Appendix 2
West London CCG
Integrated Care Strategy
2018-2020

Mobilising an Integrated Community Team through a Multispecialty Community Partnership (MCP)

Supporting Primary Care Working at Scale

Developing a road map towards accountable care

Version 20

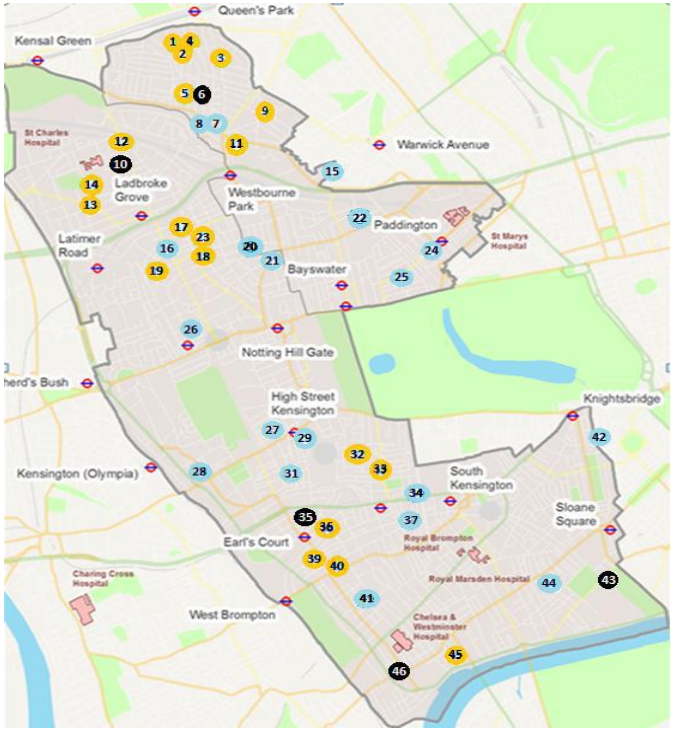
Contents

West London and NWL STP – who we are

West London CCG was established in April 2013 under the Health and Social Care Act 2012. It is made up of 45 GP member practices that in 2016/17 served an estimated registered patient population of 245,315 (QOF 2016/17) and is responsible for planning and buying (commissioning) health services for the people living in the Royal Borough of Kensington and Chelsea and the Queen's Park and Paddington area of Westminster.

Clinical Commissioning Groups do not provide any health services directly, but buy these services for our residents from providers such as NHS hospitals, GPs and the voluntary sector.

We are committed to improving the care provided to our residents, reducing health inequalities and raising the quality and standards of services within our allocated budget. Our vision is that everyone living, working and visiting West London should have the opportunity to be well and live well – to be able to enjoy being part of our capital city and the cultural and economic benefits it offers.

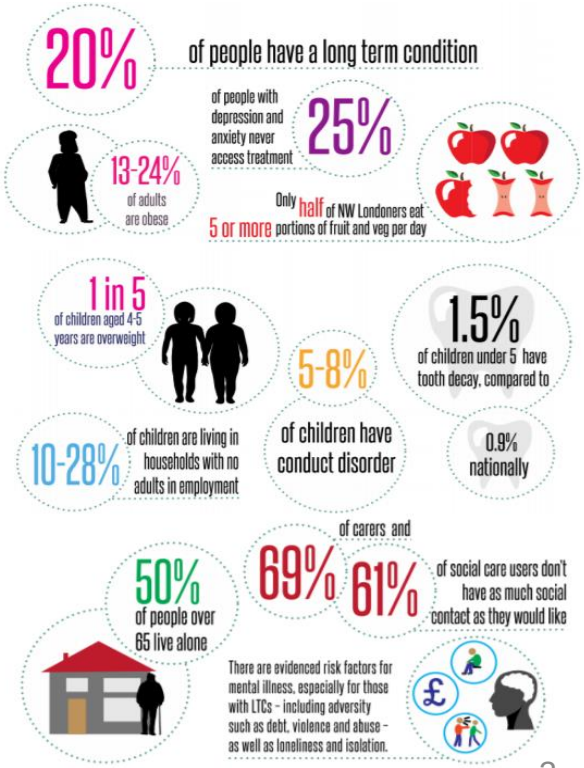


Sustainability and Transformation Plan

In 2016 West London CCG joined with Kensington & Chelsea Council, Westminster City Council and other local partners to look at what we wanted to do to make positive change happen, and feed this into the wider NW London Sustainability and Transformation Plan (STP). The STP which covers the eight boroughs in NW London takes its starting point from the national NHS Five Year Forward View strategy and translates it for our local situation

The STP is driven by a strong case for change across NW Lodon.

- Only half of our population is physically active Half of over-65s live alone and over 60 per cent of adult social care users want more social contact
- Many people are living in poverty
- People with serious long-term mental health needs live 20 years less than those without..



Our Journey

The Integrated Care Strategy is being co designed with our partners, including service users and carers, and builds on a number of programmes implemented in West London over the past 5 years. These programmes have focused on principles around integrated working, case management and care planning for those who need, and access to well-being and self care services, with GPs and their practices being central to how people are cared for.

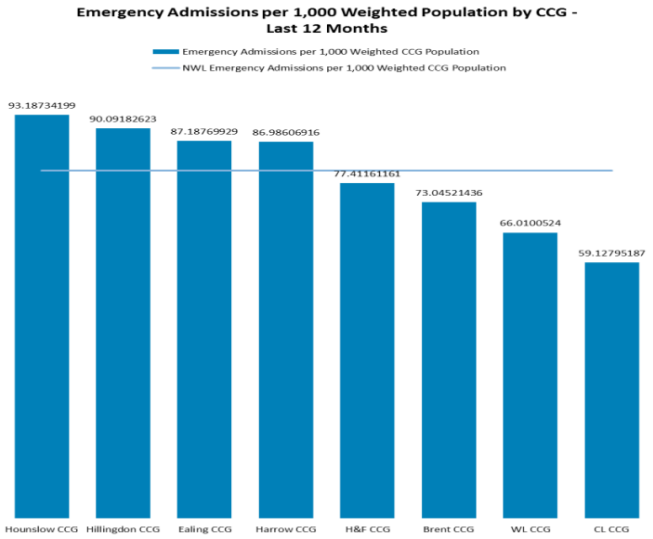
West London's **Better Care, Closer to Home Our strategy** (incorporating the Integrated Care Pilot) 2012-15 demonstrated a commitment to developing personalised, well coordinated and seamless pathways of care across health and social care, to shift care to community and primary care settings and reduce hospital admissions and improve early discharge.

The model of care described as part of this strategy was our strategy **Putting Patients First** which formalised the role of case managers and multi-disciplinary work through a Local Enhanced Scheme with all practices.

The CCG has two *Whole Systems Integrated Care* Pioneers covering two distinct but related population groups. The models of care have great synergy in terms of design and are both located in the two Hubs. In July 2015 the CCG agreed a 3 year business case to fund ***My Care My Way,*** targeting the over 65-focussed, providing case management and health and social care navigation rolled out in a phased manner, as well as a Hub model and a self care focus. In terms of long-term mental health needs across, the CCG funded a 3 year Business Case for ***Community Living Well*** in June 2016. Though far smaller in scale than MCMW, it is also predicated on Case Management, Navigators and Peer Support/Self Help, wrapped around the patient, and access to a range of health and well-being services in a single offer. It is planned to phase 'go live' in a phased approach by Q4 2017/18.

Key achievements include:

- A whole-hearted and on-going commitment to detailed co-production with service users and carers in both population groups over the last 3 years.
- Established Hubs in the North and South to co-locate service delivery.
- A 'Tried and tested' MDT approach, with skills mix and focus tailored to population needs. Motivated staff across both pioneer models, integrating delivery.
- MCMW: 24 practices with core MDT in operation, all 45 in place by 1/4/18.
- CLW: 16 existing clinicians now matched with 16 new 3rd Sector Well-Being Workers (a workforce doubled for £550K –showing the value of integration).
- CLW: demonstrable improved recovery outcomes, high uptake of navigator and Peer support services, c20 positive employment outcomes per month.
- MCMW: 2000 referrals into self care service, second lowest NEL across NWL, reduced GP appointments.



Strategy overview: Focusing on Function

"By far the most critical task in developing an MCP is to get going on model of care redesign"

NHS England 2016

This strategy develops West London's long term vision for integrated and accountable care. The aim over the next two years is to make a real difference to how care is delivered to our residents. We will focus on getting the function (the model of care) right whilst continuing at pace to work with our providers to develop our plan around the future form of the local system's accountable care approach.

We will develop our model of care with learning from the past two years of rolling out the **My Care My Way (MCMW)** service and more recently the **Community Living Well (CLW)** service. Our recent Rapid Learning and Evaluation Programme has set out the case for change by recommending:

- Closer integration with health and social care
- More efficient use of resources through single management structure and shared services where appropriate
- Integrating more care functions into MCMW (e.g. organic mental health; falls; rehab) to enhance the ability to meet patient need in the community

In order to deliver these improvements to our local model of care, our priority is to build on the current whole system models of care by integrating more care functions into these teams throughout 2018/19. This transformation will deliver a fully **Integrated Community Team** serving the whole population's health and care needs by April 2019.

Our **Integrated Community Team** will be responsible for the delivery of a single set of outcomes including:

- Proactive care to maintain good health
- Health is well managed
- Care tailored to personal need
- Reduced health inequalities
- Residents able to live independently but not isolated.
- Reduced need for secondary care/crisis intervention.
- Value for money from each intervention

Strategy overview: Developing Form

As a way of delivering our model of care locally, the case for change for **Primary Care Homes (PCHs)** is compelling. The Primary Care Home concept is a further development of an established principle in West London: clusters of practices working together to improve the health and care for their local populations. PCHs enable practices to use their resources more efficiently by providing economies of scale, which mean that they can provide more services for their patients by pooling resources to invest in technology, estates and workforce. PCHs will be the driver of delivery in their local area, managing resources to drive better outcomes for patients.

In our commissioning role as system facilitators we will support the mobilisation of **Primary Care Homes** with well funded PCH pilots launching at the start of 2018. We will work with practices to help them understand the needs of their local population in new ways, using population segmentation techniques, to tailor the configuration and skills mix of the **Integrated Community Team** for each PCH population. We are committed to supporting each individual practice to develop a practice resilience plan. The level of integration of each PCH will be determined by the appetite for change of each individual practice. However, the huge potential of closer working has been proven across the UK.

At the same time as working with local practices to develop their Primary Care Home, over the next few months the local system will begin detailed consultation on the development of a **Multi-Speciality Community Provider (MCP)** which is a type of accountable care system. Developing an MCP means:

- all partners across the CCG area will eventually share a single, capitated budget which provides funding for all of the health and care needs of the whole population (phasing begins in 19/20 with a pooled budget, with a capitated budget from 20/21).
- all partners will operate within a joined up model of care (coordinated by Primary Care Homes and delivered by GP practices, the Integrated Community Team and our north and south hubs)
- all partners will work together to deliver a single, shared set of outcomes

Primary Care Homes will be the local operational units of the MCP (*"Primary Care Homes are the practical, operational level of any model of accountable care provision"* NHS England), ensuring that the local population's needs are fully understood and resources are tailored accordingly, to provide what local people need. PCHs across the rest of the UK have had populations of between 30,000 to 50,000 so it's likely that four or more PCHs will be hosted within the West London MCP, which is likely to map over the CCG area.

To make this ambition a reality we need to focus on the next two years of rapid transformational change which will be driven through the Accountable Care Alliance Leadership Group, the CCG's Governing Body and through close-working with other CCG and partners across the NWL STP area.

Strategy overview: Key deliverables

An Integrated Community Team (ICT) with a single management structure delivered through an alliance arrangement ('virtual MCP') in 2018/19 and through a formal contract as one component of a partial MCP in 2019/20.

Building on the My Care My Way and Community Living Well models a framework for a single integrated community team will be developed which will ensure:

- A focus on co-design and delivery of a single set of shared outcomes
- A blended workforce model including social care and the third sector
- A focus on getting the care model right for older adults (65+) in 18/19 and for the whole population in 19/20
- High quality, accessible primary care with continuity with registered GP
- Continuity of care for patients and their carers through case management principles allocating resource around need, though risk stratification and tiering of patients
- Use of Hubs, embedding a multi disciplinary team approach and interface with other services as part of a wider team
- Proactive planned care and early escalation of risk when a patient becomes unstable
- Patient owned care plans and focus on the personalisation agenda with active self care supported through third sector organisations

Primary Care working at scale

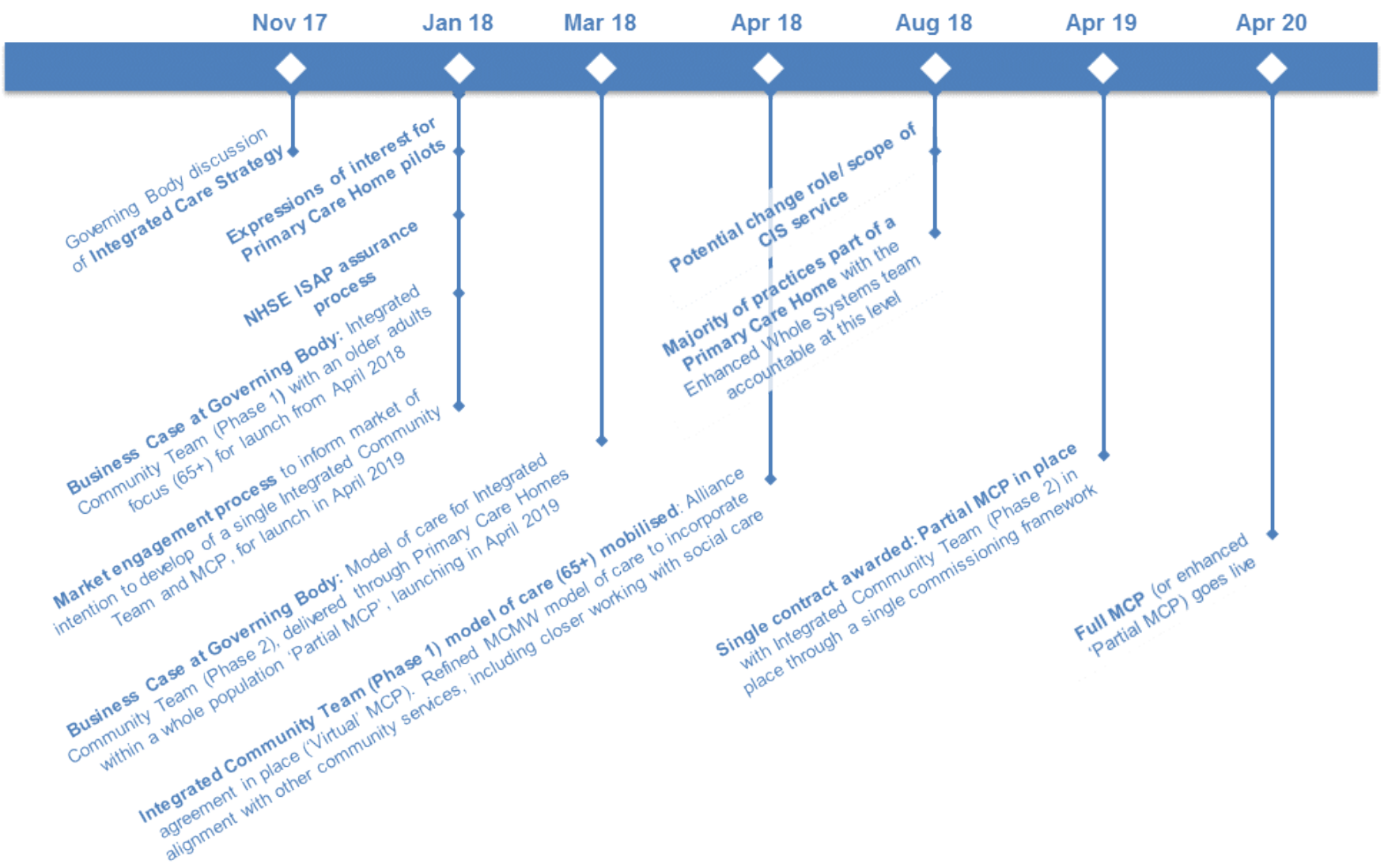
In order to build resilience we will support the development of primary care homes. This will include:

- Working with the GP federation to develop a Primary Care Home Development Plan
- Committing to providing resources at a PCH level to give practices time, capacity and capability to develop joint working
- Ensuring that the MCMW and CLW models are central to any local approach with the key principles embedded at PCH level
- PCHs developed within a North / South split in order to make best use of our Hubs
- Support practices to ensure they have long term resilience plan in place where necessary with a commitment to practices being part of informal PCH by August 2018 and formally aligned by March 2019

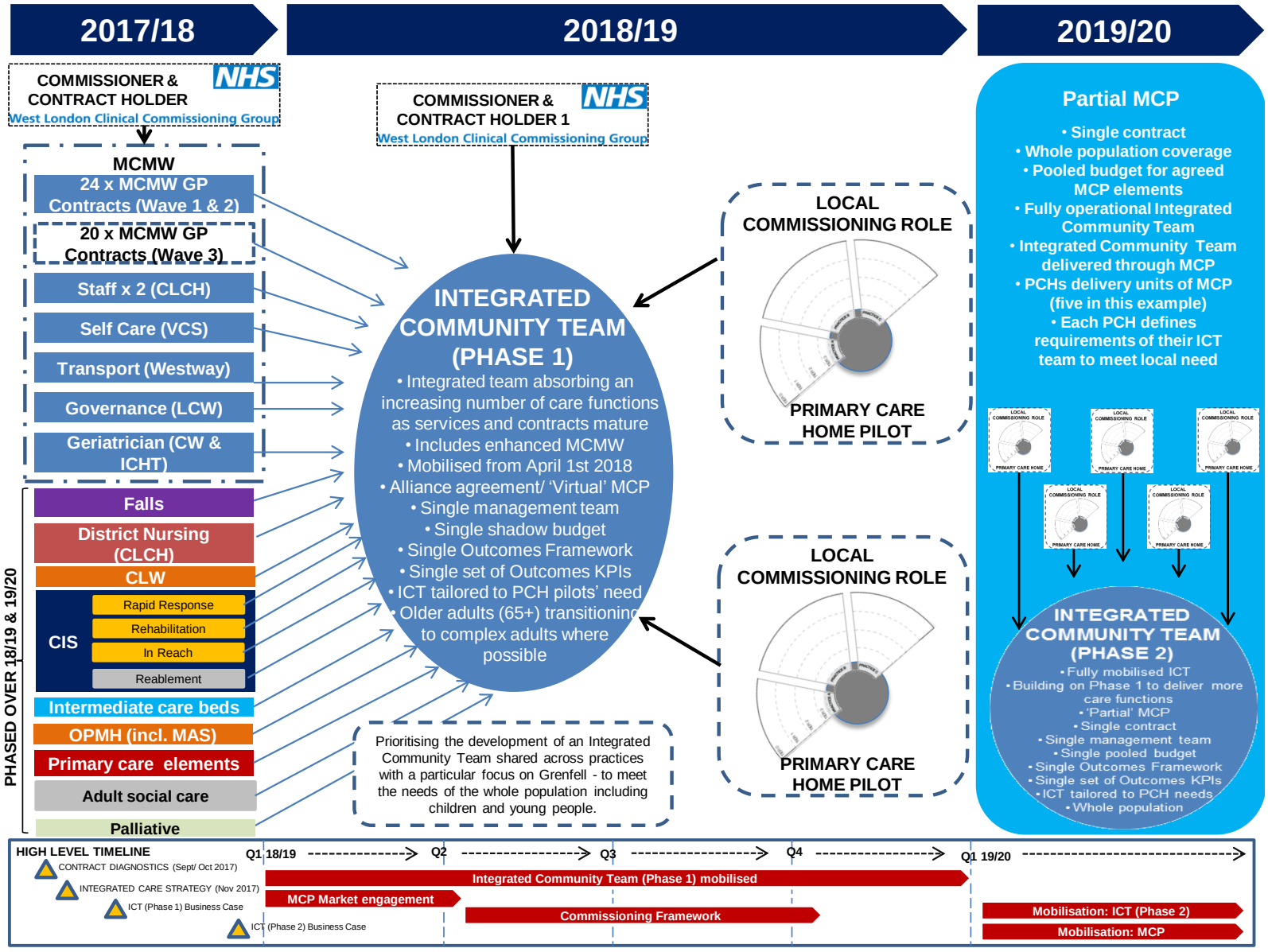
A Road map to Accountable Care

- A Single Integrated Community Team delivered at a PCH level will form part of a partial MCP by 2019/20. Our ambition is that beyond this we move to a more formal and fully accountable care system, incorporating other elements of spend potentially around our patients and primary care
- We have developed a detailed road map which will build capacity and capability to ensure that we have an outcome based approach to accountable care with a capitated, whole person budget from 2020/21

Strategy overview: Key Milestones



Strategy overview:
Developing our MCP components



Building a road map to accountable care

2017/18

- MCMW and CLW fully mobilised by the end of FY.
- 'Virtual MCP' in place for CLW. Formal Partnership Agreement signed November 2017, with shared outcomes and performance framework by Dec 2018.
- A number of individual community contracts in place across a number of organisations.
- Development of a single Outcomes Framework and single set of outcomes KPIs for our 18/19 contracts.
- Development and Improvement Programme to refine models of care and develop Business Cases for 18/19 and 19/20.
- Mobilisation of PCH pilots.
- Begin engagement with NHS ISAP Assurance process.

2018/19

- 'Virtual MCP' through Alliance agreement across all contracts/ between all local partners.
- Integrated Community Team (Phase 1) in place (65+) with additional functions as part of PCH/ Hub based model.
- Alignment of MCMW and CLW contracts with single Outcomes framework and set of outcomes-based KPIs across separate contracts.
- Commence commissioning framework for single Integrated Community Team via MCP.
- Consideration of what is in scope for 2019/20 including social care and acute.

2019/20

- 'Partial MCP' in place.
- MCP contract award: single contract, single outcomes framework and pooled budgets for agreed MCP elements.
- Integrated Community Team (ICT) mobilised and managed through MCP.
- Operational PCHs in place across the whole CCG patch, which ensure population coverage.
- Each PCH defines requirements of their ICT team to meet local need

2020/21

- Full MCP in place.
- Further care functions and services built in. In time to include : all Primary Care, Intermediate Care Beds, Outpatients, UCC, mental health, learning disabilities and acute pathways.
- Fully capitated budget covering the whole population.

Our progress against MCP 'Top 10' checklist - NHS England

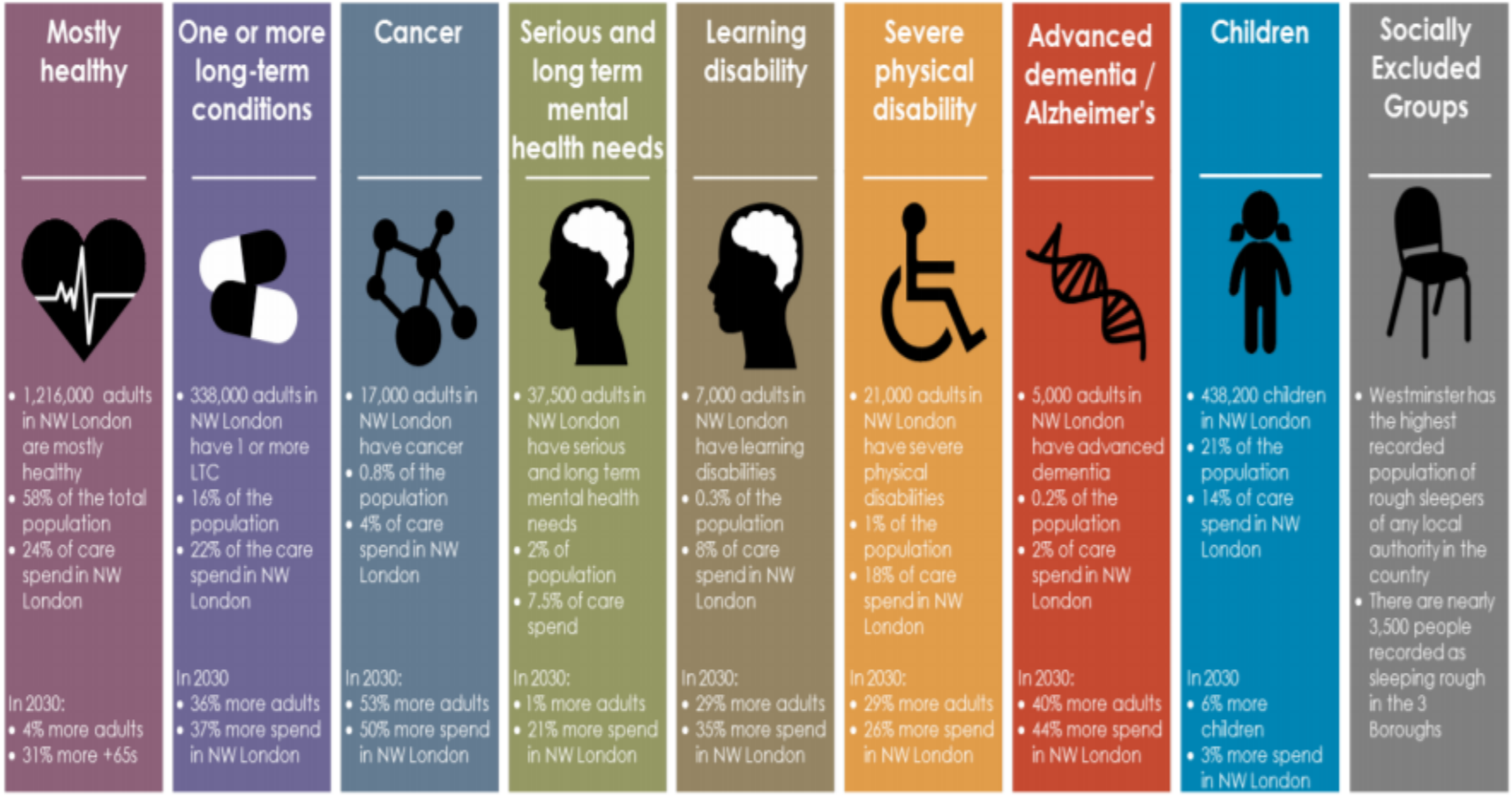
We have the right foundations in place….

MCP 'Top 10' checklist - NHS England	Gap	West London Integrated Care
Collaborative leadership		Already in place through HWBB, ALG and Change Academy
Dedicated 'engine room' that's more than a PMO		ALG and reference group in place
Transparent governance structure		Governance in place through ALG and CCG Transformation Board
Understands different needs of the diverse population and clear segmentation		Initiation population health analysis – segmentation, 'top-down', bottom-up and duplication analysis
Develop and maintain a clear LOGIC model		Emerging LOGIC model
Clear value proposition and commit to a clear return on investment		Emerging LOGIC model
Design and document each of the specific component parts of the care redesign		Business Case and updated SOPs will be developed
Systematically plan, schedule and manage the implementation		Resources need to be identified to support delivery
Learn and adapt quickly		Continued system development – e.g. learning labs, etc.
Commission and contract for the new model, so that organisational forms and financial flows are supporting your goals		Resources need to be identified to support delivery

Our Integrated Care Strategy

Our Case for Change

The NWL STP sets out the changing local demographics over the next 15 years that the local system must respond to and provides clarity on what will happen to demand if no action is taken.



MCMW Development and Improvement: Rapid Learning & evaluation findings

Key Area	Findings	Suggested Actions
Roles and Responsibilities	• Definition/ clarity for range of roles and responsibilities • Social service input/ integration • Duplication in tasks / roles undertaken by Case Managers and District nursing roles • Variation – My Care, My Way Health & Social Care Assistants focus on over 65s, whereas PCNs covered under 65s •	• Single management structure approach to support more joined up/ coordinated care delivery • Continuity and consistency of staff/ teams important for on-going knowledge of case mix and providing appropriate care • All agency participation at Practice MDT meetings • Increased trust between provider teams to remove barriers to integrated working • More flexibility within roles and expanded skills for staff
Responsiveness and Communications	• District Nursing response times can mean Community Independence Service can become a 'catch all' provider • GPs / Practice staff often approach most responsive team, even if it's not the most appropriate service as defined in specifications • Practices can receive mixed responses from District Nursing teams for management of stable housebound patients/ long term conditions • Cross border response/ access: ranging from response for patients to response for practice MDT meetings.	• More regular communication between nursing teams and practices • District and Community Nursing services improving links with care for housebound patients from community services and long term conditions (including diabetes; Cardio/ Respiratory)
Service Delivery	• Different operational hours for services can lead to gaps in provision • Weekend provision – often meaning that Rapid Response used for services such as taking bloods.	• Better access/ availability of twilight and night nursing services • Enhanced services for nursing home patients
Resources	• My Care My Way resources valued by practices - responsive care • Greater use of SystmOne – reduce paperwork • Hub space is limited – lack of free rooms for clinics •	• A&E links to My Care My Way: making use of Community Independence Service and SystmOne access in A&E • Greater use of SystmOne, and reduced paperwork, for more effective working • Making systems more intuitive for users – including new/ locum staff
Generic Case Management	• Focuses on wrap-around care • Builds a trusting relationship between the patient/carer and CM/HSCA • Built on regular (fortnightly/monthly) contacts and home visits • Supports patient and family in facing the reality of a deteriorating health trajectory • Enables patient and family to make realistic decisions about future health and social care needs • Requires dual health and social care skilled input	• Use extended GP appointments supported by MDT to make decision to refer for generic case management as patients health and functional ability is deteriorating • Develop teams of Case Managers with either a nursing or social work professional background to jointly manage an active caseload of about 120 patients. HSCA could be used for routine monitoring and home visits which could increase caseload to 180. • Use extended GP appointments supported by MDT to refer patients with anxiety, mental health and/or drug and alcohol problems to generic case management team comprising CM with a nursing (mental health) background and CM with social work background.

MCMW Development and Improvement: Rapid Learning & evaluation findings (2)

Key Area / Functions	Findings	Suggested Actions
Disease Case Management	• Currently provided by CIS/rapid response • Some input from District Nurses • Insufficient capacity to meet demand • Services are currently fragmented and not patient-centred • The current MCMW team is not consistently sufficiently clinically skilled to provide home-based disease management and integrate wider disease management support services. • Most GPs are willing to do more active home-based management of exacerbations of disease but need increased home-based clinical nursing support to do this. • Some GPs not convinced this is efficient use of health service resources.	• Use extended GP appointments to identify which patients would benefit from Disease-based Case Management. • Develop clinical case manager role drawing on District Nurse and current MCMW CM workforce • Develop relationship between patient/family and nurse case manager. • Facilitate relationship development between nurse case manager and GP to enable more proactive disease management.
Social Care	• Provided by Local Authority Adult Social Care • Joint provision between health and social care via Better Care Fund which supports CIS and re-ablement • CIS and re-ablement are universal services • Domiciliary care packages and care home provision is means tested • Social care focuses on optimising functional ability via re-ablement prior to assessment for care package • Health care focus on patient safety and risk reduction to prevent further crisis • Delays in referral and access to re-ablement exacerbates concerns about vulnerability creating additional high cost ameliorative care work • Social care is not able to provide an effective flexible response to fluctuating health needs	• Reduce delays in Social Work assessment and access to re-ablement services • Agree level of risk and vulnerability to be tolerated during assessment and re-ablement process at MDT to include family/carer in discussion • Develop care planning skills to facilitate care planning for deteriorating health and functional trajectories • Enable patients to access flexible, fluctuating domiciliary care packages integrated with Disease Case Management via CIS.
Care Planning	• Care planning focused on identifying unmet need • The language of care planning does not fit with the trajectory of health and functional deterioration which requires a process of patient and family adjustment and bereavement that takes time to unfold. • MCMW Case Managers do plan for deterioration but often can't articulate this in a care plan until the patient/family have accepted this trajectory.	• Care plans need to reflect segmented needs of the population • Care Planning needs to form part of all levels of disease management. • Care planning should incorporate disease management protocols and where appropriate advanced care plans. • Care planning should incorporate health and well-being goals.

Programme Team and development of strategy

- The key to success of this strategy is co-production with our local providers and the wider system, with all appropriate partners inputting into the detailed development and delivery of the programme.
- To assist with this, the CCG is currently participating in the NWL Change Academy (CA) Programme which is supporting the development of the Integrated Care Strategy.
  - The CA team is made up of stakeholders from across the local systems including CCG clinical leads, practice managers, the local GP Federation (LMA), CLCH, RB Kensington and Chelsea as well as two patient representatives.
- Another critical success factor for the Integrated Care Strategy is the coordination of a large amount of change activity which is taking place across the CCG. As a result, clinical and officer leads are in place to ensure representation from all of the CCG's key delivery teams.
- The CCG's programme team to deliver the Integrated Care Strategy is set out below.

Integrated Care Strategy (ICS) component	Clinical (or Subject Matter Expert) lead	CCG officer lead
Overall Integrated Care Strategy	Dr Richard Hooker & Dr Andrew Steeden	Jayne Liddle
Integrated Community Team	Dr Richard Hooker	Will Reynolds and AD Planned and Unplanned (CIS, DN, Falls)
Health and social care integration	Dylan Champion (RBKC)	Henry Leak
Grenfell	Dr Oisin Brannick	Mona Hayat
Primary care	Dr Naomi Katz	Simon Hope
Mental Health	Dr Will Squier	Glen Monks
Accountable Care Programme	Dr Andrew Steeden	Will Reynolds

Outcomes: Focusing on Quality

A joint team of clinicians and managers from both commissioners and providers have been attending the Change Academy to develop the local system's integrated care strategy. Focusing on building on the foundation of MCMW, with a focus on out of hospital and primary care-based care, the team agreed a high level Logic Model, which sets out a clear vision for the way the local system has to adapt to become more efficient and clinically effective.

INPUTS In order to deliver the purpose of the contract we invested the following:	ACTIVITIES In order to address the problem the contract requires the following activities:	OUTPUTS We expect that once accomplished, these activities will produce the following outputs:	OUTCOMES We expect that if accomplished, these activities will lead to these changes:
• Staff resource (CCG; provider; STP; ICHP/AHSN; other external expertise where required). • Clinical leadership • Infrastructure, hardware or software. • Financial Investment. • Best practice from national and international accountable care models with transferable insights.	• Comprehensive needs assessment using population health analytics and deep dive into case files of complex patients • Developing a workforce model based on care functions identified through needs analysis to make recommendations around staffing roles, responsibilities and skills mix • Refining the model of care (increased care functions; whole population; increased efficiency of effort and outcomes delivery) • Business case and commissioning framework development to deliver shorter (18/19) and longer (19/20 onwards) term efficiencies. Provider and patient engagement and co-production • Development and increased visibility of the Alliance Leadership Group – including review of membership • OD around Primary Care Home (driven by primary care) • Continuous monitoring and action learning to drive iterative improvement/ enhancement	• Single integrated community team • Single management structure • Single care record supported by integrated digital/ IT functionality • Single assessment of health and care • Single set of incentives (outcomes-based KPIs) and standards • 'Integrator' function set up to drive accountable care • Single capitated budget (virtual/ shadow in 18/19; 'live' in 19/20) • Primary Care Homes defining needs assessment of their local populations • Realistic financial plan with phased delivery of benefits • Workforce plan which provides a career trajectory for all staff, to improve staff retention and satisfaction.	**Population health** • Proactive care to maintain good health • Diseases well managed • Care tailored to local need **Patient experience** • Living independently at home but not isolated • Having one conversation • Reduced health inequalities **Financial benefits** • Reduced cost duplication by identifying and removing MCMW, CIS, DN, Practice nurse, home care duplication and identifying opportunities to use resources better. • Improved value by enhancing the cost effectiveness and quality of interventions **Staff experience** • Staff acting as one organisation with shared values (including voluntary sector, wider community assets including local businesses) • Information easily available to staff and readily shared when appropriate • Working as a single team with carers

ASSUMPTIONS

- Collaboration between commissioners and providers with strong clinical leadership.
- Staff recruited to populate workforce plan and meet skill mix requirements of the iteratively developing model of care.
- Building on the strong foundation of MCMW to develop the out of hospital care model functions, in order to drive shorter term financial benefits.

EXTERNAL FACTORS

- Engagement with acute providers to ensure vertical integration with the out of hospital pathways.
- NWL STP strategy will have an impact on elements of the local system's planning and close collaboration is required between NWL and other CCGs to ensure plans are aligned and planning resources are used efficiently.

The Alliance Operational Group have been working to develop a single Outcomes framework which will guide the collaborative development of a single set of outcome-based KPIs for all providers that jointly deliver an Integrated Community Team (Phase 1) in 2018/19.

Workforce: Emerging competency framework

As we move towards a single integrated health and social care team the need for a comprehensive competency framework, that covers all health and social care professional staff and which enables staff to fulfil their potential and provides a structure for career progression, becomes more apparent.

It is envisaged that all staff should be trained to provide as many core skills to patients to reduce duplication of effort where possible. Opportunities should be given to staff to add to existing professional skills with the right clinical and regulatory support. All staff should be encouraged to work to the top of their licence.

To do this we will need to:

- Scope, review and benchmark against all existing competency frameworks; working across partner organisations to pull together a whole community resource
- Reviewing existing complementary training modules and courses (Bucks University - Innovations in Health Programme)(Free modules to build CPPD)(Integrated learning – King's University)
- Co-design career pathways for staff and facilitate better staff retention
- Complete a workforce skills and task map and develop a systemised programme
- Share knowledge and training plans with other agencies / CCGs
- Establish a mandatory framework
- Establish a baseline to provide an overview of the current staff training situation for all staff and training required
- Develop inter-agency career opportunities and career pathways for new hybrid workers
- Identify shared baseline training and specialist training

Estates and Hubs

- West London CCG has the advantage of having in place two well established Integrated Care Centres (Hubs) from which CLW and MCMW services are run.

- Leaning from our evaluation and rapid learning show that co locating clinical teams has an impact on how care is integrated.

- An estates strategy (due March 2018) is being developed which will be in part driven by the Integrated Care Strategy to ensure that Estate is an enabler to how Hubs expand and support the emerging PCHs. The Estates Strategy will also focus on individual estates of GP practices.

- Hub Business Cases (VM Hub – Spring 2018) will align and will be based on the assumption that the hub will be central to the delivery of the strategy with clinical teams co located and with a single management team.

Capacity and capability to deliver

To support the scope and pace of transformational change resources will need to be considered:

- Link across STP area where possible to share learning and link with NWL Accountable Care Team
- Local Clinical Leadership
- Engagement and communications will be vital
- On the ground support for practices and emerging PCHs
- Focus on ‘social’ element of change and OD for this
- Identify (and potentially share) technical expertise required

As part of our joint-process to develop the local model of care and improve the productivity of the local system, the programme team will investigate how the system can do more for less and deliver better outcomes to patients through digital technology. New ways of working have the potential to enhance the capacity and capability of our GP-led community teams and the local system is committed to exploring how digital innovation can help to deliver better value, including through:

- Mobile working
- Virtual team working/ meeting
- Improved risk stratification approaches
- Systematized continuous evaluation
- Better information collection and sharing

Our plan is to quickly and safely test options in order to establish which technologies may offer opportunities to improve ways of working and efficiency. This will be achieved by developing proposals to access funds to support closer integration-in-year (17/18) and over the next two years (e.g. via BCF funding)- as well as close working with the CW+ Digital team and Imperial College Health Partners to identify ways to improve the value the local system delivers to patients.

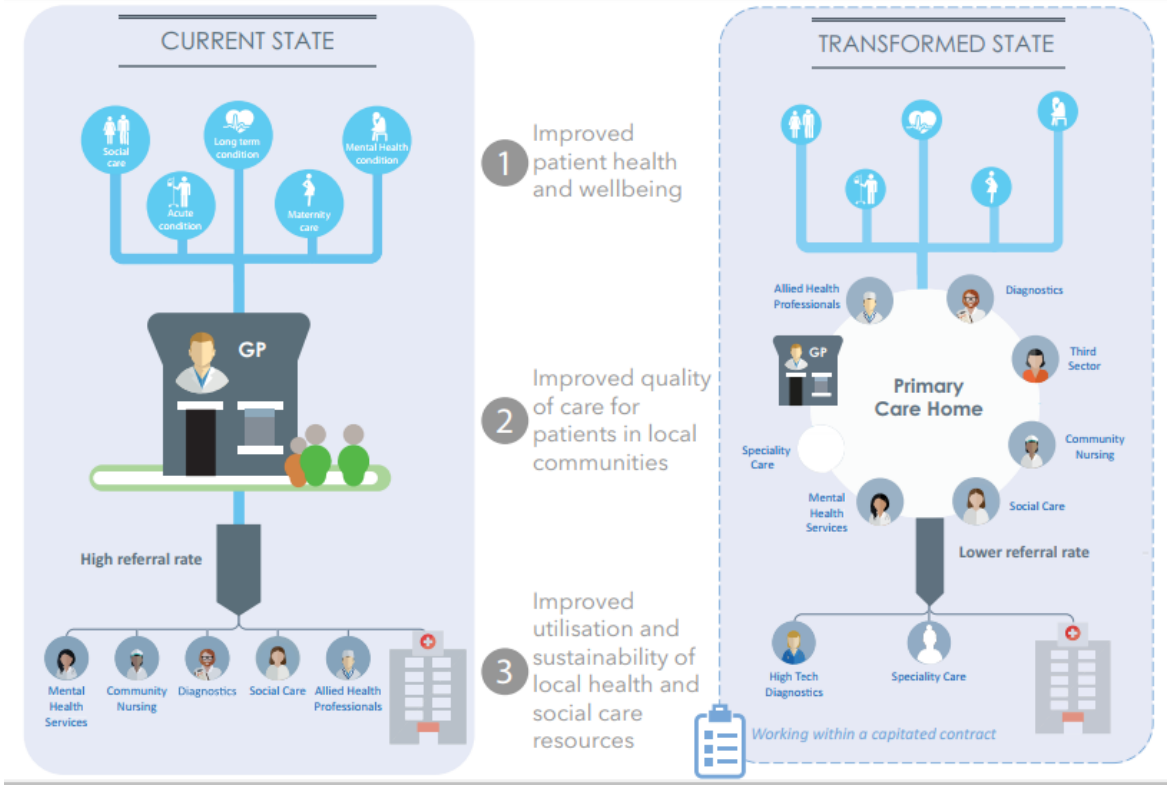
Integrated Community Team

The CCG is aiming to develop a truly integrated, primary care facing community team. This team will build on the current My Care My Way service to take on more care functions and expand to serve the whole population. The team will work to a single set of outcomes, with a single management structure and will be tailored to the population health needs of each Primary Care Home.

2017/18	Plans for a transitional change 18/19	Ambition for 19/20
- MCMW Rapid Learning recommendations rolled out across Waves 1 and 2. - MCMW rolled out across all 44 practices (including North Kensington). - Development of Integrated Community Team (Phase 1) for older adults (65+) Business Case (BC) with a range of additional care functions added to MCMW (for launch in April 2018). - Commencement of Integrated Community Team BC to cover all out of hospital care functions and whole population (due for launch in April 2019). - Working with providers to develop a single Outcomes Framework, outcomes-based KPIs and strengthened contracts.	- Launch of Integrated Community Team (Phase 1) for older adults (65+) model of care from April 1st 2018. - Service jointly managed by a single management team through with a single Outcomes Framework. - ICT providers working as a single service, with separate contracts, but an overarching Alliance Agreement. - Iterative addition of other care functions in-year where there is opportunity to do so (e.g. CLW). - Market engagement process to work with interested providers to refine the ICT Model of Care and BC. - ICT operating in PCH pilot sites, with PCHs determining needs and directing care. ICT tailored to local need, building on base model of care.	- Launch of Integrated Community Team in April 2019 as a component of a Partial MCP. - ICT covering the whole population. - Most if not all out of hospital health and care functions delivered by the ICT, including adult social care functions. - All ICT providers sitting within a single accountable care contract with a pooled budget from April 2019. - All care across the CCG directed by Primary Care Homes (PCHs), with PCHs tailoring and managing their ICT to deliver patient outcomes. - Single assessment and care plan supported by single IT system. - Optimised hub offer providing support to PCHs.

Primary Care Home: Background

The Next Steps of the FYFV is not prescriptive in terms of how accountable care should be achieved, but NHSE notes that one route is through the creation of locally integrated care for populations of 30-60k people based on GP registered populations. PCHs will allow us to start testing and developing our accountable care system – via a group of practices being supported by the Integrated Community Team (Phase 1) for older adults (65+) offer. We will be kicking-off with 'pilots sites' in January 2018.

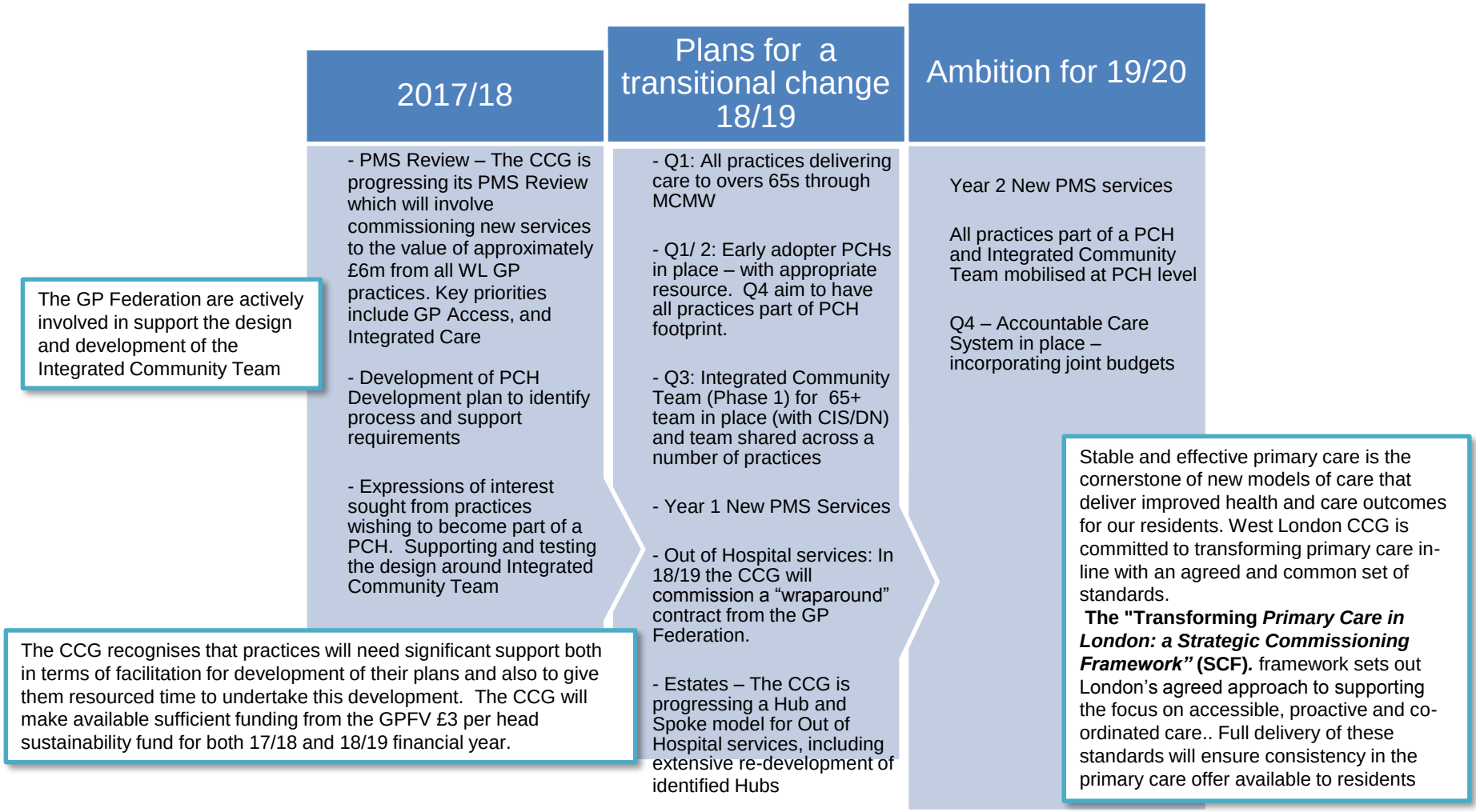


There are many variations of this, but **the four key features** are:

1. a combined focus on personalisation of care with improvements in population health outcomes
2. an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
3. aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards
4. provision of care to a defined, registered population of between 30,000 and 60,000.

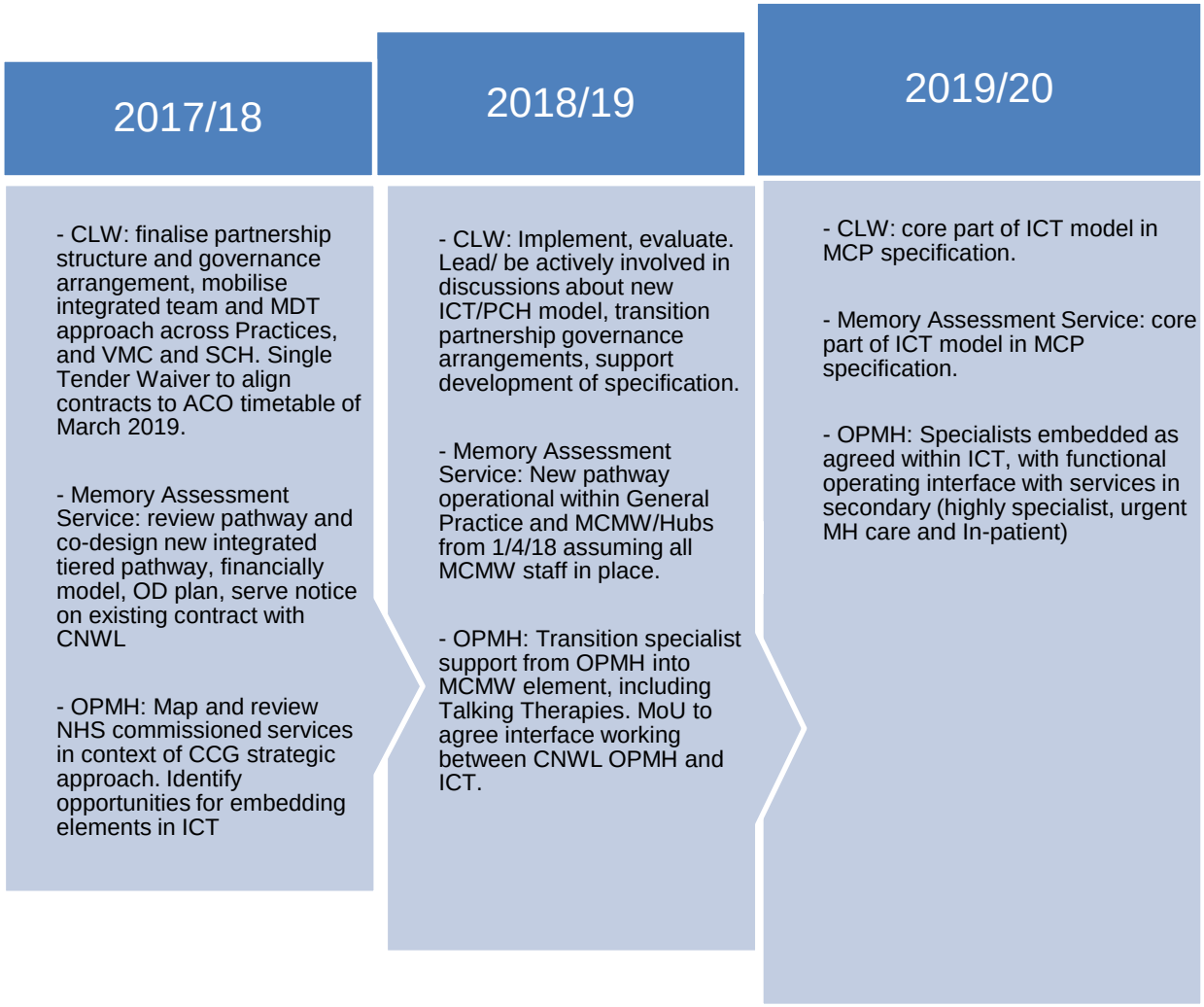
Primary Care

A key principle of the Integrated Care Strategy is keeping primary care and the GP central to how care is delivered, managed and coordinated. We will re invest PMS funds pack to practices to support delivery of the Integrated Care Strategy and we will ensure additional capacity and capability is developed at primary care level through PCHs.



Mental Health: Community Living Well, Dementia and Older Adults Mental Health

Three distinct client groups and services need to be a core part of the ICT offer.



Health and Social Care integration

Through the MCMW model a number of elements of integration are already in place. We will build on this and have ambitious plans to further integrate teams through a Single Integrated Community Team with a single budget and management structure.

We will share and agree our plans with RBKC and WCC HWBBs. We have representation on the Alliance Leadership Group and as part of the Programme Team developing the Int. Care Strategy

MCMW - current	Plans for a transitional change 18/19	Ambition for 19/20 as part of Single integrated Community Team
ASC Workers regularly attend Hub and Practice MDTs.	CIS (Rapid Response) part of Single Integrated Community Team. Q3.	Joint Integrated Community Team with associated single management structure, joint budget, KPIs and targets
Social Workers in MCMW offering advice and support.	Co-location of complex care teams at a PCH level. Q3.	Single 'assessor and case manager' able to access all resources for patients, with specialist input where required.
By Jan2018 all MCMW staff trained as 'trusted assessors' for equipment.	Developing competences and training to maximise single professional input opportunity across the 'community'.	Single IT system covering all community services.
Caseload visibility on both Health and Social Care IT systems	Aligning Health and Social Care Assessors and Independent Living Assessors roles as shared roles.	Alignment of domiciliary care at PCH level.
Tri B CIS service in place, service has access to all health records and ASC records.	Piloting 'trusted to assess' for services in other organisations, with access to both IT systems.	Partnership working with Extra Care, Care and Nursing facilities.
Hospital discharge services co-located to facilitate effective discharge and admission avoidance.	Shadow joint health and social care budget with MOU and governance arrangements in place.	Residents know how to access support through a single team, telling their story once.

NHS Services are free at the point of contact and one of the key principles around integrated care is to offer care proactively, while social care is means tested and only provided for people able to demonstrate a quantified level of need following assessment (except for reablement). Partners will need to work through the restrictions placed on the system by different statutory funding and payment models. This challenge should not be a deal breaker though, providing that partners can demonstrate that the model of care and the business case will deliver benefits for residents, the CCG and the Las.

North Kensington

In responding to the Grenfell fire and to provide focused support to the wider North Kensington community in the future, the CCG is developing a proof of concept enhanced health and wellbeing model is being piloted following a series of engagement events with stakeholders. The team will build on the current My Care My Way and Community Living Well services to take on more care functions and expand to serve the whole population. This model will evolve over time.

2017/18	Plans for a transitional change 18/19	Ambition for 19/20
Proof of concept of a central coordination hub of the key agencies* working together.	Whole population approach including children and younger people.	Support the community to build their resilience.
Utilising and expanding existing services where relationship are already built up.	Focus on recovery, health, social care and improving long term outcomes.	A wider wrap around service to include primary care, mental health, voluntary sector.
Initial framework on which the community can then build a long term service.	Built on MCMW and CLW principles including case management , care planning, navigation and MDT working and family MDTs.	Ensure people with complex needs are supported to navigate their way through the different support available for them and their family.
Focus on an integrated offer to ensure we reduce the number of times people are referred between agencies.	Aligned to the RBKC Care for Grenfell model.	Potential for patient to join the MDT so they can contribute to the discussion on the care they will receive.
Ensuring the GP is central to how care is delivered for their residents.	Family based case manager where appropriate - Family MDTs	Integrated Community Team in place via a single communising framework.
Ensuring that when someone moves out of area there is some continuity for them once they move.	Central coordination function (Hub).	All ICT providers sitting within a single accountable care contractual framework (e.g. MCP or Alliance contract) from April 2019.
A model that is delivered in a place which is most suitable for the needs of the resident.	Effective use of the hubs - 'One stop shop' principle.	Single capitated budget for ICT, (with primary care, community and some acute service budgets) managed by the Accountable Care System.
	Proactively reaching out to high risk groups and patients.	

* For example:
- Outreach
- GP
- MCMW Case Manager
- CLW – PCLN
- Mental health team
- RBKC key worker
- Community support

Accountable Care System: The journey

"Establishing an MCP requires local leadership, strong relationships and trust."
NHS England

2017/18	2018/19	2019/20	2020/21
- MCMW and CLW fully mobilised by the end of FY. - A number of individual community contracts in place across a number of organisations. - Development of a single Outcomes Framework and single set of outcomes KPIs for our 18/19 contracts. - Development and Improvement Programme to refine models of care and develop Business Cases for 18/19 and 19/20. - Mobilisation of PCH pilots. - Begin engagement with NHS ISAP Assurance process.	- 'Virtual MCP' through Alliance agreement across all contracts/ between all local partners. - Integrated Community Team (Phase 1) for 65+ in place with additional functions as part of PCH/ Hub based model. - Alignment of MCMW contracts with single Outcomes framework and set of outcomes-based KPIs across separate contracts. - Commence commissioning framework for single Integrated Community Team via MCP. - Consideration of what is in scope for 2019/20 including social care and acute.	- 'Partial MCP' in place. - MCP contract award: single contract, single outcomes framework and pooled budgets for agreed MCP elements. - Integrated Community Team delivered through MCP. - Operational PCHs in place across the whole CCG patch, which ensure population coverage. - Each PCH defines requirements of their ICT team to meet local need - Fully mobilised Integrated Community Team	- Full MCP in place. - Further care functions and services built in including all Primary Care, Intermediate Care Beds, Outpatients, UCC, other acute pathways. - Fully capitated budget covering the whole population.

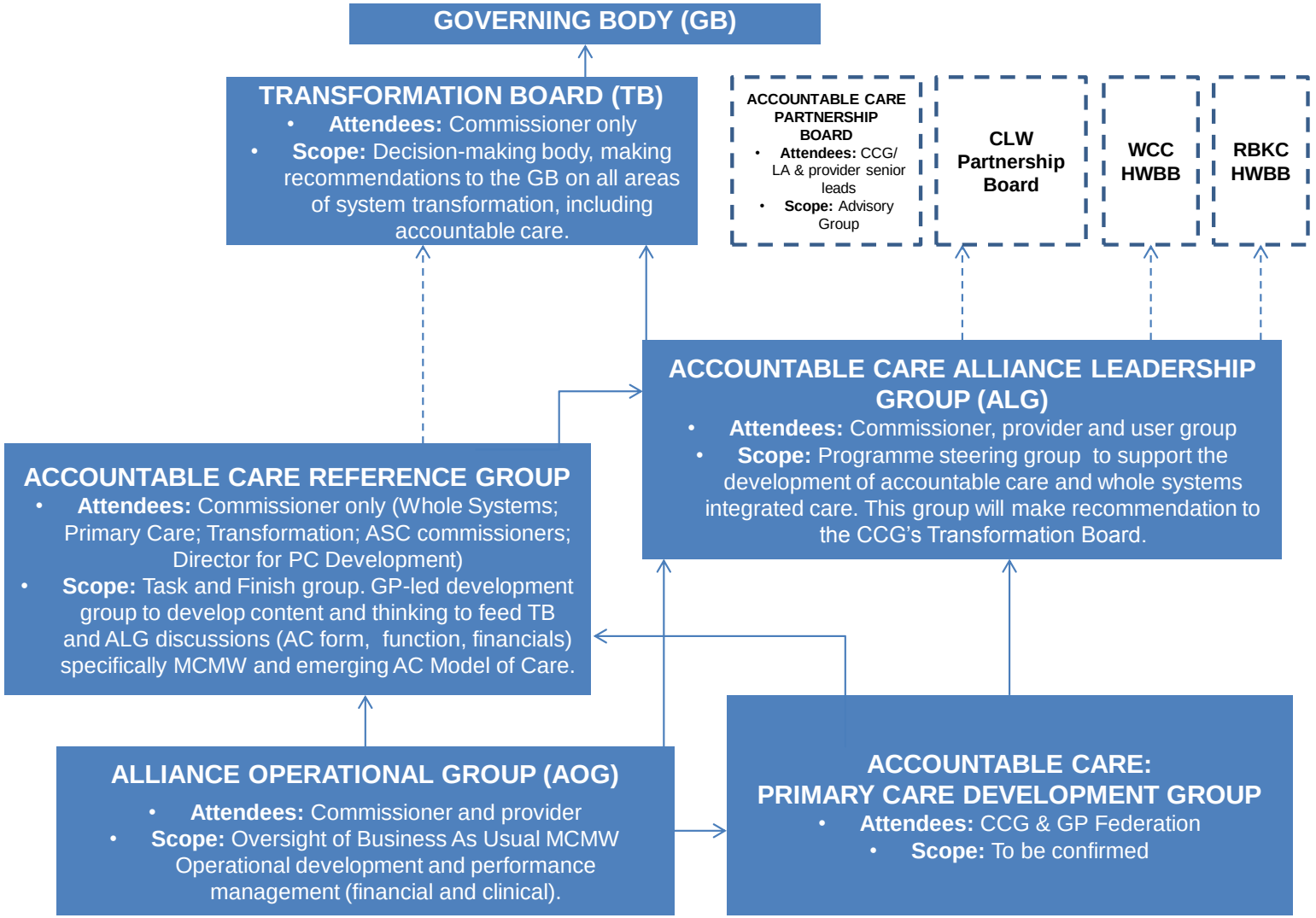
Accountable Care: Blending local and NWL STP approaches

- West London CCG agree that NWL CCG AC plans should share a set of common elements so that NWL has a coordinated approach to accountable care development across its STP footprint, whilst also recognising different starting points and capitalising on the firm foundations within West London.
- We acknowledge the common features or 'ingredients' of successful accountable care from NHS vanguard learning and will use these as a framework for both our local and NWL-wide work. **The below table sets out our delivery trajectory for these 17 'ingredients'.**

	Accountable Care 'Ingredient'	17/18	18/19	19/20
1.	Outcomes based contracts (& putting an end to activity based payments)		✓	✓
2.	Core outcome measures in key population or service segments – esp patient described outcome measures / targets		✓	
3.	Alignment on priority targets – eg 65+, frailty, children etc.		✓	✓
4.	Long-term contract (c.10years)			✓
5.	Pooled budgets			✓
6.	New payment mechanisms (based on outcomes, shared accountabilities)		✓	✓
7.	New risk / gain share arrangements			✓
8.	Capitation methodology			✓
9.	Requiring providers to increasingly focus on primary & secondary prevention	✓	✓	✓
10.	Shared Data / BI capability and information flows – building on and expanding the WSIC dashboard		✓	✓
11.	Single contracts covering multiple providers (ie all providers that are necessary to deliver target outcomes)		✓	✓
12.	Culture and system change – to prioritise new ways of thinking, working (ie a one system, one budget mindset) & staff development	✓	✓	✓
13.	Multi-partner provision – Primary Care, Community definitely need to be in 13a. MH, SC	✓	✓	
14.	One set of back-office functions across the AC partners		✓	✓
15.	Requiring providers in existing contracts or allied arrangements to commit to becoming part of wider accountable care arrangements as and when required		✓	✓
16.	Locking progress into contracts (contract updates, CVs etc)	✓	✓	✓
17.	Use of readiness matrix assessment / accreditation standards to support provider capacity and capability development toward AC working; driving principle to reduce unwarranted variation supports need for consistency	✓	✓	✓

KEY ✓ Delivered in year ✓ Partially delivered in year ✓ Highlighted element delivered in year

Managing the change: Governance



Provisional Governance structure

Managing the change: Engagement approach

The Integrated Care Strategy (ICS) is the next iteration of and a direct continuation of the Whole Systems Integrated Care approach which was subject to a public consultation and signed off by the WLCCG Governing Body in 2015. The ICS forms part of a longstanding strategic direction set by the local system three years ago which has been tested numerous times at GBs that are open to the general public.

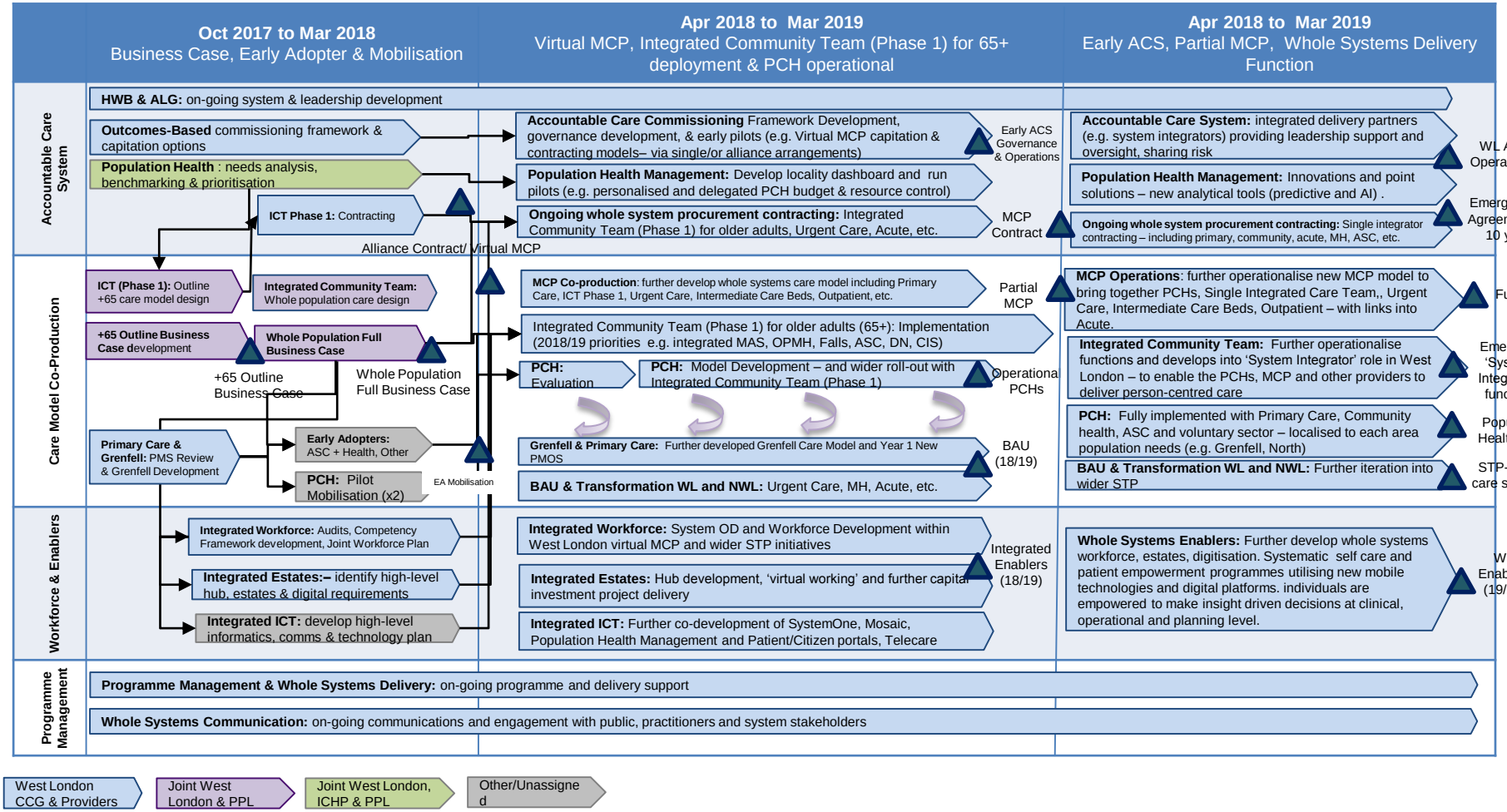
Wide ranging engagement has taken place with patients and the local system on this Integrated Care Strategy including:

- During the Change Academy where a mixed group of commissioners, patients and providers drew up the outline outcomes framework for the ICS **(September 2017)**
- CCG Transformation Board where the draft ICS was signed off by commissioners and patient reps **(September 2017)**
- Draft strategy was shared by Dr Richard Hooker – clinical Lead at West London 's GP Plenary**. (September 2017)**
- Governing Body Development Session where the next iteration of the ICS was signed off by commissioners and patient reps **(October 2017)**
- Violet Melchett Steering Group **(October 2017)**
- Accountable Care Alliance Leadership Group **(October 2017):** the system's key group for steering accountable care signed off the approach.
- Individual meetings with our providers' senior management **(October 2017)**
- Patient engagement including individual and group meetings with patient representatives **(ongoing)**.
- The Integrated Care Strategy is being submitted to the Patient Reference Group **(7th November 2017)**
- The strategy is also being submitted to the CCG's Quality and Safety Committee and Governing Body on **7th November 2017.**

In addition to all of the above engagement taking place to date, we are aware that this is just the start of the process. On approval, the ICS will be converted into a detailed Programme Plan, which will include an Engagement plan. As the transformation programme progresses, detailed consultation on the development of the associated models of care will be taking place with users of all of the services involved in the system transformation.

On approval of the ICS, a full Engagement Plan will be developed and tested with local stakeholders and patient groups to ensure that the live plan reaches all groups that have a stake in the delivery of the Strategy are consulted

Managing the change: 2018-20
Integrated Care Strategy on a page



Managing the change: Quality and Equalities and Inequalities Impact Assessments

- The intention of the strategy is to improve quality and reduce inequalities of service provision and outcomes.
- To this end, a Quality Impact Assessment tool has been submitted to the CCG's Quality and Performance Committee (QPC) on November 7th, 2017.
  - Following advice and steer from the QSC, further steps will be taken to ensure that all impacts on the local community are understood, mapped and managed to deliver better quality services for all of our local communities.
- Furthermore, an Equalities and Inequalities Impact Assessment has also been completed and submitted for the Strategy to the CCG's Quality and Performance Committee (QPC) on November 7th, 2017.
  - Following advice and steer from the QSC, further steps will be taken to ensure that all impacts on the local community are understood, mapped and managed to deliver increased equality and reduced inequality in our service provision to all local residents and communities.

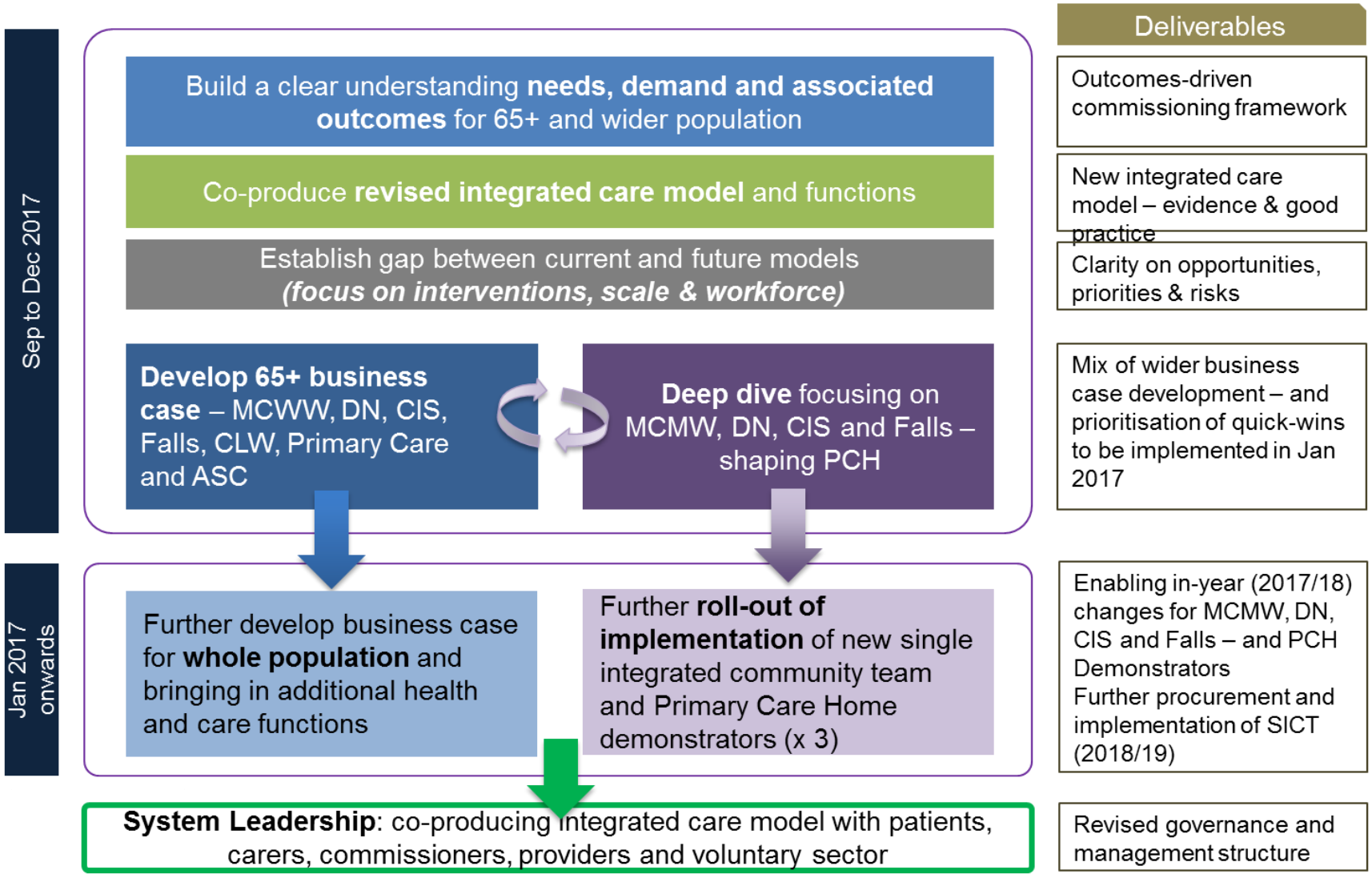
Integrated Care Strategy: Key risks

Risk/ Issue?		Likelihood	Consequence	Score	Mitigation
Risk	**Financial- Impact on Business as Usual** The transition to accountable care and scale and speed of the change is very disruptive, leading to a loss of focus on business as usual and delivery of short term efficiency savings, leading to an unsustainable financial position for the CCG and local providers.	2	5	10	The programme plan should be structured to ensure that delivery of savings (transactional and transformational, both QIPP and general cost control) is phased, with the change programme delivering, short, medium and longer term savings and enhanced cost-effectiveness to support the delivery of WCCG and the wider NWL STP area's financial sustainability.
Risk	**Financial- Failure to deliver anticipated benefits** The transition to accountable care does not deliver the planned financial savings, leading to an unsustainable financial situation for the local system and wider STP.	2	5	10	The change programme will involve a comprehensive, 'bottom up' business case development process which includes providers to ensure that accurate data and conservative, realistic assumptions are used when determining the financial impact of delivering the integrated care strategy and the move to accountable care.
Risk	**Provider workforce** The development of the Integrated Care Strategy and move towards a single, integrated community team destablises the workforce and staff decide to leave.	2	5	10	Co-production with our local providers and clear communication of desired system goals to the market will provide assurance to staff and follow a 'no surprises' ethos. Comms and engagement should also emphasise the key benefits to staff and local providers of the move towards a single integrated team and accountable care more widely. To this end a Comms and Engagement lead will be appointed to manage this part of the programme.
Risk	**Change Programme team capacity** The scale and speed of the change programme is substantial, putting too great a strain on limited CCG programme delivery resources, leading to delays in the programme and/or sub-optimal outcomes.	2	4	8	The CCG is taking steps to ensure that the programme team has sufficient capacity and capability to deliver the change programme. This means recruiting to vacant posts in the Whole Systems teams (Contracting and Commissioning support manager; Comms and Engagement lead) as well as drawing on the resources within other teams in the CCG (and potentially, local providers) to support the delivery of the integrated care strategy.
Risk	**Lack of engagement** Local system stakeholders are not sufficiently well engaged which leads to slow decision-making, difficulty in getting the right input and at the right time from local providers and this has an impact on both delivery timescales and the quality of the change programme's outputs and outcomes.	2	4	8	The governance structure for Whole Systems is already well established and has made great strides in delivering real change with the roll out of the MCMW service. This structure will be the driving force behind the CCG's accountable care change programme and this structure has been adjusted accordingly to ensure that the right people attend the right meetings, governance groups take place in a timely manner and decisions are expedited. To ensure visibility and attract stakeholders of appropriate seniority, the Alliance Leadership Group will be attended by Fiona Butler, the CCG's Chair of the Governing Body.

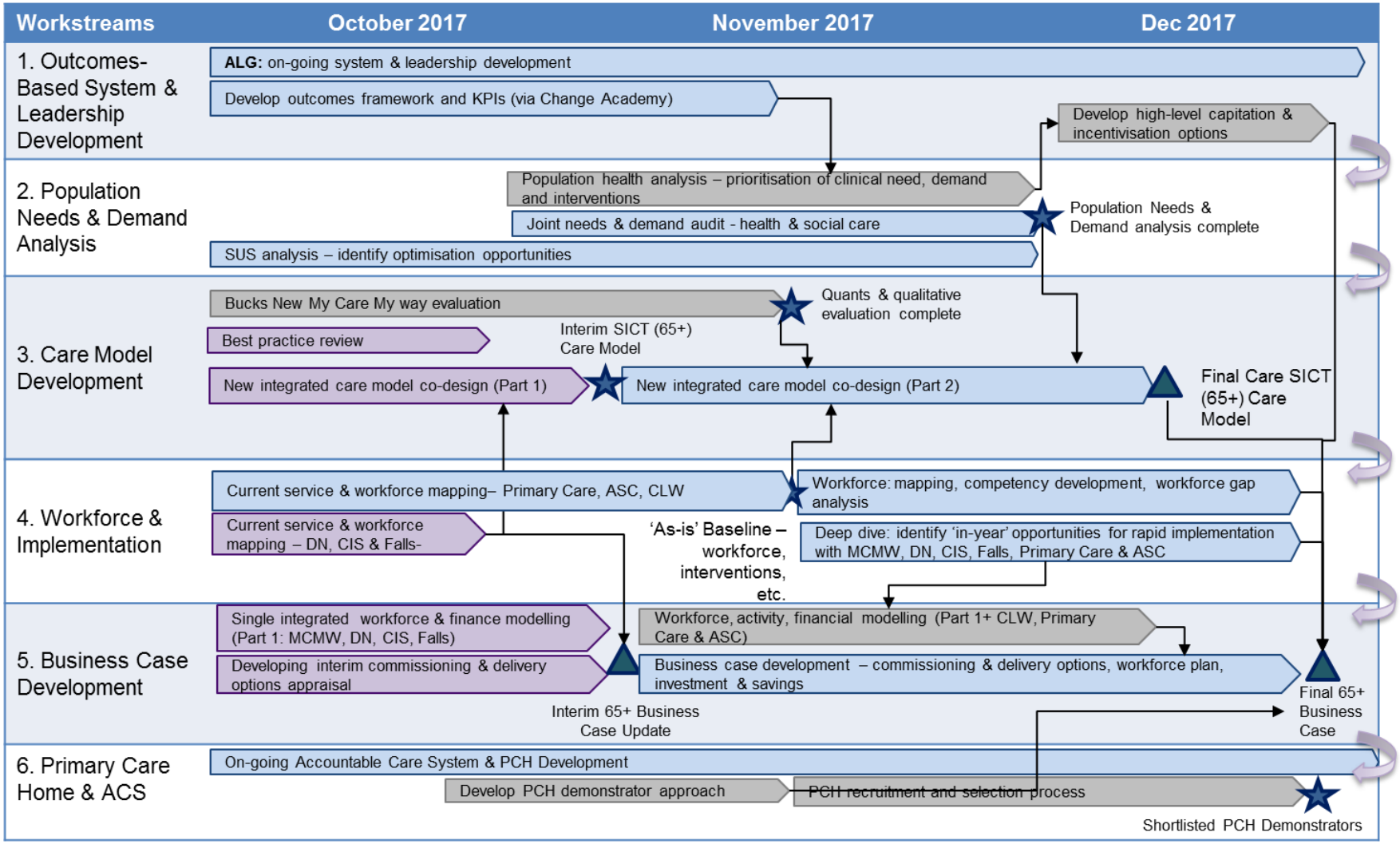
APPENDIX 1

Detailed plans for 17/18

Integrated Care Strategy: High-level approach for Q3 (Oct to Dec 2017)



Integrated Care Strategy: Detailed Plan Q3 (Oct to Dec 2017)



Integrated Care Strategy: Critical input, decisions and milestones (Q3)

#	Input/Decision/Milestone	Who/Where	When	Impact
1	**Integrated Care strategy 'buy-in'** – approach and mobilising wider system stakeholders (co-production)	• ALG • CCG GB (Public)	• 25 September 2017 • 7November 2017	Essential to get provider and wider system leadership 'buy-in' to support our approach – and **release operational capacity to support development** (e.g. Federation, LA, CLCH, voluntary sector)
2	Access to current baseline of **services and workforce and activity data**	• CCG & Providers	• Mid October 2017 • (Deep Dive) • Mid-November 2017 (Other)	Critical to work with commissioners and providers to establish 'as-is' and opportunities to **meet BC deadline in Dec 2017**
3	**Establish feasibility 'deep-dive'** and quick wins area (e.g. DN, CIS and Falls)	• CCG GB	• Late October 2017	Clarity on **savings and improvement opportunities** profiling in-year (2017/18) and 2018/19
3	**Interim 65+ Business Case** – strategic input and development	• AOG • CCG GB Development	• 16 November 2017 • 21 November 2017	Critical to engage with senior leadership across **CCG and system to shape final BC**
5	**Outcomes & population health needs** commissioning framework sign-off	• ALG • CCG GB?	• 7 December 2017 • TBC?	Input into 65+ business case – and, critical input to shift WL system **towards PCH, Accountable Care System and wider Accountable Care System**
6	**Final 65+ Business Case** – strategic input and development	• ALG • CCG GB • CCG GB	• 11 January 2018 • 16 January 2018 • 20 February 2018	Need to mobilise immediately with providers on in-year changes – and meet **re-procurement deadline for August 2018** (deep-dive)

Integrated Care Strategy: Critical input, decisions and milestones (Q4 onwards)

#	Input/Decision/Milestone	Who/Where	When	Impact
1	For completion			
2				
3				
3				
5				
6				