South Worcestershire Clinical Commissioning Group

A **New Model of Care** for South Worcestershire

Implementing the **NHS Five Year Forward View**

November 2015

Introduction

The purpose of publishing this draft strategy is to outline our initial thinking regarding our intention to commission services using a new model of out of hospital care from 2018/19 onwards. The document is designed to initiate a process of public, stakeholder and potential future provider engagement that will be regularly revisited as the strategy is deployed.

If you have comments on the content of this strategy or would like to be involved in how it is developed please contact david.mehaffey@worcestershire.nhs.uk .

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Summary on a page 4

1. Context and background – The NHS Five Year Forward View 5

The NHS Five Year Forward View sets out the clear challenge facing health and social care over the coming period. It identifies the key challenges, such as additional pressures created by unhealthy living and an ageing population, and a £30bn efficiency challenge. It outlines a limited number of new care models that it expects to develop in local health and care economies from 2015/16 onwards and how these should be taken forward.

2. Where are we now? 10

We start from a traditional base of multiple commissioners securing services through multiple contracts with multiple providers. Whilst we have developed some strong approaches to integration, such as through Well Connected, we still pay for services through input focused short term contracts where providers are not incentivised to work together towards common goals. We have an acute provider in severe financial difficulty and a community health provider amongst a declining group of providers that is still able to plan for a surplus. We also have General Practice battling increased demand alongside diminishing resources and a shortage of GPs. The performance management regime sets providers up to "pressure each other" into change rather than incentivising them to genuinely work together for mutual improvement. This system needs to change in order to secure financial sustainability for commissioners and providers at the same time as continuing to provide high quality care to the population.

3. Where do we want to be in five years? 18

For our most complex patients we want to have a simplified system where there is a single commissioning pot that is used to secure services through one long term contract with a collaboration of providers that is able to deliver care in a more integrated way. That contract will be let to a single provider or collaboration that structures their services around the needs of patients, not the convenience to the providing organisations. We want to incentivise providers to be innovative and to work together and we intend to do this through letting a long term capitated contract based on the achievement of outcomes. Initially this will focus on people living with frailty but we intend to extend this concept out to a wider population who regularly rely on health and social care services to live their normal lives.

4. How will we get there? 22

We will follow a programme of change over the next four to five years which includes clear milestones and interdependencies. We have set out what we intend to commission, how we intend to commission it and how we think potential providers will need to respond. We have based, and will continue to base, our strategy on engagement and co-production principles with our patients and public. We will need to retain flexibility to change the way we commission services as national policy becomes clearer and in response to what our patients and public tell us through our engagement processes. There may also be changes in procurement or other legislation that we will need to reflect. In time we will set out a clear timetable for procuring our chosen model along with the patient related quality outcomes that we want to achieve. We do not underestimate the scale of the challenge facing us and we recognise the risks. We will need to create a transformation fund to support the change we need to achieve.

5. How will this change affect patients? 26

Successful implementation of our strategy will transform care for patients. Patients will experience care that is more integrated and organised, they will receive more consistency of contact, regardless of whether they are being cared for at home or in hospital. They will be more involved in their care planning and their information will be routinely shared across all members of staff who are actively involved in their care. Patients will get to know their carers better and they won't experience the false divides that are currently evident between care given by different agencies. Ultimately, success will mean that there are fewer breakdowns – be that of a patients' health or the care system that supports them, meaning fewer emergency hospital admissions and a smaller proportion of people requiring residential care.

6. Timelines and milestones 30

Aspects of the strategy are already in place now and we will continue to build upon these. As previously identified our approach needs to be inherently flexible to adapt to changing needs, be those of a changing legislative framework or in response to what our patients and stakeholders tell us. Within this strategy we set out our initial intentions but we recognise that we may need to adapt our course over the coming years. We are seeking to escalate the scale and pace of the change process from 2016/17 onwards with a view to procuring a capitated outcome based contact from a new provider model during 2017/18 for implementation during 2018.

Summary on a page

South Worcestershire Clinical Commissioning Group

Our Ambition

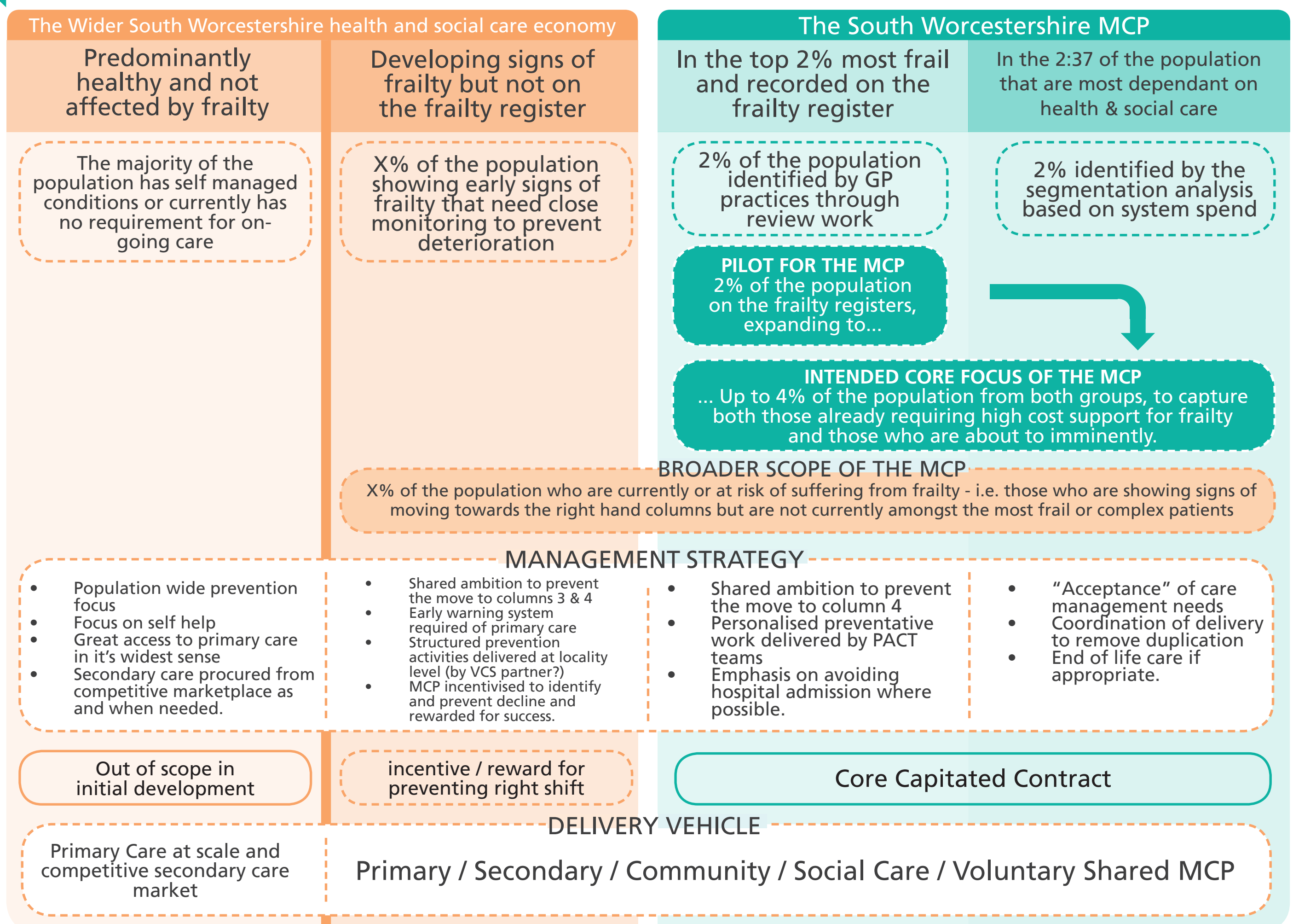
From 2015

- Programme commissioning and primary care commissioning separately approached, with some overlap but not integrated at scale.
- Separate contracts let for separate providers serving the same patient. Some overlap through the Better Care Fund, but very limited in scale. Provider work funded through a mix of a activity and block based contracts.
- Lots of handover of patients each day and week for the management of the same or similar conditions.
- Multiple assessments undertaken by different agencies with limited sharing and large gaps in IT interoperability.
- Competition/ blame driven approach whereby perceived “failure” in one part of the system is picked up by another part.
- Little Population segmentation in terms to differentiate need and identify different treatment plans

To 2020

- Services delivered by organisations that are commissioned through one contract based on a capitated budget with outcome driven measures, requiring care providers to work in cooperation with each other not in competition.
- A single assessment process shared across all care providers and recorded on IT systems that interoperate fully.
- Population is segmented to identify a target group of individuals who are most likely to benefit from a transformed approach to care planning and delivery.
- More proactive and coordinated care for those on the verge of becoming part of the target group of patients with high levels of need.
- A provider “collective” incentivised to deliver services in the most cost effective way that meets the outcomes defined and to work with people at risk of joining the target group to prevent their deterioration

Our Approach



Chapter 1

Context & Background

The NHS Five Year Forward View

Whilst the NHS benefits from being a “protected budget”, this should not be misinterpreted as meaning that NHS services do not face a significant financial challenge. Since the 1970’s NHS funding growth has averaged nearly 4% per annum. For the most recent government spending review period this growth has been 1.5% per annum, the lowest increase over a five year period in the history of the NHS and less than half the level of growth seen in the preceding five years. In 2015/16 this growth was 1.3%, an increase on the initial plan of 0.1% following an increased allocation in the Autumn statement.

In November 2014, NHS England published a “Forward View” to set out the strategic challenges facing the NHS over the following five years. The document identified a £30bn funding gap that would emerge over the five year period if growth in funding continued at the current rate. A financial gap which would need to be closed by local health and care systems:

- Working together to **reduce demand** for services.
- Delivering **greater efficiency**, through:
  - * Catch up – with all parts of the system achieving the efficiency of the most efficient (often referred to as tackling unwarranted demand).
  - * Frontier shift – Finding new ways of moving the whole system forward.
- Receiving **increased funding**

The national financial challenge

The document identified that a combination of reduced demand and increased efficiency could potentially realise £22bn of the gap – leaving an £8bn gap to be closed via additional funding. The incoming Government has pledged to meet the £8bn funding requirement, but this money is not expected to find its way into the system until the end of the five year period.

A national £22bn efficiency programme is significantly greater than any efficiency programme the NHS has successfully delivered to date. In recent years the NHS has delivered efficiency gains equivalent to around 0.8% per annum.

Meeting the £22bn challenge effectively means that the NHS will need to deliver between two and three times the level of efficiency over the coming five years when compared to the preceding ones.

The Five Year Forward View Financial Gap

The local financial challenge

The national financial challenge is reflected locally within the Worcestershire health and social care economy. Worcestershire Acute NHS hospitals Trust faces a significant financial challenge and needs to deliver a large efficiency programme. The Trust's deficit has grown annually and is forecast to grow again in 2015/16. Worcestershire Health and Care NHS Trust also has a challenging efficiency programme but is currently delivering a planned surplus. Worcestershire County Council is perhaps facing the most significant challenge of all – real terms budget reductions at the same time as facing growing demands because of the Care Act and the demographic changes. These financial challenges will have a significant impact on the way services are currently delivered across the acute, community and social care sectors.

In addition to the social care savings, Worcestershire County Council is also planning for an in-year reduction to the Public Health Ring Fenced Grant (PHRFG). Public Health Services are funded above capitation in Worcestershire, which is likely to lead to a higher level of cuts to funding in this area going forward.

The CCG is currently delivering against its financial plan for 2015/16 but faces on-going challenges around QIPP as inflationary uplifts do not fully cover the growing cost of healthcare. The recurrent programme budget for the CCG is below target funding by £3.3m (1.1%) based on the current NHS England funding formula allocation to CCGs. A review of the funding formula is currently underway nationally and it is hoped that this will recognise the increased costs of delivering healthcare in more rural areas. A change in funding formula reflecting sparcity should benefit the CCG financial allocation.

Future planning allocations for the CCG do not include any assumptions of the additional £8bn earmarked for the NHS by 2020/21. At this stage the allocation and timing of the £8bn is not known at a CCG level and because Worcestershire as a whole is funded at around capitation under the current formula it is possible that uplifts will not be seen locally.

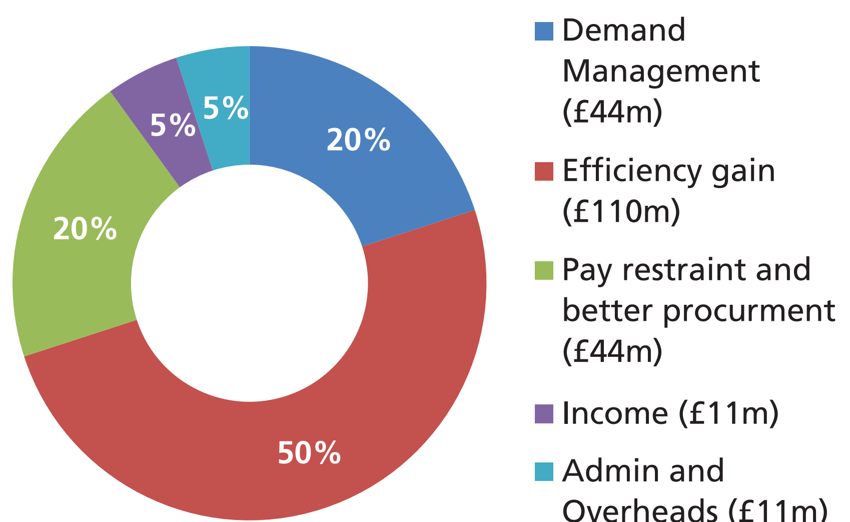
The Worcestershire health economy typically accounts for 1% of national expenditure – meaning that the local challenge over the coming five years is equivalent to £220m. Current planning assumptions suggest that this is likely to be addressed in the following way:

Demand management will be a combination of public health driven prevention work and commissioner driven policy changes.

Efficiency gains will be largely an NHS provider issue aimed at getting "more for less" and will cover primary, community and acute care.

Pay restraint will be the 1% for four years as announced in the budget and **better procurement** will be the delivery of existing targets around better prices and standardisation of product use.

Income will be focused on areas such as overseas patients and **admin costs** will incorporate things like further running cost reductions.



Context & Background

Responding to this level of challenge requires more than tinkering around the edges and there is widespread recognition that genuine transformation in the way in which NHS services are delivered is required.

This transformation will need to be driven through three strategic themes:

Getting serious about prevention	
Problem / Opportunity	**Action to be taken**
• 1:5 still smoke, 1:3 drink too much; 2:3 are overweight, childhood obesity doubles during the primary school years • Health inequalities in part drive these statistics – smoking in pregnancy is 2% in West London but 28% in Blackpool	• Incentivising and supporting healthier behaviour • Local leadership on public health • More targeted prevention • NHS support to help people get and stay in employment • Improvements to workplace health
Empowering patients	
Problem / Opportunity	**Action to be taken**
• Even people with multiple long term conditions may only spend 1% of their time with health professionals • Empowering patients, carers and networks to manage more effectively when they are on their own will be critical	• Improving information for patients, driven by improved IT opportunities • Support to manage their own health, supported by renewed approach to the voluntary sector and group based support. • Increase direct control patients have over their long term care
Empowering communities	
Problem / Opportunity	**Action to be taken**
• Engaging through new ways with communities and citizens in decisions about health and care services as well as building on the existing energy of communities	• More supporting to carers • Engaging community volunteering • Stronger partnerships with the voluntary sector • The NHS as a local employer

Different operating models and structures will be required to deliver this transformation and the NHS Five Year View clearly states that the traditional structures where primary care, community care and secondary care operate in isolation is a barrier to delivering services in the way they will need to be delivered in future.

A number of possible new models of care were identified:

Multispecialty Community Providers (MCPs)	• Based on the registered list, an expanded role for primary care that builds upon the "expert generalist" philosophy. GP practices to work more closely with social care, community nurses, therapists and other community based professionals to deliver a broader range of care based around people's needs. • Over time it is perceived that larger MCP groups could take on the employment of social workers, consultants (physicians, paediatricians, geriatricians, psychiatrists), or bring them in as partners as part of the team. They could run community hospitals and generally support the shift of traditionally hospital based care out more into the community. • It is perceived that these entities could take on responsibility for devolved budgets for their registered patients.

Primary and Acute Care Systems (PACS)	Vertical integration between acute and primary care and there are a number of models developing around England based on lead or prime contractors or joint ventures. The Forward View states that NHS England will now permit the development of "new variants" for integrated care by allowing single organisations to provide NHS list based GP and hospital care alongside mental health and community services. Several potential models are perceived: • **Acute Led** – with Acute Hospitals opening their own GP Surgeries with registered lists. The Forward View recognises the importance of managing the risk of these surgeries becoming "feeders" for the hospital rather than being the keepers of community care. • **MCP led** – with mature MCPs taking over the running of its main district general hospital. • **Accountable Care Organisations** – the most radical model where the PACS provider would take over the whole health needs of the registered list of patients under a delegated capitated budget.
Urgent and emergency care networks	• Making more use of **primary care**, community mental health, ambulance services, pharmacies and urgent care centres. • **Networks of linked** hospitals ensuring specialist care is accessed when needed More consistency of **provision over seven days** where it makes a clinical difference to outcomes. • Proper funding an integration of **mental health crisis services**, • Strengthened **clinical triage** and advice in the urgent care system, locally we need to develop this as part of the urgent care centre.
Viable smaller hospitals	NHS England does not want to pursue a strategy of closing smaller district general hospitals and is developing three themes to help make them more viable: • Adjustments to the NHS payment regime – allowing more flexibility in the way in which national tariffs are applied to enable smaller trusts to be viable. • Implementation of the Future Hospital Model to establish new medical staffing models to enable smaller hospitals to be viable. • New organisational models for smaller hospitals, which might include shared management or back offices, "leasing" out part of its site to other specialist providers to provide local services or full integration with the local community services provider.
Specialised care	In areas where there is a strong correlation between the number of patients and the quality of care (through clinical specialism) then a greater standardisation of care will be pursued. There is much more that can be done and NHS England will work with local systems on rolling three year reviews.
Modern maternity services	Having a baby is the most common reason for hospital admission in England. For low risk pregnancies, babies born in midwife led units did as well as those born in obstetric units. NHS England will support the development of these services through: • Commissioning a national review of provision to report in the summer of 2015 • Review the tariff system to support rather than constrain choice • Make it easier to develop midwife led units
Enhance care in care homes	1:6 people over the age of 85 live in a care home, yet they are not always the most suitable or necessary choice of care for people. As part of the Better Care Fund, NHS England want to see more models of shared care including medical reviews, medication review and rehabilitation services.

NHS England recognises that a key part of its role going forward will be to facilitate and exercise discretion to enable local innovations to succeed. This will involve developing prototypes of each new care model and also assessing the characteristics of different health economies to help them choose the right care models. At an NHS Planning event Simon Stevens talked about "five or six different types of health economy", and this is expected to develop into a more structured policy.

The Worcestershire Vanguard Application

There has been a national programme to identify "Vanguard" sites where potential new models of care can be developed and tested with national support. Where appropriate these will be rolled out nationally if they are proven to be successful. Worcestershire submitted a Vanguard application but was not chosen as one of the small number to be managed through the national programme. However, the Worcestershire Vanguard was based on an existing programme of work that was being pursued and there is no intention to divert from this path simply because the Vanguard bid was not chosen.

The Worcestershire Vanguard submission identified a proposed new approach to providing care to patients currently suffering, or likely to suffer ill health through "Frailty". Frailty is not to be confused with old age, as it can afflict people of all ages, but is a condition that is exacerbated with age.

Whilst this application was ultimately not successful, going through the process of submission helped us to identify and construct our plan around the direction of travel. It is from this base that we are now developing our future strategy to move towards a Multi-specialty community provider (MCP) model built around frailty. However, it is important that we time our development to ensure that we learn from the national models and don't simply furrow our own path alongside a nationally supported programme seeking to achieve the same long term outcomes. This will be reflected in our timelines for implementation so we ensure that there is sufficient time for learning and reflection from other projects nationally.

In March 2015, the first wave of Vanguard sites was chosen. There were three Vanguard types spread across the 29 projects in PACS, Care Homes and MCP areas. In July, a second wave of eight Vanguards was announced, known as Urgent and Emergency Care vanguards.

A further wave of Vanguards will be announced in the autumn – known as acute care collaborations, they aim to link local hospitals together to improve their clinical and financial viability. Applications to become an acute care collaboration closed on in July with a final decision on the successful organisations and partnerships to be made in late September 2015.

Led by the New Care Models team and supported by the seven arms-length bodies, the development of the Vanguard models is based on 4 key values:

- Clinical engagement
- Patient involvement
- Local ownership
- National support

The developing support programme covers eight key enablers:

- Designing new care models
- Evaluation and metrics
- Integrated commissioning and provision
- Empowering patients and communities
- Harnessing technology
- Workforce redesign
- Local leadership and delivery
- Communications and engagement

The New care Models Board has made a clear commitment that the Vanguard and Pioneer programmes are both key vehicles for the implementation of new care models and so the support packages for the two programmes are aligned under the leadership of The New Care Models team. Therefore, through our pioneer status, we have access to the learning, networking and support tools available for Vanguards and for bespoke support though the Pioneer Support team.

Chapter 2

Where are we now?

The starting point for South Worcestershire

What our patients and public tell us about integration

Since our inception as a CCG we have been working with patients and the public to understand what is most important to them and design services better suited to meet their needs. The general public view is often that the NHS is a single organisation and people are often surprised to learn about the multiple commissioner and provider organisations and the complexities this brings to the local system. As part of our on-going discussion with our local community the theme of better integrated care across organisations is repeatedly raised as an area where significant improvements could be made, summed up by the following quote from one of our patients:

"We don't want see the joins. In other words, we see the NHS and care as one and do not understand, or want to know about, all the various elements."

During 2015, the co-production work with patients organised by the Young Foundation looked at this issue specifically and the theme of better integrated services has continued with the co-production of the new primary care contract. With this the ideas of a holistic and well-co-ordinated service that wraps around patients, particularly those with long-term conditions, has been prevalent. Even prior to this work much discussion has taken place within our patient forums such as the Patient and Stakeholder Advisory Group and South Worcestershire PPG Network. The issue also regularly surfaces at public events and during programmes which involve working closely with the local community such as the Strengthening Healthy Communities project. The following quote from another patient sums up some frustration with the current system and makes a suggestion to how things could be improved:

"We need to get everybody around the table that has an interest in the outcomes you need, see if they have some shared objectives and then pool the resources available to give more people the outcome they want?"

Our extensive work on engagement to date is just the start of what we intend to do going forward. It has helped us shape some initial ideas into a working proposal that we can develop into a new service model to commission in future. We intend to do much more engagement with patients and the public over the coming years as we refine our approach further. This will start with a structured programme of engagement events during 2015/16 and will continue with regular engagement forums throughout the on-going development and implementation of the strategy.

How we commission services now

We don't currently commission services in a way that helps achieve this:

- Programme commissioning and primary care commissioning are separately approached, with some overlap through delegated responsibility for commissioning primary care and the development of the local contract with primary care – locally known as the "Promoting Clinical Excellence" contract.
- Separate contracts are let for separate providers serving the same patient groups – primary care, community care, acute care, social care, ambulance, out of hours etc with some overlap through the Better Care Fund, but very limited in scale. There is lots of handover of patients each day and week for the management of the same condition.
- There is often a competition/blame driven approach whereby perceived "failure" in primary or community services means acute trust admission or "poor" discharge planning in acute leads to primary and community services finding it hard to manage transfer back to the community.
- There is little customer segmentation in terms of overall approach although there is some use of risk stratification and other patient focused planning tools.

Where are we now?

Recognising the challenges ahead, South Worcestershire CCG has already started to implement changes to the way in which we commission services. In July 2014, the Health and Well Being Board approved the Five Year System Plan for Worcestershire, which outlined planned changes in a number of areas.

In particular we outlined our desire to commission services using an outcomes based contract for a defined population using a capitated funding approach which would require existing primary, health, social and voluntary sector providers to come together in a provider collaboration of some form. Whilst this was published before the NHS Five Year View, the ambition and intent was consistent and there does not need to be a fundamental change of direction as a result.

Bringing together a new commissioning strategy will involve bringing together the following elements into a more unified approach.

Primary Care Commissioning

Alongside the financial challenges outlined in the previous chapter for our providers, there are also significant pressures facing primary care. There is rising demand both in terms of numbers of patients and their complexity, recruitment challenges and many experienced GPs leaving general practice. The fact that, this year only a minority of the primary care training places could be filled in traditional GP practice environments highlights the need to start thinking differently around future commissioning models. These circumstances come together and mean that business as usual is no longer possible and change within primary care is necessary.

In 2015/16 SWCCG was given delegated responsibility for commissioning primary care. During the first year of delegated commissioning the CCG set about pursuing the following priority areas:

- Proactive care for older people living with frailty
- Excellence in the management of long term conditions
- Responsive, timely access
- Health improvement and prevention
- National priorities e.g. mental health, learning disabilities and cancer
- Best practice – making quality referrals, coding.

For 2016/17 these priorities and principles will be built upon, along with an increasing focus on payment following the achievement of outcomes. The strategic approach to commissioning will reflect the need for different levels of integration:

- Commissioning some services from the 32 individual practices working alone in some areas.
- Commissioning from clusters of practices working together, either at a local level or a South Worcestershire wide level, where there is a common approach to service delivery.
- Commissioning from “partnerships” with other providers as part of a wider package of care and support.

The second and third bullet points in particular need to be aligned to the wider CCG new model of care strategy. In this area, the Primary Care Commissioning Strategy has initially identified the top 2% of people living with frailty or multiple long term conditions as being the group that needs the most targeted and integrated care. This is similar in scope to the Well Connected vision, but further work is required to ensure absolute alignment.

For 2016/17 our approach is to seek initial integration through flexible use of the Promoting Clinical Excellence contract. However, in 2017/18, this element will be more formally integrated into the MCP commissioning strategy. During the coming year, in the main it will be for practices to determine how they respond to this approach, but we recognise that in other parts of the country change is being driven through organisational mergers and vertical alignment whereby Community Services and Acute Services providers are starting to employ GPs directly to deliver out of hospital care. This, in part, also reflects the desire of some GPs to move away for the uncertainty of the partnership model to a more structure employment salaried role.

In our commissioning role the CCG does not intend to specify that any particular model should be actively pursued over another but what we are clear about is the need for a strong and vibrant primary care sector that can combine with community services and social services in a way that has not been achieved before.

Where are we now?

We recognise that current or future providers of integrated care services in South Worcestershire will want to explore a variety of options for organisational structures to deliver integration and we would be willing to explore the proposals put forward by interested providers.

Primary Care Federation – Stay Well Healthcare

GP Practices alone, working in isolation, face extreme difficulty in meeting the growing need of populations for long term care (Addlicot and Ham 2014). In response many primary care leaders (for example the RCGP) and policy experts have called for the development of collaborations of practices. Recently in the press there have been many reports of federations, collaborations and new super-practices. In Birmingham there are plans to create GP practice with 180 partners and in the East of England there are plans to create a single practice that has a registered list of 100,000 patients.

The Kings Fund has previously commented that GP Federations covering populations of 50,000 to 130,000 (or as small as 30,000 in rural areas) are likely to be the right size, but it is important that they are built around natural communities with common issues. The proposed new GP contract talks of the need to operate at a scale of 30,000 or more patients to be eligible, adding further emphasis to the importance of working at scale. During 2014, the 32 member practices of South Worcestershire CCG joined together to form a single body to co-ordinate their interests as primary care providers. Covering a population of almost 300,000 is likely to mean the need to subdivide down into smaller chunks to enable projects on the ground to take shape. Indeed, there are some natural groups emerging, such as the Upton and the two Pershore practices, covering a population of circa 30,000 and the four practices in Droitwich and Ombersley, covering a similar sized population.

Operating singularly on a scale covering 300,000 people may require enhanced systems and infrastructure akin to the existing community providers, particularly around areas such as clinical supervision, risk management, CQC compliance, finance and estates, HR and organisational development, bidding for new work, communications and community engagement etc. Aligning these issues more formally between the GP Federation Provider and the Community Services provider is an option that the CCG would be interested to see explored. Equally we would welcome alternative proposals from other potential providers as to how best to secure integrated working between community services and primary care. Our choice of provider model is not pre-determined, but we are clear that the chosen provider model must support our ambition to secure genuine integration. Of course structure and form are provider decisions, but it is important to recognise the role that CCGs have in market management and quality assurance across the provision of primary and community services. Therefore an interest in sustainability and robustness of providers is relevant in this context.

Alongside delegated commissioning responsibility, the creation of Stay Well Healthcare has given the CCG the opportunity to engage with primary care in a new way and contract using different models. The Federation has quickly established itself as a key provider of healthcare services in the area. For example:

- The provider of the primary care services at Farrier House Surgery
- The provider of GP resource in the Urgent Care Centre at Worcestershire Royal Hospital
- The coordinator of South Worcestershire's enhanced services work

Looking to the future the CCG will be looking to commission more and more services from primary care at scale and ability of primary care to federate at either County, sub County or locality level will be an important part of securing a sustainable provider model over the life of this strategy.

Prime Ministers Challenge Fund

In 2015/16 Stay Well Healthcare was allocated £2.8m from the Prime Minister's Challenge Fund to improve access to Primary Care. The resource will be used to:

- Create a virtual hub which the population can access between 8am and 9pm seven days per week.
- Enhanced locality access schemes to enable extended access to face to face appointments.
- Improved IT systems to enable better sharing of patient records to support more seamless care arrangements.

Where are we now?

The breakdown of funding is shown below:

Item	£k per annum
Multi-disciplinary Virtual Hub	£948,400
Locality Hubs	£716,000
Online access and self-help	£260,000
Sharing of Patient Records	£227,000
Leadership capacity, change management, data collection and communication	£645,000
Total	**£2,796,400**

Seven day access to primary care, initially supported in pilot stages through this significant investment but in the longer term through a tested and proven model will be a key part of the MCP strategy. Our new commissioning strategy seeks to minimise the number of handovers between providers and therefore the development of core local primary care services beyond the traditional Monday to Friday 8am to 6pm model will be an important building block.

The PMCF initiative is in its early stages and we are currently piloting a range of initiatives. We will review the success or failure of these initiatives as we determine the best approach to support our commissioning strategy. Whatever the outcome, our ambition is to ensure that there is excellent access to primary care and this is provides the foundation from which to coordinate the other services that patients need.

Additional investments in community services

In the last 3 years the CCG has recurrently invested an additional £2.5m in community services. The first tranche of investment was for £1.3m in 2013/14 for the expansion of Enhanced Care Teams. The second tranche of investment was the £1.5m in 2015/16 in relation to the £5 per head (whereby the CCG earmarked resources equivalent to £5 per head of population over the age of 75 to support the national policy on the "Accountable GP"). Almost £1m of this funding was directed toward Proactive Care Teams to complete the investment in the community services business case approved by Clinical Executive in July 2013. These investments provide a strong base from which to develop our commissioning vision in response to the Five Year Forward view in relation to new models of care.

Additional investments in primary care services

The CCG has supported growth in Primary Care and this is reflected in the additional investments that have been made in supporting primary care services in recent years. The additional investments include:

- Local Enhanced Services money
- Funding for the management of localities and an investment of £50k per locality to support pump priming of local initiatives.
- Development of the Promoting Clinical Excellence (PCE) contract, which has invested over £1.1m in Primary Care in 2015/16, including the recycled PMS Premium of £500k and IQSP funding £120k
- Levelling off on the minimum funding to support practices that had core GMS contracts at levels significantly below the national formula.

The South Worcestershire Alliance Board

The National Association of Primary Care has put forward a view that in future primary care and community care should be seen as one service. Locally, the development of an Alliance Board is a step towards having a seamless service that meets this aim. In 2014/15 an Alliance Board between Stay Well Healthcare and Worcestershire Health and Care Trust was formed to oversee the development of services in response to the £5 per head investment. Initially this Alliance focused on planned care; namely the new monies associated with "£5 per head" (proactive care) resource as well as district nursing and care home nurses.

Where are we now?

This approach was developed in the light of the Worcestershire "Windmill" sessions that were held in April 2014 to consider the future health and social care across the County. Local providers met shortly after these events to explore the emerging commissioner intentions at the time and to consider how they might collaborate going forward. The particular focus was on support to those the patients who have the most complex needs and highest resource utilisation across health and social care. This work was involved Worcestershire Health and Care NHS Trust, Worcestershire Acute Hospitals NHS Trust, the emerging local GP Federations, social care and the voluntary and community sector.

Agreement was quickly reached in a number of key areas:

- Providers confirmed that they were willing to work together in a more innovative way.
- Recognition of the need to be more radical in service development plans but that much of what was possible would be 'evolutionary' and not 'revolutionary'.
- Developing a jointly agreed vision / plan supported by a scalable, incremental approach to change (albeit at a faster pace than before) was the safest way to achieve practical change on the ground that would be recognised by patients.
- There should be an evidence base to support developments and that robust monitoring of the impact of changes in patient outcomes during the transition was important.
- Change should be co-produced between commissioners, providers, patients and carers. Change should be clinically led and managerially enabled.
- Commissioner leadership and participation was essential and needed to go beyond transactional engagement.
- Quality incentives would be needed and that there would need to be a different approach to managing risk.
- Recognition that time and resources were required – both in facilitation, project management terms and back fill to enable changes to happen. Access to transitional money, whether local or national would help to drive the agenda at scale and pace.

There was broad agreement that out of hospital care models were likely to coalesce around the GP registered list and therefore General Practice Federated Vehicles would be central to any development. From the outset this initial focus on "rewiring" care and support for people with more complex/multiple long term conditions was co-designed with patients through the Young Foundation coproduction workshops and involved social care as well as CCG commissioners.

Over the last 12 months the Alliance Board has implemented the new Proactive Care Team (PACT) through a formal agreement intended to support the governance and conditions associated with this joint decision making and shared accountability for quality, performance and budgetary control. It has also assured both parties of the intent to work collaboratively and flexibly whilst ensuring that any risks associated with contractual non-compliance are the responsibility of both parties. PACT staff are now in post and operational interfaces continue to be formalised to maximise the impact of these roles in relation to keeping those most at risk of admission, independently living at home.

The Alliance Board is driving a synergy where the benefits are greater than those obtained by organisations that traditionally support people with multiple long term conditions acting individually. At the Alliance Board away day in July 2015 partners were able to explore actions to ensure the developing shared purpose drives sustainable change.

Integrated Recovery Programme

The Integrated Recovery Programme (IRP) is a suite of projects that has begun to integrate the health and social care elements of older people's recovery services. Recovery services aim to support older people to return to independence after episodes of ill health, enable them to remain in their own home and reduce the need for long term care. A significant number of these services are currently commissioned separately by either the CCGs or Worcestershire County Council and are provided by a variety of providers. Feedback from patients, their families and carers and the workforce suggests outcomes, patient experience and efficiency could be improved if this range of services were delivered in an integrated way.

Where are we now?

The vision for the programme, which is well underway, is to achieve:

- A seamless, patient-centred, health and social care recovery pathway for the frail elderly in south Worcestershire, delivered by providers who work across organizational boundaries
- A service which has a single point of access that makes it easy for professionals and patients to navigate
- A service in which patients and their families will feel safe, supported and be at the centre of planning for their recovery in their own homes.
- There was broad agreement that out of hospital care models were likely to coalesce around the GP registered list and therefore General Practice Federated Vehicles would be central to any development. From the outset this initial focus on "rewiring" care and support for people with more complex/multiple long term conditions was co-designed with patients through the Young Foundation coproduction workshops and involved social care as well as CCG commissioners.

This will result in:

- Improved patient experience and efficiency as a result of a reduction in the duplication, inequalities and inefficiencies that exist in health and social care recovery services currently.
- Funding following the patient and commissioning of appropriate levels of care rather than decisions based on availability.
- More patients living independently and safely in their own homes thereby reducing the need for long term care placements for patients.
- More flexibility to deliver efficient mixes of health and social care tailored to patients specific needs.
- So far significant progress has been made towards achieving these aims.

Recover at Home is a combination of community based services that have been traditionally delivered by the Health and Care Trust and Worcestershire County Council. A new model of care has been agreed through extensive stakeholder engagement and piloting of an integrated approach has begun. This will ensure that we learn more about the outcomes, benefits and barriers to integration to ensure we can then commission and deliver the benefits of this approach at scale.

As part of the pilot process we are currently co-producing the specification for the service in the future, putting the patient's voice at the centre of what they need the service to deliver for them. Evaluation of the pilot is planned and a significant element of this will be determining what the patient experience has been of integration as well as the monitoring of efficiency gains and the overall quality of the care provided.

Night Services have historically been services aimed at supporting people in their own homes overnight have been separately commissioned by Health and Social Care and provided by a number of providers working to different standards, access criteria and operational policies these services. This element of integrated Recovery Programme aims to address this, developing a single integrated service able to support a greater number of people at home.

The services are currently delivered on a county wide footprint and thus far we have gained agreement to proceed with the plan to integrate services from our neighbouring CCGs. An integrated model has been developed work has started which integrates the rostering of staff at night which will enable the right staff with the right skills to respond to the assessed patient need regardless of whether they are employed via health or social care. The results and learning from this work will be reflected in the recover at Home service specification, ultimately culminating in the commissioning of an integrated service offering 24 hour care.

In addition, commissioning arrangements have also been reviewed for residential units in South Worcestershire offering 24 hour nursing and rehabilitation – this includes reviews of Timberdine Nursing and rehabilitation Unit, Worcester Intermediate Care Unit and a Howbury House Resource Centre. As a result of these reviews, the role each unit currently plays in our urgent care system has been revisited, informing commissioning plans for 16/17.

This approach reflects a very real and operational example of how services can be delivered using an MCP provider model, which operates beyond traditional organisation and professional boundaries. Starting in a small, well defined way provides a firm foundation on which to build, increasing the scope and scale of services incorporate d within the approach to quickly include all services accessed most often by vulnerable patients and their families.

Where are we now?

Better Care Fund Plan

The Department of Health has provided funding to support integrated working between health and social care since 2011/12. The clear expectation from the Government is that this funding is used for social care purposes which benefit health and improve overall health gain through jointly agreed plans. In the June 2013 spending round the Chancellor of the Exchequer announced the creation of the Better Care Fund to support the integration of health and social care. The funding is described as:

"a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities".

Although not 'new' money, the Better Care fund sets an ambitious challenge to integrate health and social care. The scale and scope of the Better Care Fund is determined by the Health and Well-Being Board in line with the following national conditions:

- Plans to be jointly agreed
- Protection for social care services (not necessarily spending)
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of changes in the acute sector

In Worcestershire the focus for intervention from the Better Care Fund is to support people who are currently, or who are at risk for becoming, heavily dependent of health and adult social care services to live their normal lives. Within Worcestershire the Better Care Fund is £37m of which £16.8m has been provided by South Worcestershire, with the majority of the remainder coming from Wyre Forest and Redditch and Bromsgrove CCGs.

Population Segmentation Work

A number of international initiatives have achieved significant success in identifying high risk people in their population and managing them intensively to improve people's experience of care, achieve better health outcomes and avoid the need to access expensive secondary services when their health has broken down. These models have been studied in depth and key learning for the UK includes the concept of population risk segmentation and early intervention. A small proportion (thought to be around 5%) of the population consume a disproportionately large amount of NHS and social care service resources (originally estimated to be around 40%). We know there is both a key need and an opportunity to integrate commissioning processes and budgets to commission coordinated proactive care for this group of people differently. Our approach to this is to start by being clear on the different needs of service users and how we can best respond to those needs. To this end, as a system we have already commissioned a piece of work from Midlands and Lancashire NHS Commissioning Support Unit to help identify the individual patients that we should target through our new model of care in order to have greatest impact on our desired outcomes.

During 2015/16 we will be finalising this work by incorporating primary care expenditure analysis and, ideally, by resolving the remaining information governance issues that have prevented the amalgamated data being broken down to identify individual patients who can be actively targeted with a new way of working. With explicit consent information sharing for direct care is both desirable and legally permissible, however professionals can be confused by real and perceived restrictions. Simplified 'how and when to share information' guidance is being developed nationally. However, information sharing for commissioning purposes has different restrictions and Worcestershire is involved with work being led nationally to enable commissioners to resolve the governance issues that impede commissioners sharing information for the delivery of capitated budgets.

Social Impact Bond

In 2015/16 Health and Social Care partners across Worcestershire commissioned an exciting new service model for tackling social isolation via a Social Impact Bond. Via this initiative socially minded investors are providing investment to enable a structured approach to identifying socially isolated individuals and signposting them to services that will help reduce their isolation. There is a wealth of evidence to show that socially isolated individuals are more likely to be frequent users of health and social care and are more likely to require long term support.

Reconnections Limited has been awarded the contract to deliver this service and, through their lead provider (Age UK Hereford and Worcester) are now implementing the delivery plans to achieve the commissioner specified outcomes. Commissioners are only liable to make payments to the providers under this operating model if the outcomes are achieved.

This innovative way of funding activity to tackle isolation sits neatly with our next raft of plans that will be focusing preventative work on the cohort of patients who are at risk of entering the group that will be cared for by the newly formed MCP approach. Early intervention to slow down the rate of people joining the target cohort will be an important aspect in securing sustainability of the new approach.

Acute Services Out of Hospital Care

There is currently little integrated provision of out of hospital care by acute service specialists in Worcestershire. To access specialist acute care patients generally need to travel to hospital. Whilst there are some isolated examples of acute outreach services, such as ENT clinics in Malvern, Dermatology Clinics in Evesham, Blood Transfusions in Community Hospitals etc, these are generally stand-alone services that have developed over time rather than part of a structured integrated care strategy.

Looking ahead there is a very strong and immediate need for the local acute services provider to engage directly in the development of the plan for providing integrated out of hospital care. The starting point for this should be engagement in the Alliance Board and support for the implementation of the Integrated Physician role in the county.

These initiatives combine to provide a combination of opportunities that can be brought together and commissioned through the new Multi-Specialty Community Provider model of care that the CCG is seeking to develop.

Chapter 3

Where do we want to be in five years?

A modern integrated approach to commissioning, centred around the patient not the organisations

For our population we currently commission a wide range of interlinked services, through multiple contracts with numerous suppliers. Looking to the future we want to turn this approach on its head for a targeted group of patients where we commission a single suite of services from a collaboration of providers through a single contract.

The key components of our target model commissioning strategy are:

- The population is segmented to identify a target group of "high need" individuals for who we seek to plan and deliver services differently for. The target group is to be those patients who are most likely to benefit from a new approach and is likely to be built around frailty.
- The segmentation enables us to deliver a more proactive and coordinated approach for the "target" group that seeks to improve their experience of care, achieve better health outcomes and do so at lower cost.
- The target population will have services delivered through a collaboration of providers commissioned through one contract which is based on a capitated budget with outcome driven measures.
- The provider collaboration will be incentivised to deliver services in the most cost effective way that meets the outcomes defined, in cooperation with each other not in competition or protectionist approach.
- The approach will appear similar to a "Better Care Fund at scale", and will include social services commissioning budgets, primary care budgets (possibly including some GMS funding) and CCG programme budgets.

We want to move

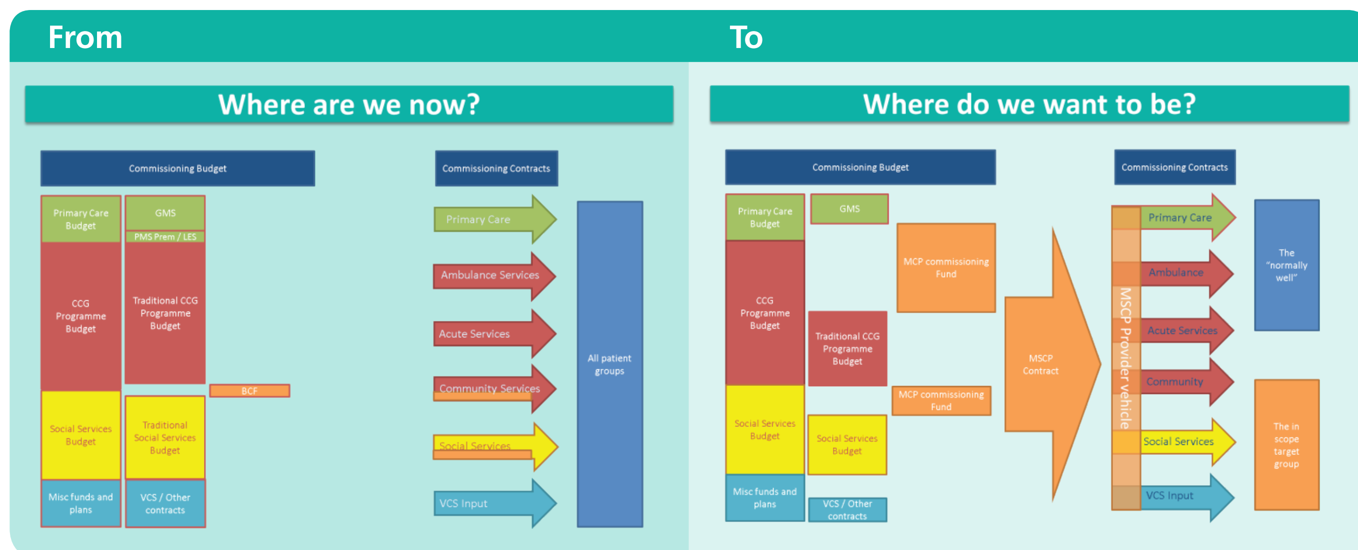
From	To
A predominantly "cared for" approach to health	A predominantly "patient owned" self-led care approach
Treating conditions	Preventing ill health
Instructing or advising patients	Working in partnership with patients
Commissioners designing and specifying services and then letting contracts to providers	Co-producing the services to respond to agreed outcome ambitions

Successfully achieving this will result in patients who are at high risk of needed long term health and social care to be managed in a more proactive way that reduces this risk.

What this will mean for South Worcestershire – our target operating model

Our target operating model is a significant move away from the traditional approach to commissioning. Ideally it will see a specific role for the commissioners as an integral part of collaboration overseeing the delivery of the new service specification. It will not be a simple commissioner : provider contracting relationship in the traditional sense where the commissioner holds the provider to account through blunt contractual levers.

Where do we want to be in five years?



The target model for in scope population is built around the development of a single multispecialty community provider (MCP). The MCP will provide services to an agreed cohort of patients – identified because they are the most "frail" and at risk of living with (or dying prematurely from) poor health that could be avoided through more proactive care. As part of the early phases of our work we need to confirm the exact scale and scope of this target group and ensure that this definition is used consistently across our transitional commissioning portfolios such as programme commissioning, social care commissioning and primary care commissioning.

It is possible that the MCP could develop out of the current Alliance Board between SWHC and WHCT. However the potential to do this without competition between other providers will be explored to check whether or not it is permissible under procurement, choice and competition legislation. If it is possible then the CCG will support this development, if it is not then the CCG will initiate an appropriate procurement mechanism to enable it find the most appropriate provider to deliver services under the CCG's specified care model. Throughout the process the CCG will seek new and innovative proposals from current or potential providers and will constantly seek to test these against the core objectives agreed through the public engagement processes.

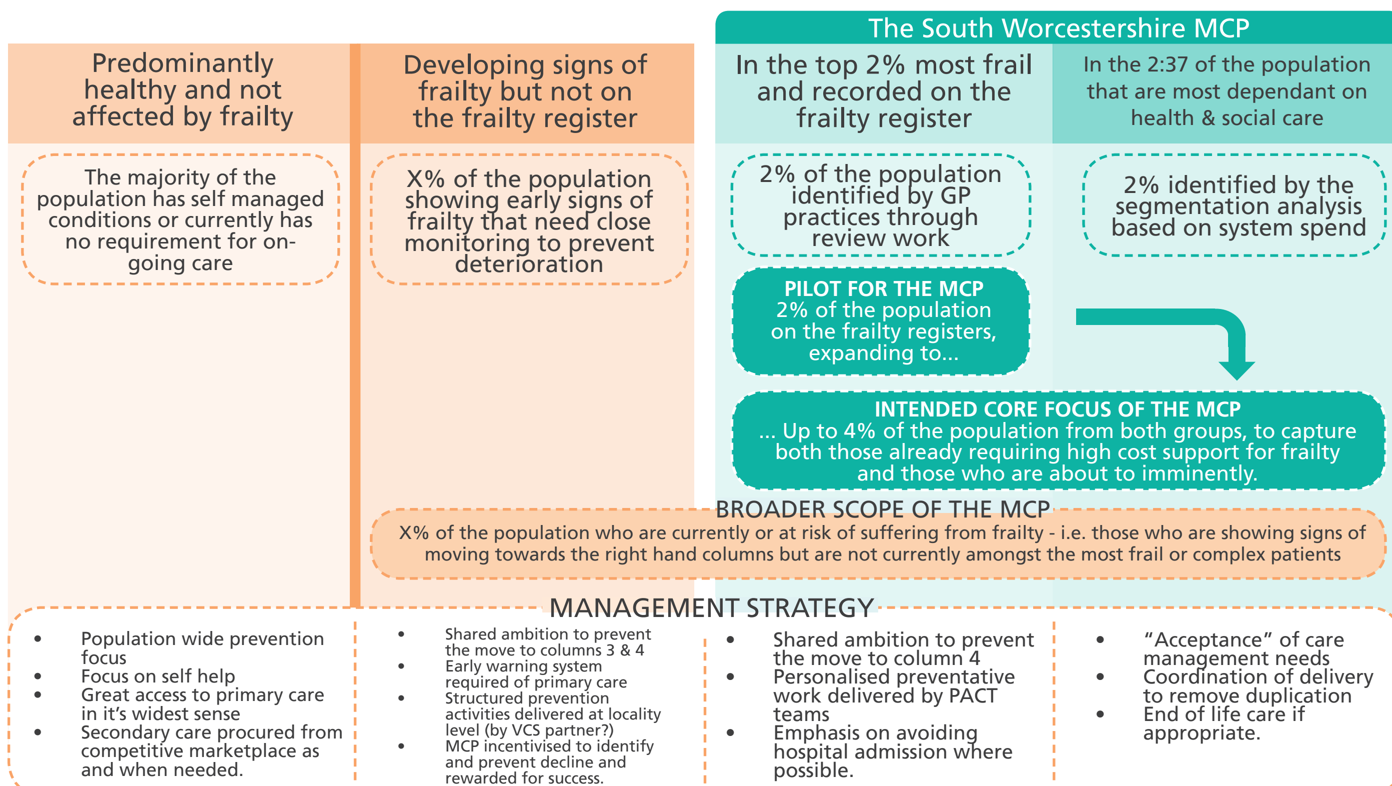
The real, and unknown, challenge at this stage is one of scale. Our strategy sets out an ambition to pursue this approach for the population of South Worcestershire, but it remains to be seen whether this is on a large enough scale to be achievable. Throughout the early phases of development we will monitor this situation and, if required, work with partners and neighbouring CCGs to explore expanding the scope of the MCP to make it viable and sustainable.

How the MCP fits within our wider commissioning strategy

Our plan on a page at the beginning of the strategy outlined the broad scope of our strategy and emphasises our intention to commissioning differently for up to 4% of our population. In order to do this we need to segment our population into broad groups to reflect their different types of need:

- Group 1 is the *"largely healthy"* group – people in this group are either free from conditions that affect their daily living or manage them so effectively through self-care that they do no depend on NHS, Council or voluntary sector services to maintain their daily living.
- Group 2 is the *emerging frailty* group – people in this group are beginning to show signs that they are struggling to, or will shortly struggle to, maintain their independence without some form of NHS, Council or voluntary sector support. This support may come in the form of low level interventions that prevent further deterioration, but if left unchecked will develop conditions that need support.
- Groups 3 and 4 are the *frailty* group – people in these groups are already requiring regular external support to help them with their daily living. People in group 3 are likely to be those that are receiving regular, but not necessarily high cost, packages of care, people in group 4 are likely to be people in receipt of very intensive and high cost packages of care such as CHC or other specialist services provided to help them remain at home. Some people may appear in both groups, but the scale of overlap is currently not known because of the current information governance restrictions.

Where do we want to be in five years?



The MCP strategy is focused on reorganising services to support those patients in groups 3 and 4 as effectively as possible. Furthermore, we intend for our approach to be one that incentivises the MCP to identify early, and proactively manage, patients in group 2 to avoid them deteriorating and slipping into groups 3 and 4. The detail of HOW this is to be achieved is still to be worked out, but the intention is clear. Again we welcome proposals from current or potential providers on how best to achieve this.

At this stage we do not see the MCP having a specific role to manage the patients in group 1, but over time the scope of services may develop to accommodate this. For example if we progress our approach to mirror the accountable care model then this may create the need to revisit this scope. Regardless, we recognise the need to develop a separate strategy to manage this population group. This strategy will need to focus on maximising the impact of self-care and supporting rapid access to high quality primary care when it is needed.

To be truly effective we will need to work with our partners in the council to integrate social services into the MCP. The complexity of means tested support and self-funded care will need to be resolved as part of this, particularly if we are going to be able to secure changes on the ground. Some changes may not be possible without changes to legislation to allow things such as NHS budgets being used to part fund social care providers to enable staff to be trained to deliver basic healthcare tasks that currently require independent visits from other professionals. Likewise, if a patient has predominantly health needs, but is in receipt of self-funded social care support, it may be more effective and efficiency for health service staff to undertake some of the social care duties during their visit that prevents the need to separate appointments. These are aspects of implementation that are beyond our local control, but we will use our status as an Integration Pioneer to explore possibilities.

Our core strategy – developing the MCP

We intend to commission from an MCP that includes primary care, community care, acute care and the voluntary and community sector. Elements of current acute care provision as well as emergency ambulance and patient transport services will need to be incorporated in some form – either as part of the MCP or as a sub-commissioned service from the MCP.

We are seeking:

- A care model that is focused on self-care and prevention, proactive acute admission avoidance and rapid discharge back to the community when acute admission is unavoidable (ie the only appropriate care option, not because other care options have failed)

Where do we want to be in five years?

- GPs and Hospital Consultants working "hand in hand" both in the community and in hospital in a range of agreed focus areas through the general and specialist spectrum of services
- A single commissioning pot, bringing together primary care (including aspects of GMS), community health services, acute health services (specialty areas to be defined), specialised health services, social care and community/voluntary sector support
- A capitated multi-year (potentially 5-10 years) contract, aligned incentives, based on the achievement of agreed outcomes around achievement of improved health and wellbeing for the cohort group not on the volume of type of healthcare provided by individual partners
- A significant shift in resource allocation from "responding to crisis" to "proactive case management", measured by a reduction in the number of emergency admissions and the number of "at risk" patients proactively supported in the community)
- Gradual introduction of transfer of financial risk from commissioner to provider over the term of the contract
- A local core GMS-type contract to remain in place for some services that cannot form part of the MCP.
- A model of care that grounds parity of esteem between mental health and physical health, which focuses on physical and mental health and well-being and which recognises the impact of deteriorating mental health on physical health

Through our co-production work with patients across the system we are ensuring that patients and carers are directly involved in the redesign of services, not just consulted upon it. The approach will provide a seamless service delivered by a multi-speciality team with a single care plan co-produced and owned by patients and their carers. Care co-ordination and care navigation will provide one central contact point for patients in an emergency or declining situation and a navigator will help patients through the system. The patient will always be at the centre of the process and the bureaucracy around case management between different stakeholders will be removed. Earlier intervention remains central to the model, identifying those at risk sooner with embedded planned and preventative approaches that foster self-help and independence. Learning from robust care planning, team interventions and recovery principles in mental health and learning disabilities working in this way underpins the step change from unplanned to planned care, including a timely and co-ordinated approach to secondary and tertiary care services as required.

What this will look like…

For our communities and patients	For staff
• Access to a comprehensive primary care offer through local practice clusters that will be the first point of contact and will co-ordinate all care for people with multiple needs. There will be a range of primary care (including voluntary, community and social care) services at a scale greater than typical existing practice footprints	• System wide support to work collaboratively and reduce professional isolation through being part of an integrated workforce that shares skills and expertise.
• Having a voice in local health and care services and the opportunity to shape community responses and opportunities.	• The removal of system and organisational barriers between primary, community and hospital employed staff. Staff will be supported by a system wide commitment to use and develop people's skills and expertise and to align incentives and financial reward accordingly.
• Access to specialist advice and support in the community with hospital staff and primary and community services working together to a single care plan developed in partnership with patients and their families.	• Recognition of the role of social work and social care services in supporting adults needing care and support and their carers.
• Local approach to prevention and self-care which promotes understanding of what people can do to maintain their own health and independence and providing self-care.	• The opportunity to shape new roles and approaches, for example new approaches to primary care nursing, the 'care navigators' initiative to build on the strengths of our voluntary and community sector and the from individuals to support their local communities.

Creating "Accountable Care"

As the model matures we will look to delegate more and more responsibility to the delivery providers for designing services and holding budget responsibility. The ultimate aim will be for a very small commissioning function that defines a set of outcomes that we wish to achieve but delegates responsibility for service design, delivery and resource allocation to the provider to best determine how to achieve those outcomes. including a timely and co-ordinated approach to secondary and tertiary care services as required.

Chapter 4

How will we get there?

In order to make the initial steps the following actions are proposed:

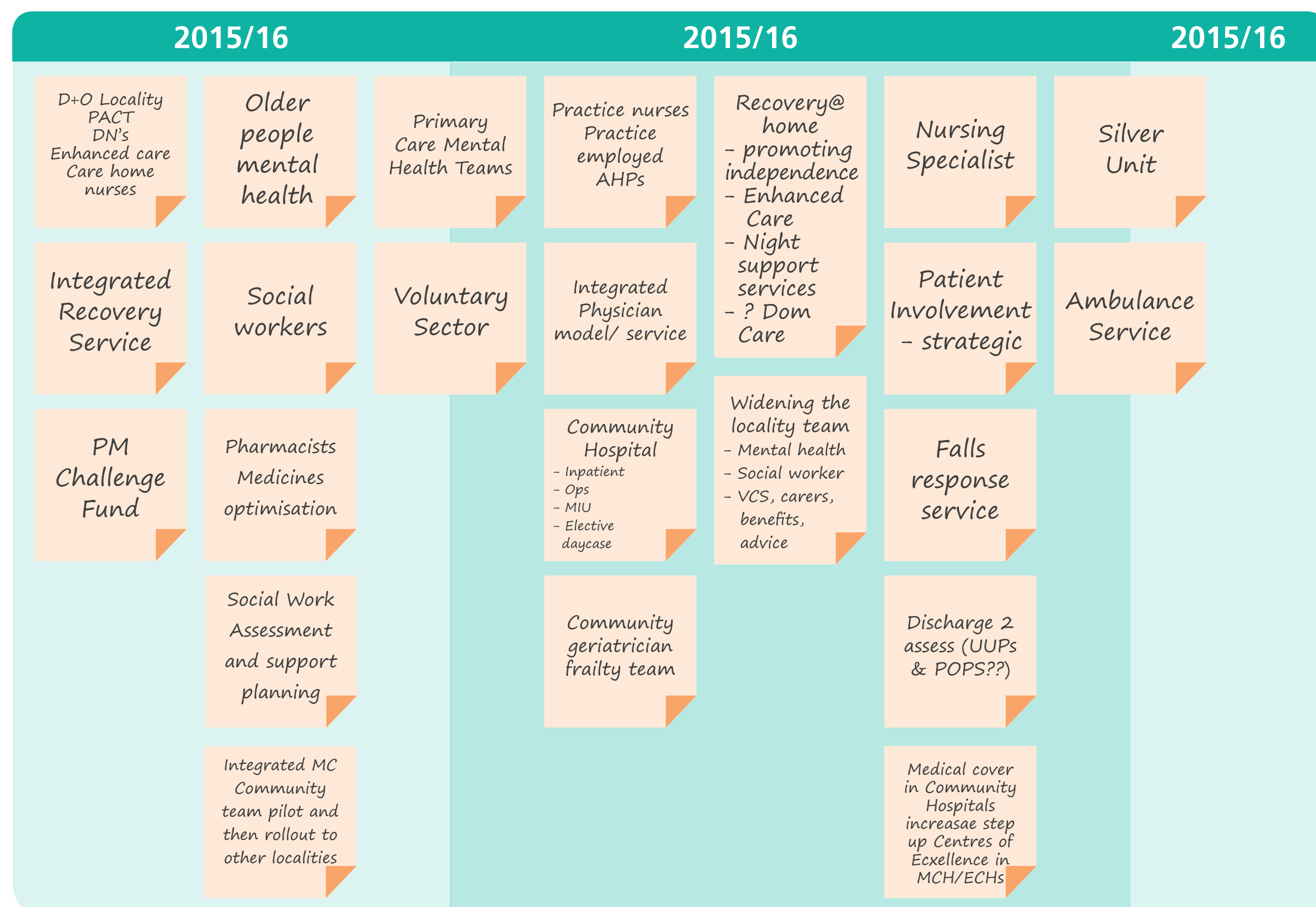
Strategic Issues and Actions	By
Through the Primary Care Committee, **finalise the Promoting Clinical Excellence Contract** for 16/17 and ensure it has an expanded focus on working at scale through a greater proportion of resources allocated to locality and area wide initiatives, with a significant shift away from individual practice level allocations. Expressions of interest will be sought from practices wishing to collaborate and work together as networks in the delivery of key local and CCG priorities.	**Nov 2015**
Establish a programme board and task and finish group to oversee the implementation of the New Model of Care strategy.	**Nov 2015**
Embark on a **robust process for patient and stakeholder engagement** to ensure that the CCG addresses its duty to consult but more importantly ensures that patients and their carers are at the heart of the redesign process.	**Dec 2015 to Feb 2016**
Identify the target cohort of **patient and services** to be included in the initial development of the MCP model (details of the proposed initial scope are outlined below).	**Dec 2015**
Agree extended scope of services to for future management by the Alliance Board in the 16/17 and 17/18.	**Dec 2015**
Develop the commissioning strategy for the new model of care including the scope and structure of the target operating model for the MCP (further detail on this is provided below).	**Mar 2016**
Review the existing governance and reporting arrangements to ensure they support the development of this new way of working - such as relationships between the Alliance Board and stakeholder boards/governing bodies, the Health and Well Being Board and supporting infrastructure.	**Mar 2016**
Implement the single assessment process across all organisations and alignment of IT systems to ensure easy transfer of essential information across the system.	**Mar 2016**
Clarify and respond to the appropriate **procurement guidance and legislative frameworks** to ensure that the CCG implements a compliant procurement process when implementing the new strategy.	**Ongoing**

Operational Issues and Actions	By
Via the **commissioning intentions** process in September 2015, communicate the intended commissioning strategy to existing providers.	**Sep 2015**
Agree a pilot area to work with a devolved shadow budget for population health, including some core primary care funding, prescribing and medicines resource, funding for relevant targeted outpatient specialties and a "reserve" to fund emergency admissions, community health services (district nursing), social care services (practice based social workers) local authority public health funding (smoking cessation), voluntary sector (Social Impact Bond) and other relevant areas.	**Oct 2015**
Link into **existing workforce programmes**, especially the primary care workforce planning group and NHS trust provider workforce plans. The MCP model require new roles that are currently either only in the early stages of development (for example Physician' Assistants and Community Geriatricians) or are just conceptual (for example integrated primary care nurses). A remodelling of the local health and social care staffing resource will be required.	**Ongoing**
Scaling up of the Worcestershire Health and Care Trust **"home to clinic"** programme to ensure that local resources are most appropriately targeted to achieve maximum impact. This will require a mind shift for some professionals and patient groups.	**Ongoing**

We have already begun the journey and have a strong base from which to work. In July 2015 we held a joint strategic awayday involving a wide range of local partners - Worcestershire Health and Care Trust, Stay Well Healthcare, Worcestershire County Council Adult Services, and the CCG. It is intended that this will be the first of many sessions and future sessions will have significantly expanded membership to incorporate the full range of partners that will be integral to the future model.

Identifying the target cohort for patients and services – pilot running

The main focus of the awayday was to agree the priorities and timelines for developing the new care model. The potential scope of the expanded alliance could include the following areas over the first two years:



We believe that the best way to progress with the new approach will be to pilot the new ways of working in a small area before seeking to roll out to a wider population. In order to do this, we are planning to work with a target group of four general practices covering a population of around 35,000 patients.

Working with these practices we will identify 2% of patients in group 3 across the area and work with community health, social care and the voluntary sector to identify how the MCP model could be implemented locally. This will involve the need to set up shadow budgets and flags for identifying how these patients experience care throughout the course of the year. We intend to establish an approach whereby the patients are engaged in the active learning from the exercise so they can report their personal experiences from the new way of working. Where possible we will try to mirror the work of the strategic level population segmentation work to establish whether the patients on the frailty register are also in receipt of intensive packages of care across multiple providers.

This pilot exercise to identify the target cohort will help us to test whether we are focusing the strategic approach on the group that is most likely to benefit from a new way of working.

Developing the Commissioning Strategy

The following aspects of the commissioning strategy need to be clarified by the end of March 2016, ready for shadow running in 2016/17:

- The **outcome areas** that will be used to define success and the specific KPIs that will be used to measure delivery and achievement of these outcomes. A clear outcome framework will need to be developed to support this, including developing a scheme to incentivise new ways of working, supported by a local quality premium paid the following year linked to achievement.

- The **budgets** that can be aggregated to create the new MCP commissioning fund. This will involve whole budgets (for example specific aspects of the Better Care Fund that already support integrated working) and parts of budgets where it is not appropriate to transfer everything – for example certain aspects of GMS, A&E spend for the patient cohort and others. These budgets can be shadow monitored in the pilot area.
- Clarify how the **resources will flow** across the system and what the arrangements might be for patients who need to move in and out of the cohort during the course of the year – for example resources for end of life patients or patients who develop a level of frailty that moves them in scope.
- Identify initial links to **out of scope services** in the initial pilot – for example 999/111, GP OOH services.
- Establish how changes to **primary care commissioning** can be used to support joint working and integration at scale from 2016/17 and beyond.
- Develop the **commissioning timetable and procurement plan**, including arrangements for shadow working and evaluation.
- Agree the **proposed financing arrangements**, linking to the national Monitor group where appropriate.
- Develop the **shadow draft service specification** and any appropriate shadow contract documentation.
- Explore and clearly **define the level of delegation** and strategic approach – from the CCG “letting” the contract to a collaboration of providers, through the CCG being an integral partner in the collaboration of providers through to almost complete delegation of tactical commissioning functions to the provider via an ACO type model.

Finalising the Promoting Clinical Excellence Contracting arrangements

The following activities will be pursued:

- Consultation to continue on implementation of the CCG’s primary care priorities agreed on 10 September and its strategic direction of primary care.
- Developing a framework for supporting a “collaborative care model” which supports practices working together in networks to be developed and agreed.
- Investing in areas which develop and embeds transformational change skills in primary care. Areas of focus will include developing programmes focussed on localities or groups of practices working together to meet the changing needs of patients and the increased complexity of managing more patients with multiple conditions.
- Developing the concept of distributed leadership across participating practices to develop capability and enable the spread of innovation. We will support the operation of these networks including training and employment of additional staff (care co-ordinators, pharmacists etc) to allow GPs to manage their workload with in order to spend more time spent with most complex patients
- Implementing the Five Year Forward View in South Worcestershire Page 28
- Expressions of interest to pilot this new way of working to be sought from groups of practices providing care to a population of 30,000 and above. It is anticipated that the CCG will use existing resources to create between four and eight investment pots to support the delivery of this work at scale.
- Developing a funded primary care workforce development plan which addresses the existing recruitment and retention issues in general practice and offers a more positive future career path in primary care.

How providers need to respond

Concurrent to the development of the commissioning strategy, providers who will potentially form the core of the MCP will need to gear up to be ready to respond. We anticipate this including:

- Creating and beginning the implementation of a **leadership development plan** to support delivery of the new ways of working.
- Establishing a **clear strategy for working in collaboration with primary care**. For example this might include developing the existing alliance board, including wider membership as outlined in this document.
- Identify and implement **preferred organisational structures** (including legal model) to best meet the commissioning intention, including how to extract relevant services from existing provider models across the system.
- Creating a shared **change and organisational development** programme to identify and address skill deficits, strengthen inter-professional working relationship and improved operational working to remove duplication and interface “frustrations”.
- Defining a **new workforce model** to deliver the new way of working – this may include transfer of existing social workers to a new employer, expanding interface physicians, blurring the lines between primary and secondary medical care in the management of long term conditions, amalgamating roles such as practice nurses and district nurses becoming “primary care nurses”.
- Identifying how to manage the **legacy services** that are outside the scope of work and how to ensure they remain sustainable.

How will we get there?

- Developing improved provider **information and intelligence sharing** to enable effective early identification of people at risk – for example sharing vulnerable person's bin collection requests, home fire safety inspections that identify vulnerable people etc.

Supporting system change

The CCG has a clear role in leading the change across the system. This includes:

- Identifying and structuring the right balance between creating financial incentives for change and providing developmental support.
- Setting out a comprehensive approach to building system capacity, capability and resilience for change in partnership organisations, including a phased plan of evolving development needs.
- Addressing change management and cultural issues at the different levels:

Individual	System leadership & change	Inter-organisational working
• Leadership development • Clinical engagement • Culture change for front line staff • Peer support • Education • Extended / new roles	• Workforce planning • Activity planning and system modelling • Governance and accountability • System capacity and capability for change • IT strategy • Estates strategy	• Workforce capacity development & Management • Quality improvement methodology • Consultancy support

Resourcing the change

Delivering the scale of change outlined in this strategy will not be easy or cheap, but successful implementation is necessary to secure system financial sustainability and to maintain the quality of services provided. A transformation fund will be created to support:

- **Dual running costs** – there will inevitably be a period where providers will need to dual run as we move from one model of care to another.
- **Programme management** – change on this scale needs a fit for purpose Programme Management Office to lead it. Much of this can be achieved through re-aligning existing resource, particularly through our existing Well Connected Programme. However, this will need to be supplemented in the early years.
- **IT capital investments / software** – some work has already been undertaken on new systems to support integration. The common use of EMIS web provides a good base but this will need to be developed and all providers will need to commit to using systems that can integrate.
- **Estates** management and ownership – there will inevitably need to be different use of the existing public sector estate to support this change. There is surplus space in many GP practices and community hospitals alongside severe pressure of acute sector medical beds and some emerging capacity issues in specialist residential and nursing care. Re-aligning use of the estate will be addressed through the system estates strategy that CCGs are leading the development of.
- There will need to be dedicated **legal, procurement, governance and contracting** advice to support the complexity required
- Following on from the patient segmentation project, further work will be needed on **data analysis and modelling** in order to identify the specific patients
- Piloting and developing **new workforce roles** such as health and social care assistants/practitioners (operating at band 4 in the community with limited supervision) – work with Worcester University.

Creating a transformation fund will only be possible if there is successful delivery against the CCGs already challenging QIPP programme. Options for creating the fund include:

- Stretching the **QIPP target** in future years to create a transformation fund that is free from existing commitments.
- Use of the **primary care transformation fund**.
- **Prioritisation** and opportunity cost – re-organising and re-prioritising current work and expenditure commitments in order to create headroom to change.
- Redefining the existing use of resources to support **locality working** and using the money to create a pot to fund change at grass roots primary care level – use the money to develop a plan, use the money to incentivise change etc.

How this change will affect patients

As highlighted earlier in this strategy, we know that patients are keen for better integrated services. In implementing the type of model described in this strategy where services for the frail elderly are more joined up, it is important that we articulate what this will mean for patients. This is best reflected by the National Voices 'I' statements taken from their narrative for coordinated support for older people and adopted by the CCG:

"Taken together, my care and support help me live the life I want to the best of my ability"

"I can build relationships with people who support me."

"I am recognised for what I can do rather than assumptions being made about what I cannot"

"Where appropriate, my family are recognised as being key to my independence and quality of life"

"I can make my own decisions, with advice and support from family, friends or professionals if I want it"

"I can maintain social contact as much as I want"

"I can do activities that are important to me"

"I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me"

"I am supported to be independent"

Successful implementation of this strategy will mean that these statements are everyday comments for the patients and public of South Worcestershire.

How this change will affect patients

Public and stakeholder engagement

Throughout the development, deployment and implementation of this strategy we expect to use our existing patient engagement processes, alongside dedicated and specific engagement exercises, to ensure that patients and carers needs remain at the heart of what we are trying to achieve. We pledge at this early stage that if engagement exercises tell us that we are heading in the wrong direction, we will stop, take note and respond accordingly.

What it means in reality

This strategy is ambitious and complex, but ultimately seeking to achieve something simple and straightforward – **joined up care**. The following table explains what we intend this to look like for patients on the ground:

The way in which you experience care will change

From	To
You may currently be required to attend multiple hospital appointment for your different health conditions and you may receive several different visits at home or in the community, but with no single care coordinator.	Your clinic appointments and home visits will be coordinated and you will have one regular key contact providing basic health and social care support.
You may feel that you are constantly being *"handed off"* from one agency to another and feel like nobody is really interested in you as a person, just your different conditions in isolation.	For your everyday health needs you will see the same nurse whether that is through a home visit or a trip to the surgery and you will see the same GP, who may also be involved in your treatment when you are in hospital. This care will be supplemented by specialists where needed, but you will not feel that your care is being handed over in the same way as before.
You may have to tell many different people the same basic information and you may feel that nobody is sharing that information with other people who care for you.	You will take part in one assessment and all the information you provided will be shared amongst everybody who needs to know the information in order to provide your care. You won't have to provide basic information multiple times. You will have the opportunity to say if you don't want your information shared between different people who provide your care.
When you require hospital treatment you may spend many hours in Accident and Emergency, sometimes in a corridor, before being admitted to a bed.	You will not be taken to Accident and Emergency unless you have an immediate life threatening condition. Instead you will be admitted directly to a ward where the care is coordinated by a team that includes some of the people who care for you are not in hospital.
When you are admitted you may experience multiple moves before you ultimately leave hospital and may feel that your hospital stay is much longer than it needs to be as people try to organise the care you need for when you leave.	Your everyday care team will plan your discharge as early as possible to avoid any unnecessary delays when you are ready to return home or to another place of care.

As part of the patient and stakeholder engagement process we want respondents to tell us what else they would like to see change in the way in which their care is provided and we will actively seek to add more statements to this table as the strategy develops.

How this change will affect patients

A patient story of how it will be with better integration – *The Recovery at Home Service*

Mrs A lives alone. Her small house has two floors, and the bedroom and bathroom are upstairs. She has no formal care in place, but her Daughter visits every weekend, and does her shopping for her. Her neighbour also pops in once or twice a week for a cup of tea, and to make sure that Mrs A has everything she needs.

Mrs A has Parkinson's Disease. She is gradually becoming less mobile, and is now finding the stairs a struggle. She is starting to find it difficult to look after herself, and her home. Her Daughter has been worried for some time, and has suggested that they look at getting her some help. Mrs A has always been proud of her high standards, and she feels very frustrated when she notices how dirty and untidy her house has become. But, she is also a very private person, and cannot come to terms with the idea of letting unfamiliar people into her home. She knows that the situation is only going to get worse, but she wants to retain control and keep her independence until she has no other option.

Over a month or two, Mrs A starts to feel unwell, and the usual chores are more of a struggle than usual. She becomes muddled, and forgets where she has left her medication, and whether she has taken it or not. She tries to hide this from her Daughter, who has enough on her plate caring for her family, and she is worried that she will over-react and insist on getting some care in. On one particularly bad day, she finds that she cannot get herself down the stairs, and is not able to get herself anything to eat or drink. She feels that she has reached a crisis point, and phones her GP practice to ask for help.

Her GP tries to call her, but the line is constantly busy. He is concerned, and goes out to visit her at home. When he arrives, he finds that the phone is off the hook. The house is in chaos, and he notices that her medication is all over the place. She cannot tell him when she last took it, or when she last ate or drank. Mrs A clearly needs some support, so the GP calls the Patient Flow Centre, via the single point of access contact number, and make a referral to the Recovery at Home Team.

The referral is triaged, and the details are immediately passed on to the Recovery at Home Service. A nurse contacts Mrs A by telephone and arranges to visit her that afternoon. The nurse picks up on Mrs A's anxiety about losing control, but reassures her that she just want to help her get to the bottom of why she is feeling so unwell, and to see what support can be offered in the short term to get her back on her feet.

Within 6 hours of the referral being made, the nurse visits Mrs A at home, and completes a detailed assessment of her health needs. The nurse takes care to ensure that Mrs A has time to talk about her preferences and fears for the future. From this she concludes that there are no new serious health concerns, and that her change in condition is almost certainly due to Mrs A not taking her medication. She is concerned about her mobility and agrees with the GP that she is currently at risk of falling. The nurse suggests that Mrs A needs some additional care, at least in the short-term. Mrs A agrees to a carer coming in twice a day to help her get up and to help her get to bed. The nurse explains that the carers will also help her to put systems in place to manage her medications better. Mrs A is asked about her daily routine, and they agree an approximate time for the visits to fit in with her preferences and habits. Mrs A declined an additional visit in the middle of the day, as she felt that she would soon lose her confidence if someone was doing everything for her. It was also agreed that an Occupational Therapist would visit to see what adaptations could be made to Mrs A's daily routines and environment to make it safer for her, and help her to maintain her independence.

The nurse asks Mrs A for permission to share the information from her assessment with other health and social care professionals, and explained that this would mean that she did not have to keep repeating herself to everyone who visited. She also agreed to call Mrs A's Daughter to explain the plan of care, and to give the Daughter an opportunity to input into the assessment.

Although Mrs A was reluctant to accept help, she felt relieved that she was getting a bit of support for a few weeks, and felt confident that after this time, she could get back to normal.

The first carer visit was arranged for that evening to settle Mrs A upstairs for the night, ensuring that she was safe until the morning. Over the next five weeks the carers visited twice a day as planned. Mrs A was very impressed that when members of the Recovery at Home Team said they would visit, they turned up on time. On the rare occasion when this was not possible, they always let her know so she didn't worry.

Most of the care was provided by three carers, who Mrs A got to know well. She really valued this consistency, and was able to form good relationships with these carers, and started to look forward to seeing them. Regardless of who visited, they always seemed to know what had happened since they last visited. They worked hard to set up systems to help Mrs A to organise herself more effectively, and over time began to step back and let Mrs A take control of her new routines. This was supported by an Occupational Therapist who also arranged for some adaptations to her home to make it easier to move around and do tasks that she had previously found difficult.

After 4 weeks, the same nurse came to visit Mrs A at home to see how she was getting on, and to reassess her health needs. With permission from Mrs A, she had also arranged for her Daughter to be present. With help from the Recovery at Home Team, Mrs A was feeling much more like herself, and was able to undertake most daily living tasks. With the adaptations in place, Mrs A felt that she could manage to get herself to bed, but she still found mornings difficult. The nurse agreed to make a referral to social services for an assessment and support for a package of care.

They also had a conversation about the future, and how she could expect her condition to deteriorate over time. The nurse very sensitively talked to Mrs A about end of life care planning, and how important it was for Mrs A to decide what was important to her in this respect before her condition deteriorated too far. She left them with a copy of an Advance Statement, which she suggested Mrs A and her Daughter talked through together. Information leaflets were provided on where to access further help and support.

Mrs A was discharged from the Recovery at Home service after 5 weeks of care. Social Care arranged for morning calls to be established, and information was shared between the Recovery at Home Team with the new carers. This meant that they were aware of all of the systems that had been put in place to help Mrs A cope as independently as possible. The GP arranged for an team discussion regarding Mrs A's ongoing care. Due to Mrs A's deteriorating condition and prognosis, her care was picked up by the Proactive Care and Case Management Team (PACT). She was visited at home by her case-manager, and given the contact details both in and out of hours should her situation change, or she became unwell.

Despite this being a stressful time for Mrs A and her Daughter, they were both extremely positive about the care that had been provided by the Recovery at Home Team. Although they were both aware that the future prognosis was not good, they took some comfort from the fact that there was a plan in place, and they knew where to access help in the event of a further health crisis.

Chapter 6

Timeline and Milestones

Year 1 – 2015/16 (by March 2016 unless specified)

Commissioning Issues	Provider Issues
• Undertake a robust patient and stakeholder engagement process on our initial plans (Feb 2016). • Establish system wide vision and group to oversee the development of the changes (Dec 15). • Build consensus to approach with other commissioners and identifying what's in and out of the MCP (Dec 15). • Identify the scope / population segment we are targeting (Dec 15). • Identify changes required to service specifications to deliver alliance board delivery methods (Nov 15). • Identify further expenditure to be moved from the health and care trust budget to the alliance board budget (Dec 15). • Establish MCP commissioning fund within the annual finance planning round (linked to Better Care Fund Finance Plan. • Establish transformation fund to support the change. • Identify first tranche of acute service spend to shift across to the MCP commissioning fund for 2016/17. • Test the principles of the approach in diabetes. • Integrate the outputs from the co-production workshops.	• Establish clear strategy for delivering the commissioning vision. • Re-establish VCS input. • Identify areas where GPs can work in acute care and hospital consultants can work in primary and community care (grey area working). • Develop District Nurse / Practice Nurse joint working.

Year 2 – 2016/17 (by March 2017 unless specified)

Commissioning Issues	Provider Issues
• Revisit our patient and stakeholder engagement process to address emerging issues that were not identified at the start. • Implement phase 1 changes to services specifications within existing provider contracts (Apr 16). • Establish the procurement options for the longer term model (Oct 16). • Decide commissioning options for what's out of scope and establish how this can be sustainably commissioned (Oct 16). • Establish floors and ceilings for contract options (Oct 16). • Identify required changes to the finance and contract monitoring mechanisms (Oct 16). • Identify elements of GMS budget to shift across to the MCP commissioning fund for 2017/18) (Oct 16). • Plan for the use of shadow budgets in 2017/18 and a capitated outcome based contract for 2018/19. • Incorporate diabetes into the wider MCP model.	• Expand membership to incorporate aspects of acute provision, including ambulance service. • Expand grey area working beyond initial pilots. • Explore options and legalities for future MCP provider board. • Explore options for structuring those services outside of the MCP. • Establish formal shadow MCP board and governance arrangements.

Timelines and Milestones

Year 3 – 2017/18 (by March 2018 unless specified)

Commissioning Issues	Provider Issues
• Revisit our patient and stakeholder engagement process to address emerging issues that were not identified at the start. • Begin procurement of longer term model (Apr 17) • Test finance and contract mechanisms for monitoring the shadow working arrangement and shadow run the capitated outcome contract (Apr 17) • Implement phase 2 changes to the service specification within existing provider contracts. • Revisit core budget allocations between CCG programme, GMS and MCP fund budgets (Oct 17) • Identify risk / reward mechanisms to support the revised contracting approach. • Collaborate with other commissioners on the "what's out" element of the MCP. • Award contract for the longer term model (Mar 18)	• Establish full legal structure / model for MCP provider vehicle

Year 4 – 2018/19

Commissioning Issues	Provider Issues
• Implement single commissioning model (Nov 18) • Implement capitated budget for defined population.	• Implement single provider model (Nov 18).

Year 5 – 2019/20

Commissioning Issues	Provider Issues
• Evaluate and refine	• Evaluate and refine