 and service mobilisation to commence from April 2020

Next steps therefore include:

- **Workforce information request** to support pilot new ways of working
- Further development of **local models of care**
- Further delivery of the **system rebalancing programme** through CCG QIPP – with further recommissioning letters coming to providers in due course
- Further market engagement events, with the sharing of questions and answers at those events
- Further communications from the CCG on the work of this programme.