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Dudley
Metropolitan Borough Council

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 10**

REPORT SUMMARY SHEET

DATE	28th June 2017
TITLE OF REPORT	Development and Commissioning of Dudley's New Care Model – the Multi-Specialty Community Provider (MCP)
Organisation and Author	Neill Bucktin – Director of Commissioning – Dudley CCG
Purpose of the report	To advise the Board of progress to date with the development and procurement of a MCP
Key points to note	1. Dudley was established as a "Vanguard" site in 2015 and has been working to establish a new care model – the MCP as part of the national new care models programme. 2. Some initial evaluation has taken place, the early findings of which demonstrate some benefits to the system 3. To establish a MCP contractually, the CCG and the Council need to conduct a procurement exercise which commenced properly on 9 June 2017. 4. It is anticipated that a contract will be in place by 1 April 2018.
Recommendations for the Board	That the position in relation to the development of Dudley's new care model be noted
Item type	Strategy
H&WB strategy priority area	Integration of services

DUDLEY HEALTH AND WELLBEING BOARD

DATE 28th June 2017

REPORT OF: Neill Bucktin – Director of Commissioning – Dudley CCG

TITLE: Development and Commissioning of Dudley's New Care Model – the Multi-Specialty Community Provider

1. PURPOSE OF REPORT

To advise the Board of progress to date with the development and procurement of a MCP

2. BACKGROUND

The Board will recall that in 2015 Dudley submitted a successful bid to become a Vanguard area as part of NHS England's new care models programme, the intention being to develop a MCP. This report describes the original proposed care model, some early evaluation findings and progress with the procurement process necessary to establish a contract for a MCP

THE CARE MODEL

Dudley's population is characterised by people who are living longer with more complex health and care needs. These needs can require input from a range of services – general practice, pharmacy, community physical and mental health services, social care and the voluntary sector. People present in the first instance to their GP with whom they are registered. Demand on primary care and other services is increasing. This means that as a system:-

- we need to join up services better to provide an effective response to complex need that does not fit neatly into existing organisational models;
- we need a more resilient GP service that can manage its registered patient population and cope with increased workload, whilst recruiting and retaining a modern workforce.

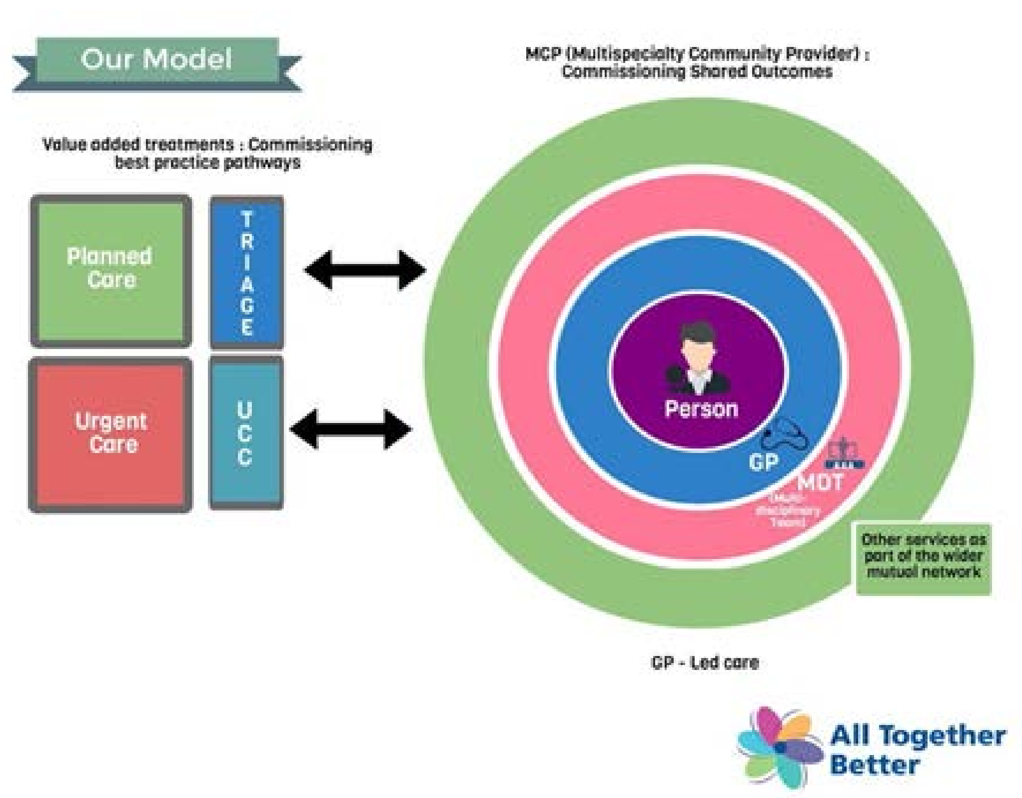
The MCP is seen as the most appropriate model for dealing with these challenges.

The MCP is based upon the registered GP list and as such the registration of a patient with a practice is the starting point for the MCP. From this the basic care

model centres upon a series of practice based multi-disciplinary teams (MDTs)which bring together the key community based services required to provide an effective response to people with increasing levels of complexity.

These teams are connected to more specialist community based services within a community and ultimately have access to the most effective care pathways for access into those elements of care that are not the responsibility of the MCP – planned and urgent care services delivered by hospital (secondary) care.

The teams have a shared responsibility for providing a set of interventions to a shared population and delivering a shared set of outcomes (see below). They must manage that population effectively to prevent inappropriate use of both hospital and care home services, as well as facilitating access back into the community for people being discharged from more intensive forms of care to support their independence.



The CCG has accessed additional resources made available by NHS England to support the development of the model and put in place those services that are required to meet the national prescribed model for an MCP. There are 4 key "care elements" that contribute to this:-

- whole population – prevention and population health management;
- urgent care needs – integrated access and rapid response service;

- ongoing care needs – enhanced primary and community care;
- highest care needs – coordinated community based inpatient care.

Additional resources have been committed to support:-

- increased practice based pharmacist capacity;
- centralised repeat prescribing service (Prescription Ordering Direct);
- support to care homes including a telemedicine service;
- new forms of workforce to support the MDTs;
- a new "social prescribing" service – "Integrated Plus";
- an organisational development programme to support MDT working.

The CCG has also carried out further work to rationalise the outcomes framework which forms part of the GP contract and this is further supported by all local practices using the same clinical IT system.

EVALUATION – EARLY FINDINGS

The evaluation of the new care model is being undertaken by the Strategy Unit and its partners ICF and University of Birmingham. The work has been organised into two main strands. They are set out below, alongside headline findings from each strand.

Overall system level

a) A programme of interviews with strategic stakeholders from across the system (in summer 2016) showed:-

   - a shared, clear definition of difficulties facing Dudley's system ('Do Nothing' was not seen as an option);
   - a broadly shared / logically described sense that an MCP could address these difficulties;
   - tensions and challenges putting this model into practice;
   - the need to focus on primary care entering into procurement.

b) Headlines from the latest quarterly performance report (to the end of Jan 2017) showed:-

   - recent stabilisation in the otherwise upward trend in emergency admissions;
   - a fall in delayed transfers of care and emergency bed days;
   - a fall in unplanned hospitalisations for ambulatory care sensitive conditions.

This requires further analysis to establish a clear "cause and effect"

Specific schemes within the new care model

a) An evaluation of the Multi-Disciplinary Teams (MDTs) in primary care (reported May 2017) found:-

- consensus that MDTs are the right way to coordinate care for some patients;
- evidence of expected benefits for staff (in particular) and patients;
- evidence of reductions in primary care use – voluntary sector element vital;
- an apparent impact on length of stay but not admissions.

It recommended: operational tweaks – including methods of targeting patients; and better use of data – especially patient reported measures.

b) An evaluation of the Long Term Conditions (LTC) Framework for primary care (reported April 2017) found:-

- variation in implementation by practices and consequential results;
- some evidence of efficiency gains in practices;
- improvements in care planning / shared decision making.

It recommended: further work on care planning and shared decision making; positive use of variation (find and replicate good practice); and more research on practice costs / likely system benefits**.**

Plans for this year's evaluation include a repeat of the overall strategic level stakeholder reviews; ongoing monitoring of system-wide measures; follow-on work from the MDT and LTC framework evaluations; and a focused evaluation of specific schemes funded using NHSE's 'transformation fund'.

THE PROCUREMENT PROCESS

The national framework for MCPs describes 3 models that can be developed:-

- a virtual MCP using existing contracts and bringing providers together using an "Alliance Agreement";
- a "partially integrated" MCP – where GPs retain their existing contracts whilst entering into an "integration" agreement with the MCP;

- a "fully integrated" MCP – where GPs relinquish their existing contracts for a salaried or other option.

The local proposal is likely to be a hybrid of the latter two options. The scale of change involved requires a procurement.

The framework further describes the arrangements that should underpin a MCP contract:-

- the MCP receives a "whole population budget" covering the cost of the services it is responsible for;
- the contract is long term – in our case 15 years – in order to create a less adversarial and more developmental relationship and the space to develop preventative approaches that are capable of containing demand;
- the MCP has the "right to decide" how the whole population budget is used;
- the MCP is commissioned to deliver a set of outcomes designed to improve population and individual health status in the widest sense, including the wider determinants of health such as employment, rather than the "event based" (attendances, admissions, contacts) commissioned at present;
- the MCP must have a registered list making the involvement of general practice a pre-requisite.

In July 2016, the CCG Board approved three key documents to support a procurement:-

- the prospectus – describing the characteristics and style of the organisation we wish to commission services from;
- the service scope – the range of services to be delivered including general practice; community physical health services for adults and children; mental health services; learning disability services; some out-patient services; public health commissioned services; voluntary sector services;
- the outcomes to be delivered – building on the GP Outcomes Framework referred to above.

These documents were the subject of a consultation exercise last summer and were approved by the CCG Board as the basis for the procurement in September 2017.

The regulators NHS England and NHS Improvement have established an "Integrated Support and Assurance Process" (ISAP) which is in 3 main stages accompanying the procurement process. This is designed to ensure:-

- the procurement has been set up properly;
- the proposed contract with a preferred bidder is appropriate;
- all issues have been addressed before the contract goes live.

The CCG successfully completed the first stage in May 2017 and the second stage will be entered at the point a preferred bidder is identified.

A market engagement event was held with potential bidders in January 2017. Since that time and given the key role for GPs in the process, local GPs have been meeting with potential bidders in order to discuss what potential relationship they might be able to develop.

The Contract Notice for the procurement was published on 9 June 2017 and the first element of the process is for interested bidders to return a Pre-qualification Questionnaire (PQQ) by mid-July. The procurement process to be used is one of "competitive dialogue". This process begins in earnest in September and will run through to November. This will involve the CCG and the Council meeting with bidders to test out their proposals, focusing on key themes. This will conclude with the submission of a "solution" – a clear proposal on how the proposed care model can be delivered – before Christmas 2017.

It is anticipated that a contract will be agreed by 1 April 2018 and there will be a phased mobilisation of service delivery during 2018/2019.

3. FINANCE

Depending upon the range of services eventually delivered and the extent to which the MCP is fully or partially integrated, the total contract value will be between £235m and £275m per annum.

4. LAW

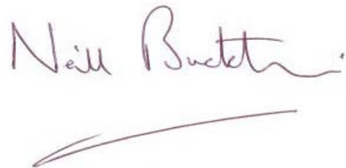
The procurement is being conducted in accordance with the Public Contract Regulations 2015 and the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

5. EQUALITY IMPACT

A full Equality Impact Assessment was carried out at the time of the consultation on the MCP proposals (Summer 2016). Reducing health inequalities is a key factor behind the development of the proposals and the outcomes framework

6. RECOMMENDATIONS

That the position in relation to the development of Dudley's new care model be noted



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