The Strategy Unit.

Scenario Analysis for Dudley's Multispecialty Community Provider Strategy

V1.2

Full Project Report

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1. Executive Summary

In 1992, the American political scientist Francis Fukuyama published his book *The End of History and the Last Man*. In the book, Fukuyama surveyed global trends at the end of the Cold War and concluded that history had ended: that humanity, having experimented with and discarded different arrangements, had now universally and finally settled upon variants of liberal democracy and capitalism.

When he wrote, and for some time beyond, Fukuyama's thesis had some resonance (at least in the West) but, more recently, history has reasserted itself. What Fukuyama saw as a final destination now seems like a phase; nationalism, protectionism and authoritarianism have re-emerged; reverberations from global economic shocks are altering the terms of the social contract; and technological advance has made control of data into an increasingly valuable commodity.

The above might seem like an over-grand introduction to a report concerning Dudley's new model of care but, at some level, each of these trends touches the work being undertaken in Dudley to transform how healthcare is delivered by implementing an integrated model of care, by setting up a new organisation – the multispecialty community provider (MCP) – and by awarding a long-term contract worth £200-300m a year.

The length of this contract (10-15 years), alongside an ongoing sense that the NHS badly needs more longer-term thinking, led the Strategy Unit to propose the use of a scenario methodology as a means of future proofing the MCP. To the best of our knowledge, the Dudley health and care system has pioneered such an approach within the National Health Service's *New Care Models* programme. We believe that, while there are some isolated examples of scenario planning in NHS organisations, the scenario method has a much greater potential to help shape a more resilient and agile future for the NHS and its partners (not least at local level), and to assist current and emerging system leaders in seeing beyond the pressing challenges of today and the established ways of framing those challenges.

This report is a comprehensive summary from our scenario work with Dudley partners to date, although in a real sense Dudley's scenario experience (and the practical value that can be derived from it) has only just begun. At a headline level, this report:

- **Amasses a vast array of evidence.** Information presented here spans the immediate and local, alongside the long-term and global. Readers will find useful insights both on the thinking behind Dudley's MCP and on its broader context. In and of itself this is likely to be of value to multiple audiences;
- **Synthesises evidence around broad trends and critical uncertainties into a set of three divergent 'scenarios'.** Each of these scenarios narrates the evolution of a plausible future. The scenarios are not predictions and we claim no particular prescience. We do claim, however, that each scenario contains enough plausibility to constructively challenge the

status quo assumptions about the wider environment of the MCP that currently underpin its strategic logic;

- **Documents the process of what was, to many, a new experience.** The mode of thought required was to look at the MCP from the perspective of the external environment and to do so with the 'hindsight' provided by the scenarios. This contrasts with the usual mode of planning. We do not claim to have replaced this but we do hope to have added usefully to it; and
- **Records the new perspectives and reframed ways of seeing the priorities of the MCP that the scenarios provoked in participants.** Facilitating a different kind of conversation amongst local partners evidently produced different and refreshing results. Participants were able to set aside the quasi-adversarial character of standard NHS' interactions (characterised by the commissioner-provider split, inter-provider competition and funding tensions between NHS organisations and local government). With all partners able to take a neutral view of the divergent accounts of the future presented, participants continually returned to the original purpose, ethos and philosophy of the MCP, and to what they would need to do together (regardless of organisational allegiances) to deliver what is necessary for Dudley's communities. Participants repeatedly highlighted the necessity of making relationships between the MCP and Dudley's residents central to the culture and operation of the MCP, and they felt this needed to be given a higher priority within the current work programme.

The work reported here has a simple underlying logic and an intensely practical focus. Drawing on interviews with multiple local stakeholders and on significant documentation (local, national and international), we present a summary of the MCP strategy (why it is expected to deliver the transformation required) and identify key assumptions on which that strategy appears to be founded. These relate to:

- Workforce supply and culture;
- The availability and acceptability of technological solutions;
- The response of individual patients and the wider local community;
- Public sector funding levels;
- Government policy around health and care;
- Local demographics; and
- The effectiveness of contractual incentives.

What happens in relation to these assumptions over a 15-year period, and in the context of services that are already significantly challenged, is likely to be highly uncertain. To explore the

range of potential outcomes, therefore, we present a summary of relevant factors in the wider contextual environment that are likely to drive those outcomes. Those factors are then used to inform the development of three extended, plausible and challenging scenario narratives. These are not presented in full here[1] but can be briefly summarised as follows:

In the **State Supreme** scenario, the effects of enduring austerity have led to a desire for much greater state control over national life, especially the determinants of public health, wealth and wellbeing.

In the **Community Resilience** scenario, there has been a loss of public trust in the ability of both private and state bodies to address the nation's needs, leading to the resurgence of local community groups, both established charities and informal collectives, as one of the prime drivers in national life.

In the **Corporate Rules** scenario, the agreement of new trade deals with global partners introduces increased competition into English health and care services, leading to a large-scale move towards insurance-based provision with a minimal state safety net.

By helping local stakeholders to immerse themselves in these scenarios, this work has enabled participants to reflect on current plans from those plausible future perspectives and to begin considering how those plans might be made more resilient, more agile and more effective. In particular, they highlighted issues relating to:

- A genuinely transformational focus on responding holistically to the needs of Dudley's neighbourhoods; and
- A strengthened focus on the critical enablers of the MCP strategy's success, especially workforce supply and culture, and the effective deployment of technology.

Underlying these key themes is a detailed set of potential actions for local partners to consider (see Appendix 3 – Summary of Actions).

We are clear, however, that the value of this work will lie not so much in a published report as in how the scenarios continue to impact and reshape local thinking, planning and implementing. To

[1] Local organisations can access these from the Strategy Unit to support further internal work. External organisations interested in advancing similar work are also welcome to make contact with the Strategy Unit – www.strategyunitwm.nhs.uk.

that end, we conclude by recommending that local agreement should be reached on enabling additional local stakeholders to respond to the scenarios and on how the insights from this and subsequent work will be used to enhance the realisation of the transformational strategy to which all local stakeholders are evidently committed. Finally, and in line with the principles of the national vanguard programme, we also recommend that ways are found of sharing this scenario work and the insights it has generated with other health systems.

2. Introduction

2.1 The context

Dudley is one of fourteen vanguard sites nationally developing the Multispecialty Community Provider (MCP) care model. The MCP involves the implementation of new organisational relationships that are intended to result in new system dynamics. The nature, scale and impact of those dynamics cannot be predicted with certainty.

Elements of this uncertainty can be assessed and mitigated through standard risk management processes, and we understand that a thorough such assessment is underway by partners and will be externally audited.

Given the essential novelty of the MCP procurement, however, there are elements of irreducible uncertainty that are not amenable to standard risk assessments. Put simply, they are too uncertain for any estimate of probability to be meaningful. This is so not least because of the potential for multiple factors to interact with each other in unpredictable (and perhaps previously unencountered) ways. Risk analysis will generally only consider single risks in isolation.

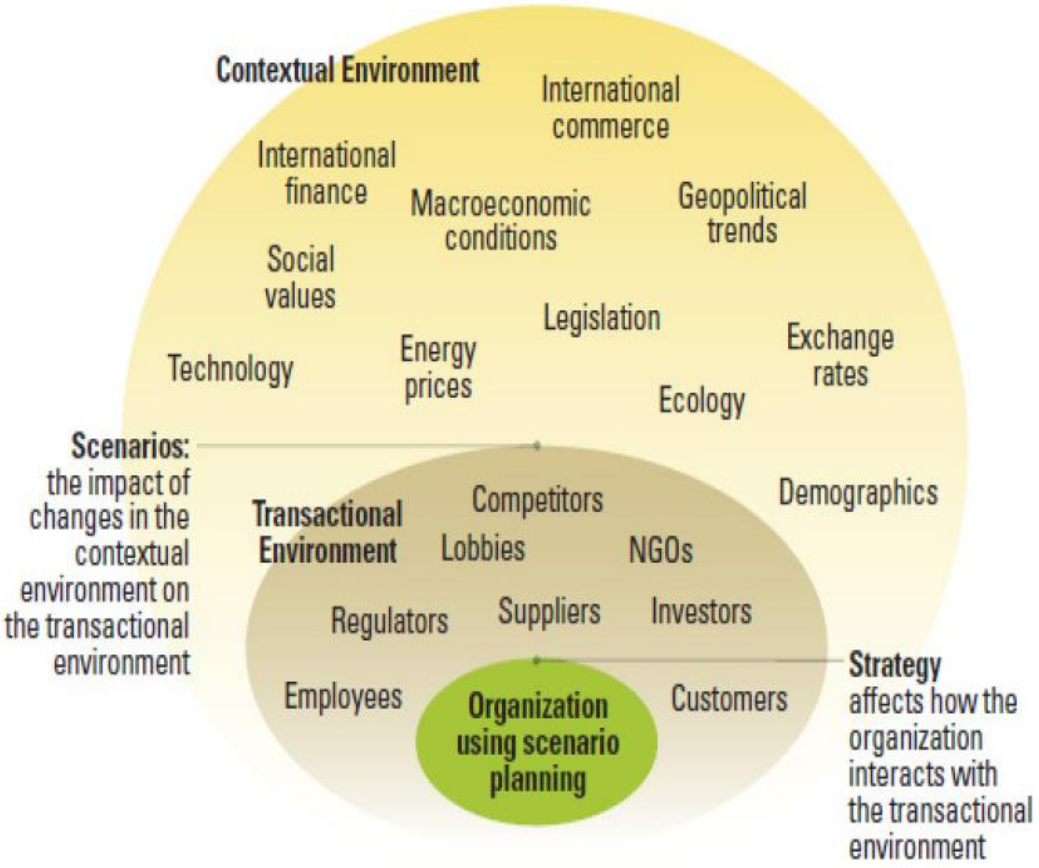
The MCP Programme Board has asked the Strategy Unit to assist it in considering a range of plausible futures that could evolve over the intended fifteen-year duration of the MCP contract, and to do so by using a scenario planning methodology. This scenario planning exercise not only provides opportunity to consider how changes to the wider context of the MCP (social, political, technological, economic, etc.) may affect the realisation of its intended outcomes but also to enable the identification by the MCP and the wider health and care system in Dudley (and beyond) of appropriate strategic responses (modifications and mitigations) to the potential futures described. The aim is to increase local awareness, resilience and agility in responding to evolving situations and to provide additional assurance to wide system partners.

2.2 Scenario planning

Scenarios are plausible descriptions of alternative futures that enable organisations to plan better for the present. Typically, a small number of contrasting scenario narratives are developed that form a method for articulating the different pathways that might exist for you tomorrow, and finding your appropriate movements down each of those possible paths; they allow you to make choices today with an understanding of how they might turn out.[2] Scenarios descriptions address the contextual environment in which an organisation operates (see Figure 1 - The contextual environment).

[2] Schwartz P (1991). *The Art of the Long View*.

Figure 1 - The contextual environment[3]



In the context of this project, the scenario planning approach involves the creation of plausible and contrasting future scenarios in relation to Dudley's MCP strategy. For Dudley stakeholders, the benefits of this work are expected to include:

- Improving organisational learning and agility in uncertain circumstances;
- Enabling the potential interactions of multiple factors to be explored;
- Providing a neutral, shared framework for partner discussions;
- Equipping partners, jointly and severally, to consider and to prepare for a range of eventualities (including those that might not otherwise be foreseen) –
    - Partnership Board can consider how decisions about the MCP might play out in different scenarios, and

[3] *Using Scenario Planning to Reshape Strategy*, MIT Sloan Management Review, Summer 2017 (Ramirez et al, 2017). https://sloanreview.mit.edu/article/using-scenario-planning-to-reshape-strategy/

- Individual partner organisations can use the same framework to consider how the MCP may affect them in various plausible futures, and how they might respond in such circumstances;

- Avoiding the potentially 'head to head' nature of different best/worst case scenarios being raised separately by individual partner organisations.

The fundamental aim is not at all to attempt predictions of the future but, by constructing a set of contrasting plausible futures, to review and refine the strategy and plans of today. The process is especially valuable in a context in which there is a good deal of uncertainty, and this is clearly (and necessarily) the case with the significant and novel procurement associated with the MCP. It is a tool for enhancing understanding, resilience, assurance and mitigation planning and consists of three key phases that are described below.

2.3 The process

2.3.1 Research phase

Initially, a single representative of each key partner organisations[4] was interviewed to explore:

- How the MCP is expected to deliver the desired outcomes;
- What assumptions this involves about the contextual environment;
- What key trends and uncertainties will be at play.

These interviews, along with reference to extensive existing MCP documentation and other relevant published sources, has supported the description of the theory of the MCP strategy and the exploration of the factors that may affect that strategy in its evolving content. This was enhanced by a small number of interviews with external experts in specific areas. This first phase is reported here.

2.3.2 Scenario development phase

Subsequently, the fruits of the research phase will be brought together in a workshop at which senior members of the Strategy Unit along with external experts will develop a number (of contrasting but plausible scenarios for how the MCP's contextual environment might evolve. The aim of these scenarios will be to provide a variety of future perspectives on the present: they will not be

[4] NHS Dudley CCG, Dudley Metropolitan Borough Council, General Practice, Dudley and Walsall Mental Health Partnership NHS Trust, Dudley Council for Voluntary Service, Healthwatch Dudley and Partnership Board Chair. Unfortunately, it was not possible to arrange an interview with Dudley Group NHS Foundation Trust during the limited interview window.

predictions or simply 'best case' or 'worse case' assessments. Scenario work can involve stakeholders to varying degrees: for this project, that involvement comprises initial interviews about the MCP and its wider context, then active engagement with scenarios developed by the Strategy Unit with additional expert input. Fuller involvement in the detailed development of the scenarios would have been ideal but the potential for this was limited by the demands (and constraints) of formal procurement processes.

2.3.3 Scenario deployment phase

This final phase is the most valuable, involving much more than simply the receipt of an output. The scenarios were presented to the Partnership Board in a workshop with additional participants from the CCG and from MCP bid partners. This formally took place as an element of the MCP procurement process. Participants were invited to assess how the MCP might be affected in each scenario and what might be done to mitigate the challenges and to maximise the opportunities arising. In reality, the value of the exercise will be found in the ongoing development and use of the scenarios, and we proposed that each partner organisation consider ways of deploying the scenarios within their own organisations to increase the system learning. Once scenarios are in use, many organisations also construct data-based 'early warning systems', enabling the MCP to identify whether any particular scenario is emerging. Where appropriate, the scenarios can also be quantified to support this.

2.4 Report

This report is a comprehensive summary of all stages of the scenario work to date:

- Section 3 begins with a narrative of the proposed Dudley MCP model, as described in documentation related to the proposal, implementation and early evaluation of the model. Summaries from interviews with members of the partner organisations have been included under the vision and key characteristics of the MCP model. Additional characteristics that were not part of the MCP documentation but were derived solely from interview data have been described towards the end of the section.

- Section 4 identifies and describes key factors from the wider contextual environment relevant to the MCP. These are derived again from interviews with members of the partner's organisations, as well as from other scenario literature and sources addressing the factors identified. These are enriched through the addition of summaries from interviews with national experts in selected areas of interest. The aim of these latter interviews is not to present a comprehensive account of pertinent factors but to seek novel perspectives to inform the subsequent scenario development phase.

- Section 5 describes how the scenarios were developed and summarises the key characteristics of each one.

- Section 6 summarises how the scenarios were presented to 30+ senior local stakeholders and how those stakeholders thinking was impacted by the scenarios.
- Section 7 proposes how local partners might take this work forward in order fully to realise its value.

3. The MCP Strategy in Theory

3.1 What is the problem?

The challenges facing health and social care services are well documented. As the nature and scale of demand for health services changes, supply of care is becoming increasingly constrained and remains largely unreformed. The financial challenges continue to place significant limits on supply of care. Changes in population need have not been accompanied by changes in the mode of provision. The care of the past was driven by episodic and curative interventions and this is in stark difference to the current proposition that involves providing care to an ageing population with multiple chronic conditions. Currently, services are not configured to address this shift in needs, nor are they sufficiently well integrated. Consequentially, this has resulted in a model of care that is unsustainable.[5]

Previous interviews with stakeholders[6] revealed a common set of issues facing the local system. Problems cited included:

- Fragmentation of different parts of the system, with services not meeting the changing needs of the local population;
- Imbalance of provision with hospital-based services favoured over services based in the community. Primary care was also considered to be under significant strain.
- Little emphasis on preventive care, with a need for more community and voluntary services, more proactive care, greater use of care planning approaches and the promotion of self-care;
- Presence of perverse incentives facing provider organisations;
- Financial unsustainability of the current system which means 'Do Nothing' was not seen as a desirable option.

The nature and scale of need is changing radically, with more of the population presenting a mixture of needs involving both medical and social care support. The CCG has identified through analytical and engagement work with patients, professionals and the public that different elements of the local population have different priorities[7]:

[5] Dudley New Care Model Logic Models (NHS Dudley CCG, 2016).
[6] Evaluation of the Dudley New Care Model Programme: Early Findings Report (The Strategy Unit, NHS Midlands and Lancashire Commissioning Support Unit,2016) Available at: https://midlandsandlancashirecsu.nhs.uk/about-us/publications/new-care-models/216-strategiclevelearlyfindings/file
[7] Dudley New Care Model Developing a Multispecialty Community Provider Value Proposition (NHS Dudley CCG, 2016) Available at: http://www.dudleyccg.nhs.uk/wp-content/uploads/2016/07/Value-Proposition-Dudley-CCG-FINAL.pdf

- Enhanced **access** to care - more flexibility in the time and mode of access. Improvements in access should result in improved patient experience and healthier lifestyles.
- Improved **continuity of care** - Those with long term conditions particularly want more consistent and proactive services that support them to manage their conditions and achieve their goals. They expect services to adapt to changing needs (mental and physical). Continuity of care should support stable long-term conditions management, reducing variation in care and inequalities.
- Better **coordinated care** - Those with multiple comorbidities, those with frailty and those nearing end of life, want services to work closer together, integrating (rather than duplicating) care closer to home and improving the experience of it. Coordination of care should enable people to remain in their own homes and receive support, whilst also reducing social isolation and ensuring people are connected to their community.

3.2 What is the solution?

3.2.1 The context

In October 2014, NHS England's *Five Year Forward View*[8] articulated a series of responses to the challenges being faced by the health system. The new care models programme was one of the most high-profile responses proposed by the report. Dudley was one of fourteen successful sites in bidding to become a vanguard for the Multispecialty Community Provider (MCP) care model. Dudley is also one of six sites working with NHSE to develop a contract for commissioning MCPs.[9]

The status quo – the doing of nothing isn't compatible with organisational survival or personal ability to continue working. We can't have everything done the way it's always been done. [Interviewee]

3.2.2 The vision

The patient is at the centre of the MCP model of care. The MCP will bring together the services of GP practices, nurses, community health and mental health services, community-based services such as physiotherapy, relevant hospital specialists and others to provide joined up care in the community.[6]

> *The people of Dudley are at the heart of our model. Our aim is to help them flourish: to support them when they need support; to guide them when they need guidance; and to*

[8] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[9] Evaluation of the Dudley New Care Model Programme: Early Findings Report (The Strategy Unit, NHS Midlands and Lancashire Commissioning Support Unit,2016) Available at: https://midlandsandlancashirecsu.nhs.uk/about-us/publications/new-care-models/216-strategiclevelearlyfindings/file

promote independence throughout. They are individuals and citizens first, patients and service users second. Our whole approach starts with this understanding and we are promoting a move away from paternalism and towards mutualism. Our model of care rests upon the unique position of primary care- starting with the person registered with the practice. The role of the GP is therefore fundamental. They take overall responsibility for the care provided by other services. In our model, these services include multidisciplinary teams, a wider network of community based and voluntary sector services organised around Dudley's five localities and the services provided on referral to secondary care.[10]

The MCP is responsible for four key areas of population health management[8]:

- Improving health status;
- Providing accessible urgent care (access);
- Providing joined up care for people with continuing needs (continuity);
- Providing intensive care for patients with the highest needs (coordination).

The person is in the centre with the services tailored around the person. GP is key to that. It's about making services more joined up, giving the continuity, coordination and access. You're going to have one main organisation as opposed to smaller organisations, with a common vision, values and coordination in delivering services. Overall it sets out to achieve the greater good for professionals and workforce, as well as people and their experience of services. [Interviewee]

The service scope sets out the full range of services to be provided by the MCP and includes[11]:

- Community based physical health services for adults and children
- Some existing out-patient services for adults and children including ophthalmology; urology; respiratory medicine; gynaecology; diabetic medicine; dermatology; rheumatology; general medicine and geriatric medicine amongst others
- Primary medical services provided by general practice
- Local improvement schemes currently provided by general practice
- Urgent care centre and primary care out of hours service
- Services currently provided as local improvement schemes
- All CCG commissioned mental health services
- All CCG commissioned learning disability services

[10] Dudley New Care Model Logic Models (NHS Dudley CCG, 2016).
[11] Service scope and service model for Multi-Specialty Community Provider (NHS Dudley CCG, n.d.) Available at: http://www.dudleyccg.nhs.uk/wp-content/uploads/2017/06/Service-Scope-and-Service-Model.pdf

- Intermediate care services and services provided for people assessed as having NHS Continuing Healthcare needs;
- End of life care;
- Voluntary and community sector services;
- Services commissioned by Dudley MBC's Office of Public Health including health visiting, family nurse partnership, substance misuse and sexual health services;
- Services currently commissioned and/or provided by Dudley Metropolitan Borough Council in relation to adult social care;
- Activities currently carried out by the CCG including, in whole or in part, service redesign; financial management; information technology; business intelligence, patient and public engagement, safeguarding, complex case management; NHS Continuing Healthcare and intermediate care assessment; and medicines management.

3.2.3 The benefits

It is expected that the MCP will bring together services in an integrated manner and use multidisciplinary teams as a means of supporting people in their homes and communities. The MCP will encourage working across all partners to enhance individual independence, prevent unnecessary admissions and facilitate speedy discharges.[12]

> *Everyone is going to want to make it work, whoever wins the contract, it's the biggest thing for Dudley. Dudley's not going to want it to fail. Partners are supportive of it, even though they may be protective of their own organisations and aren't sure what it means for their overall organisation. But I think everybody's on the same page in wanting it to deliver. The foundation and work that's happened over the last 3 years to get to where we are now hopefully will give it the building blocks it needs to grow. [Interviewee]*

The distinctive characteristics of the MCP are expected to be the following[10]:

- Physical and mental health services will be integrated;
- Out-patient services traditionally provided by secondary care will be delivered by the MCP;
- Primary care, delivered by general practice, will be at the heart of the delivery model building on the new contractual framework for primary medical services;

[12] Prospectus for the procurement and commissioning of a multispecialty community provider (MCP) (NHS Dudley CCG, n.d.) Available at: http://www.dudleyccg.nhs.uk/wp-content/uploads/2017/06/Prospectus-for-Procurement-of-MCP.pdf

- These services will operate within the MCP alongside voluntary sector services;
- The contract with a single special purpose entity will be based upon a single, whole population budget with a duration of 15 years;
- The MCP will have the right to determine how that budget is utilised to meet a set of outcomes;
- The contract will be designed to deliver those outcomes and will include a performance related payment mechanism.

3.2.4 The outcomes

Instead of units of activity, the MCP model will be based on commissioning for outcomes, with a portion of the total contract value (up to 10%) being conditional on the achievement of specified outcomes. Those outcomes are structured across four themes (see Figure 2 - Dudley MCP Outcomes Framework) and have a further level of specific outcomes incorporated within them.[13]

Figure 2 - Dudley MCP Outcomes Framework

[13] Outcomes Framework (NHS Dudley CCG, n.d.) Available at: http://www.dudleyccg.nhs.uk/wp-content/uploads/2017/06/Outcomes-Framework.pdf

3.3 How will this be achieved?

3.3.1 The Logic Model

A logic model has been constructed to illustrate the process of change through the MCP (see Appendix 1 – MCP Logic Model). This is supported by more detailed workstream-level models covering access, continuity and coordination.[14] Key elements of this logic model have been summarised into a generic MCP model (see Figure 3 - Summary MCP Logic Model)

3.3.2 Expectations

Early evaluation findings[15] document a *broad but not unanimous* consensus that the MCP model is right given the nature of local challenges. Means by which the model is expected to work include[13]:

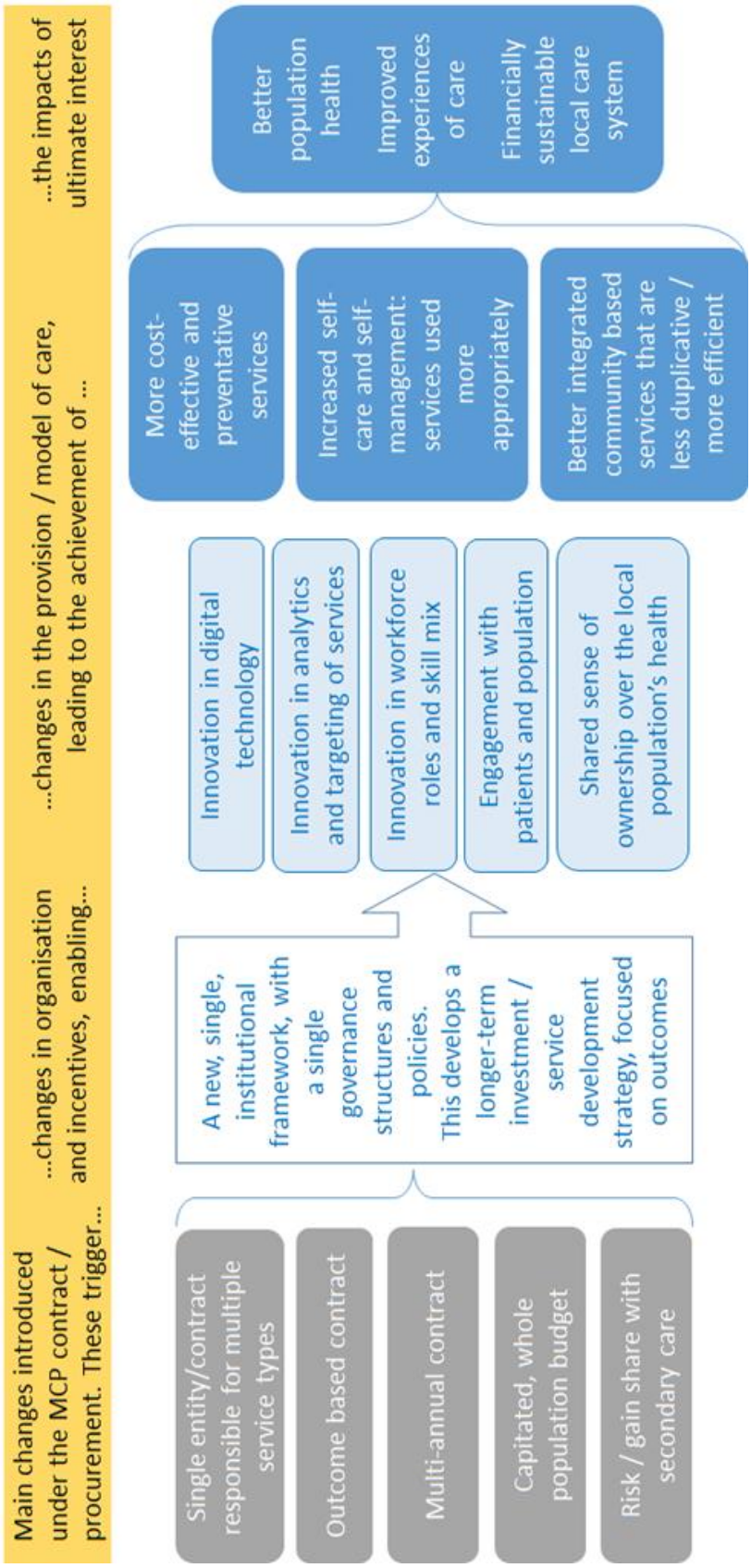
- Integrating the right services. Bringing currently separate services, teams and professionals together under a single (contractual/institutional) framework;
- Creating the right incentives. Three main features of the MCP model were seen as having an effect on provider incentives (and so behaviour): a single, long-term contract; a focus on population level outcomes; and a capitated budget;
- Changing the delivery of care. A greater focus on prevention, integrated community-based provision and patient-centred care planning; and
- More strategic commissioning. With an MCP in place, the CCG and Local Authority would have an opportunity to concentrate on their more strategic commissioning functions, rather than day-to-day contract management.

3.3.3 Key characteristics

The key characteristics of the MCP are described below, based around the review of a range of formal documentation. Additional characteristics that appeared during interview analysis but were not part of the MCP documentation have also been incorporated on the basis that they were considered equally relevant to the MCP. Direct quotes from interviews with members of partner organisations have also been incorporated, alongside summaries of interview findings.

[14] Dudley New Care Model Logic Models (NHS Dudley CCG, 2016)
[15] Evaluation of the Dudley New Care Model Programme: Early Findings Report (The Strategy Unit, NHS Midlands and Lancashire Commissioning Support Unit,2016) Available at: https://midlandsandlancashirecsu.nhs.uk/about-us/publications/new-care-models/216-strategiclevelearlyfindings/file

Figure 3 - Summary MCP Logic Model



The organisation

a) Single legal entity

The MCP will be a single legal entity, commissioned by the CCG and Dudley Metropolitan Borough Council and holding a single contract, based upon a whole population budget. It is not a partnership or alliance of separate providers.

The advantage of the MCP is that it is an antidote to the need to reform. We're being locked into a 10-15 year long term contract which is designed to ride out some of the short term reorganisation the NHS suffers from, and therefore have some long term stability within the health and social care system that we are crying out for. [Interviewee]

The contractual form entered into will have the flexibility to provide for the inclusion of primary medical services currently provided under GMS, PMS or APMS contracts, in accordance with the national MCP framework, through a "partially integrated" or "fully integrated" service model. The fully integrated version includes all primary medical services within the contract.

Interview findings

- Currently multiple organisations are working on multiple contracts. The integration of health and social care through the MCP should allow for a single approach to commissioning.
- A fifteen-year contract ensures finances are secure for the programme and not at risk of being redirected to other local health initiatives.
- The contract encourages sustainability of the programme and may buffer against changes that are inevitable over a 15-year period.
- The contract combats the difficulties and problems that may arise as a consequence of frequent short-term reorganisations.
- Longevity of the contract provides opportunities for better planning, consistency and stability which may allow time for benefits of the programme to emerge.
- However, we should consider more incentives for the achievement of certain kinds of contractual behaviours/outcomes.
- The potential inflexibility of a long-term contract and the risks associated with its high value is of particular concern.

b) Commissioned to deliver outcomes

The MCP will have a compelling vision and clear strategy for managing and delivering clinical, patient and service user outcomes as specified in its contract. The MCP will have the "right of decision" in terms of determining how the whole population budget is allocated to deliver contracted outcomes.

Probably the key outcome we're trying to achieve here is better health in the population and also trying to get people to take more responsibility around their own health and wellbeing. So I think we need to gear the contract to ensure those outcomes. [Interviewee]

Interview findings

- The MCP sets a population wide focus, giving the NHS partners key health outcomes to work towards achieving.
- Previously providers have worked on numbers and activity-based contracts. This programme will see the implementation of an outcomes-based contract. This is a completely new way of working for providers. Ideally this should improve patient experience and outcomes.
- The key outcome the programme is aiming to achieve is improved population health and a reduction in health inequalities. There is also an effort towards instilling accountability amongst people for their own health. 15 years is a significant length of time to make improvements, particularly to the poorest of populations, who currently have poor health outcomes.
- Should we consider conducting periodic reviews to performance manage the MCP and its achievement of the intended outcomes?
- There needs to be assurance that the money will be spent in a different way to how it was spent previously. By doing nothing, the health outcomes for people will not improve.
- The outcomes framework is good but weak on mental health.
- Key questions and tests for the MCP- "Has it achieved the health outcomes that it intended to achieve?" "Have we delivered better health outcomes for patients?" "Has there been an improvement in patient outcomes?" "What is the impact on patient behaviour?"

c) Focus on quality and safety

The MCP will be expected to demonstrate the highest level of commitment to service quality and patient safety.

The quality of services will be measured differently by the new MCP contract. [Interviewee]

The MCP is population-based and founded upon list based general practice. A core function of the MCP will be to support a primary care led model of care incorporating GPs as a significant component of the leadership model for the MCP. The MCP will be an engine for the strengthening, renewing and sustaining general practice. The MCP brings together a wide range of integrated services around general practice, removing historic barriers to care delivery.

e) Governance, leadership and public accountability

The MCP is based upon the principle of mutuality:

- Clear accountability to the public for the delivery of high-quality care within the resources available;
- Emphasis on co-production of care and maximising the potential of the individual;
- Promoting responsibility for individuals to manage their own health and wellbeing and to access services appropriately.

The benefits of the MCP will be realised through good governance, through keeping its eye on value for money. [Interviewee]

The MCP is a community-based organisation. Unlike any other existing NHS organisation of this scale, patients will register with it. Its success, in part, will be based upon the development of strong local relationships with, and trust from, the community it serves. Beyond the provision of integrated health and care services the MCP will have wider responsibilities as a:

- Catalyst for improving the health and wellbeing of the local population;
- Good "corporate citizen" and agent of social value;
- Good employer;
- Significant player in the local economy.

It will be accountable to key local stakeholders through a variety of mechanisms. Stakeholders will include:

- Patients
- The public
- MCP staff
- The CCG
- The Local Authority
- Regulatory bodies
- Local employers
- Civil society

Other accountability mechanisms, aside from contractual responsibility to the CCG and Council, regulatory accountability to NHS Improvement, the CQC and the exercise of the Council's scrutiny function, will include:

- Clear statements to patients and the public of the service standards they can expect;
- An annual report which will include its performance in meeting these;
- A "contract" with the Health and Wellbeing Board to improve the health status of the population through the use of a population-based budget and agreed outcome measures;
- Reference groups derived from the local population to help determine how limited resources should be spent and how community assets can be mobilised to create resilience;
- Clear links to the voluntary sector and a role for the sector in decision making;
- The use of patient feedback to enhance the care experience.

People

a) Values

The MCP will be a values-based organisation, where strong patient centred values are a mechanism to drive improvements to the quality of care and the experience of the patient. Organisational values, staff values and societal values will be congruent and consistent with the finest features of public service in general and the NHS in particular.

The MCP is big in scale but it's imperative that the patient is kept central to the model, that patient's needs are recognised and that the services offered are appropriate to their needs. [Interviewee]

I'd want to know if value is still important to the workforce- do they feel valued? Bringing organisations and workforce together, different boundaries and skills, set of staff…We've probably already lost people because they don't feel a sense of security in the MCP but actually this does create a lot of opportunity. [Interviewee]

b) The best place to work

The MCP will be a major local employer. Its employment practices will make it the employer of choice for staff. It is anticipated that it will seek to recruit, train and develop staff from amongst the local population. In interviews we heard that:

The MCP will realise its benefits by making jobs more attractive for recruitment of the workforce.

Staff with high workforce satisfaction generally deliver a better service to patients. Therefore if staff are happy they will stay in Dudley, and we create sustainability within Dudley healthcare system. Organisations with high staff satisfaction have less turn over, lower sickness levels, better efficiencies.

c) Workforce development

The MCP will identify, recruit and retain an appropriately skilled and adaptable workforce ensuring there is on-going commitment to workforce development and an emphasis on joint working, supported by a culture of collaboration, quality and patient care. Staff will be empowered through a model of distributed leadership where they take responsibility for their performance and hold each other to account. Clinicians and managers will be supported to work in different ways as part of multi- disciplinary teams, making use of new roles.

Interview findings

- Success of the MCP is dependent upon "a good, strong, engaged workforce." This in turn is dependent upon training opportunities.

We know primary care workforce across GP, nursing services in primary care, as well as practice managerial structure is a very aging population (10% GPs over 65 already, 26% over 55, 20% intend to retire earlier, 30% intend to reduce number of sessions they work – all based on feeling of not being able to carry on with current workload. Same also applies to nurses and practice managers). [Interviewee]

- The MCP aims to create a greater scale of workforce across the individual clinical specialties- primary care, community services, hospital-based services- that intend to deliver services in the community. This will contribute to better workforce design and improved sustainability of the community-based model.

Primary care needs to understand that the way they've changed working practices (moving towards MDTs) will have to continue through various other iterations. They have to understand that they have to come together to work at scale in a variety of different ways – this might be facilitated by becoming totally integrated in the MCP or by being partially integrated where they retain GMS contract but bolt on MCP part that enables them to work in the way the organisation needs. [Interviewee]

- The length of the contract is likely to see significant changes in workforce, particularly shortages in critical clinical staff, including GPs. The health service is facing a shortage in recruitment of skilled staff, a persistent issue with retention of trained staff and the numbers of those in training for skilled positions is declining. The majority of services are facing similar workforce challenges.

- Development of the future workforce is key.

If you can't attract people or keep them, then I think the MCP has possibly failed. If you don't have the best people working in a locality, the quality of care is not going to be as good. You want to attract, retain, keep not lose, passionate, skilled people because they will deliver the best care. [Interviewee]

- One key benefit the MCP is seeking to deliver is a variety of career opportunities, with opportunities for staff to gain multiple skills and operate in "hybrid roles e.g. health visitors trained to recognise mental health issues." The MCP should see a move away from single discipline trained staff. This is however, dependent upon effective training, which requires the MCP to collaborate with universities and training organisations.

- Although national policy proposes recruiting more clinical staff through medical schools, it will take at least 11 years for current students to become fully qualified GPs.

In the short-term workforce may be a big black hole and it will be financially difficult because the NHS may have to go down the route of local agencies and temporary staffing, which costs more in the long term, than having the substantive staff to employ. We don't have enough staff for what is expected of us. [Interviewee]

- A key question and test for the MCP- "Are we able to retain high quality people, running and supporting the health and social care system of Dudley?"

- The MCP offers an opportunity for staff to practice more joined up working, elements of which have already been implemented through the introduction and operation of multidisciplinary teams. The workforce is beginning to respond to the challenges and is using MDT meetings as a way to "focus on the patient as a whole."

The way that it will work will enable professionals to work together. Teams of people will work across organisational barriers- what we call our MDT teams but the MCP will create opportunity for everyone to work together in the best interest of the patient. [Interviewee]

- MDT meetings are face-to-face and provide an opportunity to discuss what's in the patient's best interest and how the different expertise across the system can be used appropriately and effectively.

New ways of working, MDTs, integrated plus, all the stuff that's happened, is a different way of working to where we were 3 or 4 years ago, so some of the workforce changes have happened in different ways. There's been evidence to prove the difference these new ways of working have made, evidence that it works not only to the system but also to people and their lives…they could potentially cross over on some professional boundaries, they can look at people holistically. [Interviewee]

- Although MDT's have so far proved to work well, there needs to be assurance that there is no duplication of conversations about patients across multiple MDTs. To this end, communication channels (including IT systems), need to facilitate effective MDT working.

- Lack of attendance at meetings is an issue that requires attention. A single approach as oppose to multiple approaches to MDT's also needs to be established.

- A key question and test for the MCP- "What new types of workforce models have come about as a result of the MCP? Have we moved away from the traditional model of working?"

Bringing together of clinicians and other health professionals from a variety of other health organisations – currently no incentive for the hospital trust through to community services to benefit, by working together in the primary care infrastructure whereas moving forward as one organisation incentivises the different component to work more collaboratively in order to see the overall organisations success. [Interviewee]

Relationships with the local system

The contract will place a requirement upon the MCP to cooperate with local partners and stakeholders.

a) Joint commissioning by the Clinical Commissioning Group and Local Authority

The CCG and the Council will be the MCP's co-commissioners as part of an evolving partnership between these bodies. Subject to the outcome of consultation by NHS England on the national contract, a single contract will be held with the MCP as a defined legal entity. Appropriate arrangements will exist where services are commissioned jointly with the Council. The contract term will be up to 15 years. The MCP will be held to account for the delivery of the outcomes set out in the contract through appropriate contractual management mechanisms. In addition, a number of existing CCG functions will be delivered by the MCP including:

- Safeguarding
- Patient and public-engagement
- Medicines management
- Financial management
- Business intelligence
- Service redesign
- NHS Continuing Health care and intermediate care assessment.

b) Centrality of primary medical service providers

As a list-based entity the MCP will have general practice at its heart. The aggregation of the populations of those practices opting to integrate with the MCP through the partially or fully integrated route, together with nonregistered Dudley residents, will constitute the MCP's population upon which its budget will be based.

For Council commissioned services, the MCP will serve the resident population of Dudley Borough. Whilst it is the clear intention of the CCG that all Dudley responsible practices should be "members" of the MCP, where this is not the case, the CCG will contract separately with the MCP to deliver services to the populations of those "non-member" practices.

c) Partnership with other providers

The contract will define the nature of the relationship the MCP will have for those providers delivering non MCP services to the Dudley population. This will include appropriate gain/loss share agreements. In some instances, the MCP will have sub contract arrangements in place with these providers. In other instances, services with contracts which run beyond 1 April 2018, will be within the scope of this procurement with those services becoming the responsibility of the MCP upon the expiration of existing contracts. These will include:

- Dudley Urgent Care Centre
- Contracts with NHS providers for services in scope
- End of life care
- Intermediate care
- NHS 111
- Voluntary sector organisations providing scope services
- Dudley MBC commissioned health services.

There are a lot of opportunities for public health within the MCP, in terms of helping to shape it and helping to make it more connected to the local population. [Interviewee]

It's also important that we get public health engagement because I think what we're trying to do is deliver care at a more local level so that it's not a hospital centric system, it's a GP centred locality system, so there's kind of a redistribution of resource, and in that we're also trying to get people to take more responsibility about their own health and wellbeing and I think there is therefore a public health role to get that part of the dimension in. I think that's a key element of the success of this model that we do get people to take accountability for their own health and adopt more healthy behaviours, so Public Health is quite key as well. [Interviewee]

Interview findings

- Engagement of public health is imperative to the success of the MCP model. Public Health is capable of offering expertise to ensure that the pathways and priorities are centred around the local population and that adequate attention is given to prevention, as well as treatment.

d) Integration of health and care services

- Children's social care will not be provided by the MCP at the present time.
- The MCP will recognise, value and promote the role of social care and social work in the delivery of the service model and the contribution both can make to overall health and wellbeing
- Dudley CCG and Dudley MBC will develop a plan setting out how health and social care will be integrated by 1 April 2020, in accordance with national requirements. The MCP will be the main delivery mechanism for achieving this change.

e) Community mobilisation

The MCP will empower and mobilise patients, their families, carers, communities, local employers and the voluntary sector

There is a growing body of indicators which estimate the economic value of contributions made by different elements of voluntary activity, including: volunteers; carers; voluntary and community sector organisations.

The MCP will work effectively and collaboratively with the voluntary and community sector ensuring there is parity of esteem between sector led services and initiatives and traditional health and care services. The MCP will work in partnership with the Council and other stakeholders to tackle the wider determinants of health; health inequalities; and build community capacity and resilience. In addition, it will work with other public service partners such as the police and fire services to develop innovative solutions to improve health and wellbeing

Through active patient engagement and community involvement, the MCP will support participation by both individuals and communities in decisions about their health and care services, as well as promoting education, self-management and peer support. In this respect the MCP will be expected to work closely with Dudley's Young Health Champions.

> *There is not much conversation about how the MCP is going to work effectively with the [voluntary] sector and what's the expectation of the sector over the next 10-15 years. We need to understand how we invest in this sector, and how we utilise resources across the*

system as a whole to enable people to do more e.g. are free rooms available, utilise more physical assets across the system as a whole to support voluntary services. Voluntary services can help with innovation and delivering services in sector but need to create space and time to have those conversations to take place and for the sector to look at what the solutions could be. [Interviewee]

Interview findings

- The main benefit of the MCP is that services will be delivered in the community and closer to home, with support from non-clinical staff and access to peer networks and social activities.
- It's important to engage and involve local councillors and politicians, making sure that communication and transparency is maintained as much as possible. The fact that some politicians may be opposed to the idea of the MCP needs to be acknowledged.
- The local authority may be concerned about giving up political power in order to be part of the MCP movement: "What does it mean for us to release power into an organisation that could be existing for 15 years?"
- Engagement of the voluntary sector is also key to a successful MCP, particularly as the voluntary sector harbours valuable information from working directly with the public, "on the ground." The MCP aims to take the pressure off primary care by redirecting appropriate referrals to the third sector. There is therefore an expectation that the voluntary sector will play a key role in the MCP.
- There needs to be more communication about how the relationship with the third sector will work.
- The voluntary sector is currently struggling to cope due to high demand, reduced capacity and insufficient funds. There has also been a rise in non-clinical needs of patients e.g. isolation. Their sustainability in the future remains uncertain due to cuts in LA funding. Many referrals are re-directed to social care which is creating pressure as the capacity to deal with these referrals doesn't exist.

The MCP will have a clear community identity and presence consistent with Dudley's five localities. Services will be delivered from accessible community-based locations consistent with the CCG's estates strategy. These will support the movement of services traditionally delivered in hospital to community settings, whilst recognising the need to deliver some forms of care in settings that do not create stigmatisation. Some of these services may be the responsibility of other providers but they will be co-located with MCP services.

The MCP will operate in accordance with the requirements of the Public Services (Social Value) Act 2013 and identify opportunities to secure wider social, economic and environmental benefits from its activities.

Service delivery

a) Coordinated processes

The MCP will ensure clear processes are in place, enabling coordinated service delivery and alignment across partner organisations delivering health and care services.

We don't know who it is going to be, we don't know how they're going to change things, we don't know how all these services that are under individual contracts, will come under one umbrella, the staff- who are they going to be employed by. How is this going to be embedded to ensure it works appropriately to achieve the overall vision and the outcomes and benefits we want for people? [Interviewee]

b) Key principles for team working

Effective integrated and coordinated care will be underpinned by a robust operational model. Common working principles will be established to enable teams to operate on the basis of:

Interview findings

- Seven-day working should support improved access for patients.
- There remains uncertainty about multiple parts of the process.
  - Shared values
  - Shared vision
  - Shared population
  - Shared decision-making
  - Shared responsibility

Interview findings

- The MCP will encourage joined up working across clinicians and non-clinicians, creating a culture conducive to sharing of skills, expertise, ideas and solutions.
- The co-location of multidisciplinary staff from different organisations in one building will encourage joined up working.
- A key question and test for the MCP- "How are we working smarter, together – how do we measure this?"

Use of digital technology

Technology will be used to redesign care, provide interoperable records, modern business intelligence and data analytics.

> *There's a piece of work to be done to actually transfer all of the staff on to the same system…and create a solution where the MCP and providers are working on systems with other providers. [Interviewee]*

Technology and integrated care systems are used to enable the delivery of outcomes, ensure that care is centred on the patient and information is used to support and manage service improvement.

Additional key characteristics are as follows:

- A single central repository of shared information accessible by all members of the MCP and patients;
- Integrated care records, updated in real time and centred around the individual;
- Multiple patient access channels;
- Able to support multiple teams and extend to meet future service integration supporting collaboration across teams and organisations;
- Risk stratification to include primary and secondary care data;
- Advanced analytical capabilities enabling pattern and anomaly detection;
- Clustering and building predictive models to improve patient outcomes and reduce costs;
- Capability to support integration with emerging technologies and apps;
- Single sign on and role-based access controls;
- Electronic delivery of documentation across the system;
- Scalable infrastructure solutions with inbuilt resilience, preferably in the cloud;
- High data quality standards, policies and processes applied across the system, ensuring data quality principles are adhered to;
- Flexible and powerful business intelligence and reporting tools to meet current and future reporting requirements, including performance, financial and management data both internally and for the CCG;
- Data sharing enabled via a system wide Information Governance Protocol and data sharing agreements with Information Governance standards meeting NHS IG framework requirements;
- Implement Epacs system in line with digital roadmap timescales;
- Implement processes and technological solutions for the Integrated Referral and Information System (IRIS);

- Meet all requirements to support the local digital roadmap.

Interview findings

- IT systems need to be conducive to effective implementation of the MCP. This includes consistent IT infrastructures across all organisations that enable information such as care plans and records to be shared.
- Effective IT systems should reduce duplication; enable effective communication and team working.
- Technology has some useful applications in both prevention and treatment. On the prevention side, technology offers access to health monitoring functionalities through wearable devices and phone apps. This could potentially help to improve the health of the population. E-cigarettes are also proving a healthier alternative to tobacco and may lead to improvements in health.
- On the treatment side, alternatives to face to face consultations are proving a popular, cost effective option. The potential of telemedicine needs to be better understood and utilised. Artificial intelligence also presents further opportunities, particularly for the care of elderly patients where robotic assistance may be an option: "In 15 years' time it might be that certain tasks of health and social care are provided by artificial means."
- Technology (specifically social media) has potential to help with the problem of isolation amongst patients.
- Technology also has potential in assisting patients with self-care.
- Deprivation may interfere with access to technology. The digital divide may also leave some members of the public deprived from such technological benefits.

Service delivery model

The model of service delivery will be built on the three pillars of access, continuity and coordination:

- The majority of our population want enhanced access to care. They want more flexibility in the time and mode of access;
- Many, especially those with long-term conditions (LTCs), want improved continuity of care. They want more consistent and proactive services that support them to manage their conditions and achieve their goals. They have needs (mental and physical) that are independent and that change; they expect services to do the same;
- Some, notably those with multiple co-morbidities, those with frailty and those nearing the end of life, want better coordinated care. They want the services that are supporting them

to work closely together, integrating (rather than duplicating) care closer to home and improving the experience of it.

a) The centrality of General Practice

This represents a fundamental shift in providing care to an ageing population with multiple chronic conditions in an integrated manner, as opposed to supplying the predominantly episodic and curative interventions that typifies care at present. The MCP's service delivery model addresses these imbalances. It is based upon the unique position of primary care - starting with the person, registered with the practice with the role of the GP being fundamental. General practice takes overall responsibility for the care provided by other services. These services will include multi-disciplinary teams (MDTs), a wider network of community based and voluntary sector services organised around Dudley's five localities, and the services provided on referral to secondary care.

b) Pathway management

Outside the MCP the CCG will commission value-added treatments provided from secondary care services. We are changing the way that we commission these services. This means moving away from current item-of-service payment mechanisms to commissioning best practice pathways of care. We expect this to form part of a gain sharing arrangement between the CCG and the MCP in the future as the MCP takes on the demand management of value added treatment services. In essence, the MCP will be the catalyst to shift the locus of care from the hospital to the community.

100k emergency contacts a year at hospital but over a million on the day appointments in primary care. All it needs is a few percentage shifts and that catastrophically impacts on the emergency department. [Interviewee]

Interview findings

- A previously acute led system now has the opportunity to deliver care to patients, closer to home: "community where possible, hospital where necessary."
- In order for the MCP to work, there needs to be acceptance of a new configuration of services, where services will move from the hospital to the community. There will be financial risks associated with this and work will need to be done to mitigate these risks.
- There needs to be acknowledgement of the interdependencies in the system- "Primary care could be damaged by work being pushed out into the community without it being supported."
- There needs to be a shift in resource (finances, expertise and configurations) to manage patients with complex comorbidities (mainly the elderly) in the community setting as opposed to hospital.
- Community nursing services will also require careful integration into the community and primary care- "Community nursing has not delivered effectively."
- Other hospital services will also need to be moved to community-based models: "dermatology, diabetes, MSK, Ophthalmology."
- The benefits of the MCP are dependent upon tackling immediate priorities, which include addressing the problem of long waiting lists and preventing potential financial instability to Dudley Group NHS FT, which may occur as a consequence of shifting services into the community.
- Alignment of clinical and non-clinical pathways with benefits for patients.
- Key questions and tests for the MCP- "What does primary care look like as a result of the MCP?" "Is patient care much more managed by primary care because at the moment it's very much hospital driven?"

c) Continuity and coordination at every level

Dudley's population requires improvements in access, continuity and coordination. This understanding therefore provides a set of organising themes for the MCP. These themes can then be used to inform improvements at multiple levels: from the individual, up to the GP and the practice, to the locality and whole system. Indeed, we see acting at multiple levels as a pre-condition for our success.

We feel the whole thing could be substantially more efficient with less barriers, less silos and less divisions in making decisions for people and with people. [Interviewee]

The MCP starts with the person, registered with the GP who then brings in and coordinates services in the community – including those provided by the voluntary sector.

Interview findings

- The MCP is about a move away from silo working and towards co-ordinated service delivery for patients- "There's evidence to prove that despite the challenges there's some real good outcomes for people."
- Multiple agencies making decisions for patients in silo, has created problems for the health service. Lack of coordination between health and social care has also resulted in a rise in expenses for health care.
- Organisational boundaries need to be broken down in order for care to be delivered in a more coordinated manner- "clinic without walls' approach, gives better ability to treat patients consistently, public don't recognise individual NHS organisations just the NHS."
- Patients are commonly suffering from "isolation, loneliness, low level mental health, anxiety, depression." The MCP has the opportunity to connect these patients to services like integrated plus that can subsequently manage contacts with third sector organisations. This will reduce burden on GP appointments and home visits.
- A key question and test for the MCP- "How does the system fit together? Patients that were repeatedly accessing the wrong services, are they now in a system that manages them more effectively in accessing the right services?"

d) Empowering patients to set their goals and manage their own care

The MCP will reshape the relationships between services and citizen. Healthcare's success has been founded upon the specialist training and knowledge of clinicians. However, we have not made sufficient use of the specialist knowledge and experience of our patients. Only they can define the goals that matter to them - and only they will know whether and how possible courses of treatment will fit with their lives. The MCP will combine these types of knowledge, especially when it comes to managing long-term conditions and combinations of mental and physical health needs.

We've got to make sure people are empowered to play their part, for them to take some responsibility and for them to recognise they can do things themselves. People have to recognise different parts of the service and know how to navigate it. [Interviewee]

Interview findings

- The key outcome aiming to be achieved by the MCP is improved health of the population, through patients taking more responsibility for their own health and wellbeing.
- In order for the MCP to work, there needs to be an element of demand management – working with patients who are particularly high users of services. There may be value in looking at the influence of wider determinants of health such as "poverty, lack of social infrastructure, loneliness" that translate into inappropriate use of health resources.

Interview findings

a) Sustainability

- Exaggerated assumptions about cost savings lead to unsurprising failures in their achievement. The NHS is rife with examples of overstated cost saving assumptions.
- It will take several years for the intended outcomes to be realised and to see noticeable changes. The first few years of the programme will therefore require "an act of faith" and upstream investment in preventative strategies, in order to see the benefits downstream. But investment upstream, combined with costs of keeping the system running may incur great expenses instead of achieving cost savings.
- If the MCP does not deliver in the short term (3-5 years), this will put pressure on the programme, its partners and others involved. It will also put pressure on system leaders to deliver more than intended in order to prove the MCP has not failed.

Did the 15-year contract hold due to planning assumptions from different sectors? Did it give the ability to shape what we have or were we driven to a place because of national policy, and we've had to change it? Have we had to do contract renegotiation – various regulatory bodies span the programme – how will they react to their organisations being locked into a 15-year contract if the same level of financial pressures and quality pressures continues? [Interviewee]

- Without the financial incentives to reward health promotion activities, population health will remain unaffected and this 15-year contract will be no different to the current situation.

It's important that there are people in the MCP who are keeping a long-term finger on the pulse and looking ahead, looking at how the whole system works, as oppose to trying to trouble shoot specific problems. [Interviewee]

- There will be significant impacts on organisations involved with the MCP, including Dudley Group, Dudley and Walsall Black Country Partnership and Dudley CCG. The way that these organisations are commissioned will change, along with their remits and working cultures.

Dudley Group will go from being an acute community provider to just an acute provider. [Interviewee]

b) Engagement of all partners

This is a population wide, NHS wide, local authority wide approach we're talking about, by getting all the partners in the same room, and therefore there's a much stronger opportunity to have a less fragmented system and more opportunity to have a healthcare system that embraces population health. [Interviewee]

- All the relevant people need to be part of the MCP and committed to it, in order to ensure effective wider collaboration- this is still not the case. Wider collaboration is imperative for understanding the intricacies of the relationship between the MCP and social care.

There needs to be acceptance and then buy-in from the various components that are coming together. [Interviewee]

- The voices of all parties need to be heard in order to ensure their commitment throughout the contract period. This includes their input in decision making. GPs in particular have knowledge about patients that may be valuable in informing decisions about service delivery.
- Engagement of clinicians is vital to ensure a change in culture and behaviour that is conducive to the MCP model.

The first thing it needs to do is to be able to get through the next 12-month assurance process, so it needs to be given support by NHSE and NHSI. But then once it is in place it needs to work in partnership with the other providers and the council and the CCG and other organisations so that it can be as successful. One of the benefits of having providers like Dudley Group involved is that they can enable that to happen. It needs to be developed in partnership with all those organisations and stakeholders because nothing can survive on a silo on its own, that why we're doing this because what has happened in the past hasn't worked. [Interviewee]

- A key question and test for the MCP- "Are all partners still involved – new model, untested contract that will challenge everybody involved to think differently. How do you manage risk-share?"

3.4 Problems so far

Significant changes in care and resulting outcomes for the population are likely to follow only after the MCP provider is established. However, work that has already been done to prepare the system for the MCP has resulted in some early signs of outcomes.

At the same time, implementation of the new care model has been challenging work that has raised some issues for the local system, including the following[16]:

- Work to establish the MCP has raised organisational conflicts and system risks;
- The CCG-LA relationship is generally strong;
- Further work is needed to clarify the elements of the MCP model in more detail;
- More needs to be done to prepare Primary Care for participating in the MCP; and
- The Partnership Board is not realising its full value.

[16] Evaluation of the Dudley New Care Model Programme: Early Findings Report (The Strategy Unit, NHS Midlands and Lancashire Commissioning Support Unit,2016) Available at: https://midlandsandlancashirecsu.nhs.uk/about-us/publications/new-care-models/216-strategiclevelearlyfindings/file

4. The MCP Strategy in Context

In this section we highlight the key assumptions that, from a review of written sources and stakeholder interviews, appear to underpin the MCP strategy in the sense of being critical enablers of its success. We also identify and explore key contextual factors that may support or challenge those assumptions.

4.1 Key assumptions

The theory of the MCP strategy, as defined above, embodies a logic for how the actions the MCP is expected to take will lead to the desired results (see Figure 3 - Summary MCP Logic Model). Underlying that strategy and logic is a range of assumptions about why this will be the case.

The following have been identified as the most critical assumptions relating to the envisaged success of the MCP over the duration of the contract:

a) The required **workforce** can be sourced (supply will be of the necessary scale and type) and will be willing to work in the required ways (changes to working culture and practices will be achieved);

b) **Technological solutions** can be delivered and will be acceptable to users (staff and patients), and medical advances will not simply increase demand on resources;

c) **Patients** will comply with the new model of care (accepting more local care, taking greater responsibility for lifestyle improvement and self-care and accepting data sharing between providers) and local communities will participate in becoming more resilient and creating greater social capital;

d) Total net annual changes to health and care **funding levels** will not be materially different from the recent past – including for local government and the third sector – and the MCP can be protected against the short-termism of annual NHS budgets;

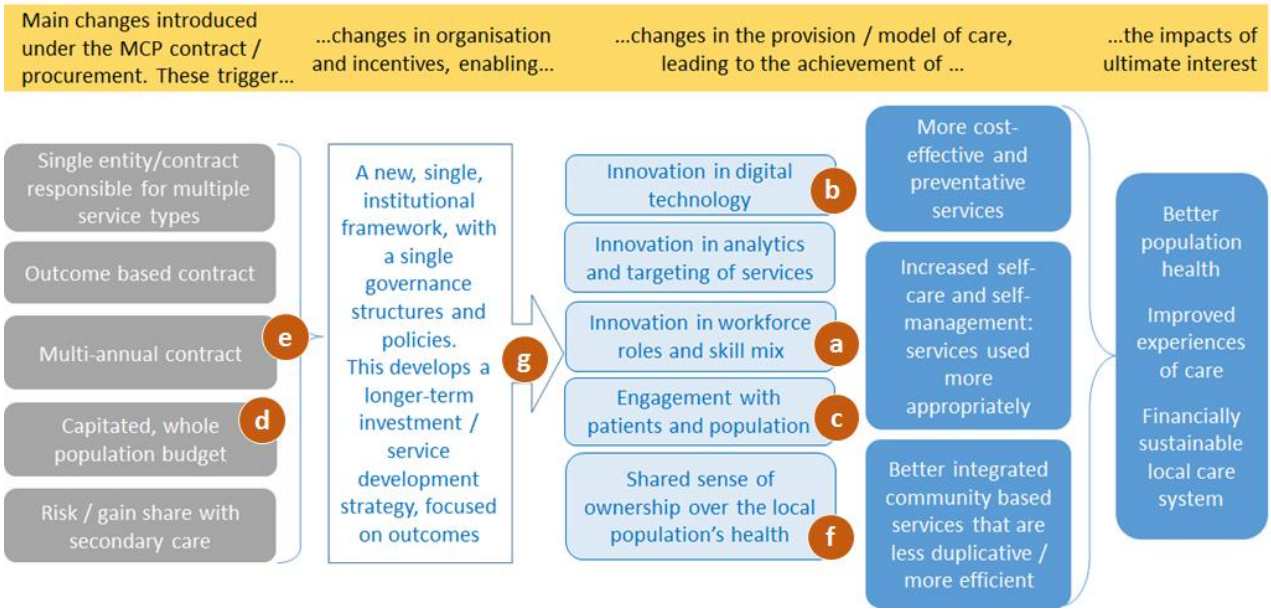
e) There will be no radical change in health and/or social care **policy** (e.g. introduction of a competitive, insurance-based model);

f) The local **population** will remain relatively stable in terms of its projected size, nature and underlying health challenges; and

g) The new contractual arrangement will drive the alignment of **incentives** across the health and care system and will result in activity and cash flows that are sustainable for both commissioners and providers (and that it – or associated risk share agreements - covers all likely eventualities).

These assumptions can be plotted against specific components in the summary logic model (see Figure 4 - Assumptions in the Logic Model).

Figure 4 - Assumptions in the Logic Model



All of these assumptions relate to what may or may not happen within the MCP's transactional environment – that is, the network of partner and stakeholder organisations and individuals that will somehow interact with the MCP (see Figure 1 - The contextual environment). They reflect the reality that the success or otherwise of the MCP does not simply depend on the robustness of its planning or the effectiveness of its implementation but on the dynamics and behaviours found in its transactional environment. The way that transactional environment may itself evolve over fifteen years cannot, however, be predicted with any certainty. Whilst the MCP can have real influence on partners and stakeholders (e.g. it can seek to promote certain lifestyle choices to the local population or to lobby for certain regulator or governmental action) and *vice versa*, the transactional system of which the MCP is part will be subject to more powerful influences from the wider contextual environment. Those influences will relate to what are commonly described as PESTLE-type factors.[17]

4.2 Key contextual factors

Our interviews with stakeholders explored how the MCP might be affected by developments beyond its control. In addition, we also consulted a number of published sources that highlight factors affecting the delivery of health and care services.

[17] Political, Environmental, Social, Technological, Legal and Economic (Media and Ethical factors are sometimes additionally identified).

In analysis undertaken in 2014 by the Centre for Workforce Intelligence[18], for example, the following contextual factors were identified and defined:

FACTOR	DESCRIPTION
Economy	This is the economic system in which the health and social care system functions. This includes global economic influences, national finance, GDP, work and reward, monetary systems, health and social care budgets, funding, and affordability.
Environment	The theme involves the state of the natural environment. This incorporates the quality of the natural environment, climate change, water availability and quality, food, and agriculture.
Population	This includes population characteristics such as age composition, gender ratios and regional distributions, and the drivers of the population change such as births, deaths and migration.
Society, Culture and Behaviour	Social community, social behaviour and public attitudes are involved in this factor theme. It includes ethical norms, quality of life, expectations of the health and social care system, and the extent at which the public is empowered. It also includes interpersonal relationships, social support networks, community engagement, health behaviours, public health education and prevention, and education.
Health and Wellbeing	Health and well-being of the population are under this factor theme, including the demand for both health care and social care and support.
Politics and Legislation	This is the political framework in which the health and social care system operates. It primarily involves the UK, but is also influenced by EU and international policies. It includes litigation and is manifested in laws which inform standards and regulation.
Research and Technology	Technology, and its application in the health and social care system, includes technology development, innovation and diffusion, and the impacts on service delivery, availability, outcomes and costs. Research builds knowledge and understanding of the causes of ill health and lack of well-being, impacts on technology and how care is delivered.

Similarly, Health Education England identified *five key drivers of change that we believe will shape the needs of future people and patients, and which, in turn, will drive and shape the nature of the demand placed upon the health and social care service*.[19] These include:

- Demographics
- Technology and innovation
- Social, political, economic and environmental
- Current and future service models

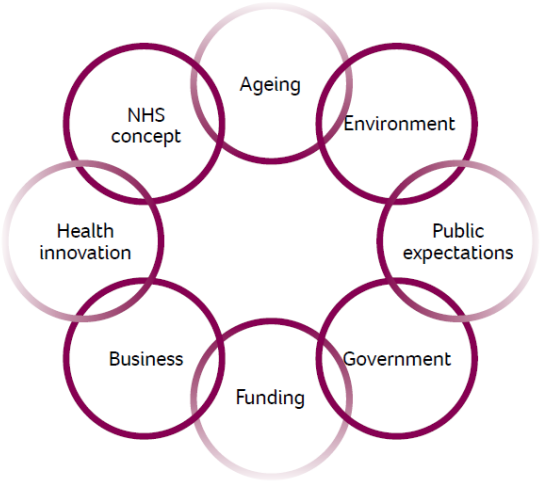
[18] CfWI (2014) Horizon Scanning Analysis of key forces and factors. Available at: http://www.horizonscanning.org.uk/app/web1/files/download/technical-paper-horizon-scanning-factor-analysis.pdf

[19] Health Education England (2015) Framework 15: Health Education England Strategic Framework 2014 – 2029. Available at: https://hee.nhs.uk/sites/default/files/documents/HEE%20Strategic%20Framework%20-%20Framework%2015.pdf

- Expectations (patients / staff).

In developing a set of scenarios for healthcare in 2013, Skills for Health identified *some very core, key drivers in the healthcare environment..... widely recognised as the key factors that will instigate change over the next 10-15 years*[20] (see Figure 5 - Skills for Health drivers).

Figure 5 - Skills for Health drivers

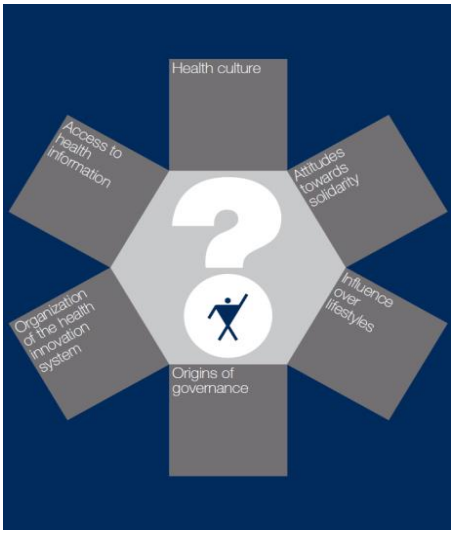


Also, in 2013 the World Economic Forum undertook a scenario exercise with leaders of health system from around the globe. This included the identification of *six critical uncertainties that might significantly reshape the context in which health systems form and operate.*[21] These uncertainties in the contextual environment resulted from hundreds of interviews and workshops and were defined as follows (see Figure 6 - WEF Scenario Factors).

[20] https://www.hospiceuk.org/docs/default-source/default-document-library/working-towards-a-hospice-workforce-that-is-fit-for-the-future5d9941124ccd608dad24ff0000fd3330.pdf?sfvrsn=0

[21] *Sustainable Health Systems. Visions, Strategies, Critical Uncertainties and Scenarios* (WEF, 2013). http://www3.weforum.org/docs/WEF_SustainableHealthSystems_Report_2013.pdf

Figure 6 - WEF Scenario Factors



- Attitudes towards solidarity: Will solidarity – the willingness of individuals to share the population's health risks – increase, decrease or be conditional upon certain factors?
- Origins of governance: Will power and authority be predominantly located at the national, supranational or local level?
- Organization of the health innovation system: Will innovation come from within or outside the existing system? What will be the level of funding? What will be the types of innovation produced?
- Access to health information: Who will take responsibility for collecting and analysing health data? Will people give their consent for their personal data to be used?
- Influence over lifestyles: To what degree will active influence over individual lifestyles be accepted and implemented?
- Health culture: Will healthy living be a minority choice, a civic duty or an aspiration?

Finally, in exploring what the European healthcare system might look like in 2040, United European Gastroenterology identified the following drivers[22] (Figure 7 - UEG Scenario Factors).

Figure 7 - UEG Scenario Factors

[22] https://www.youtube.com/watch?v=u04nlyMdsQs

Whilst the same broad range of factors will have applicability to multiple strategies and plans, the exact nature of the uncertainties those factors give rise to will vary with the nature of the strategy in question.

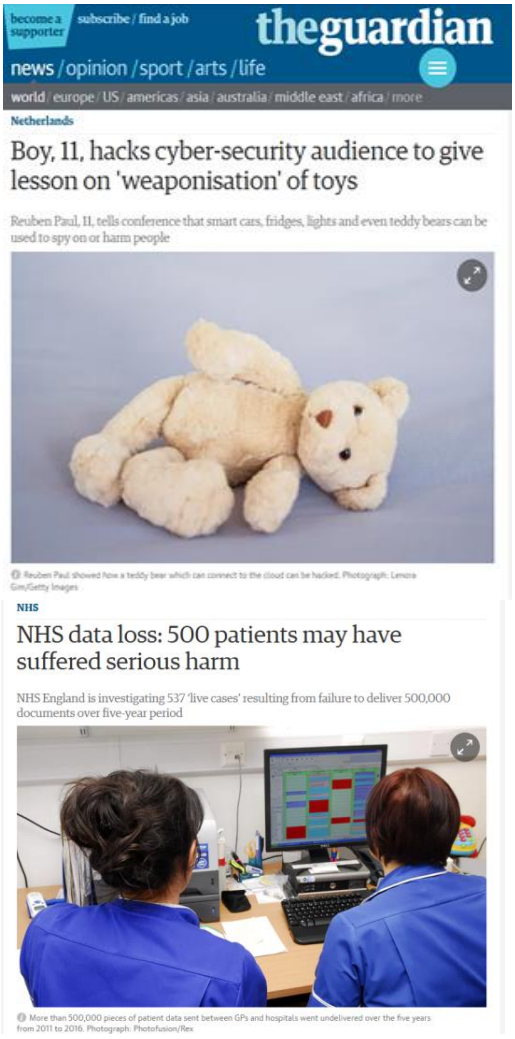
In what follows, and informed by interviews with local stakeholders, we have identified a set of contextual factors that could impact the outcomes of the MCP strategy, and we suggest ways in which that impact might operate. The dynamics thus described then provide the core building materials for constructing a range of plausible future scenarios.

4.2.1 Social attitudes

There are a variety of ways in which social attitudes might impact the advancement of the MCP strategy over fifteen years:

a) The MCP's model of integrated care across services relies on the ability to share patient data and for it to be readily accessible in all patient encounters. In order to achieve this there has to be public consent. The significance of this may grow as technological capabilities are extended: a person who is content for two clinicians to share information about them may not be content for a device to share their medical data with other devices, people or organisations.

   The number of those who currently oppose data sharing in principle – who believe that each professional encounter should be hermetically sealed from any other unless they specifically consent otherwise - may be low but that number could grow in response to any increased evidence of risks to personal privacy and/or security. Equally, the public appetite for technology in health could grow as innovations emerge and benefits are reported.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Netherlands

Boy, 11, hacks cyber-security audience to give lesson on 'weaponisation' of toys

Reuben Paul, 11, tells conference that smart cars, fridges, lights and even teddy bears can be used to spy on or harm people

Reuben Paul showed how a teddy bear which can connect to the cloud can be hacked. Photograph: Lenore Gini/Getty Images

NHS

NHS data loss: 500 patients may have suffered serious harm

NHS England is investigating 537 'live cases' resulting from failure to deliver 500,000 documents over five-year period

More than 500,000 pieces of patient data sent between GPs and hospitals went undelivered over the five years from 2011 to 2016. Photograph: Photofusion/Rex

b) The MCP model reflects what is sometimes termed the 'left shift' of activity from (generally) more distant hospital settings to more local community settings, including the patient's own home. This will rely on a willingness from patients to access local services (rather than continuing to default to A&E for a wide range of issues, for example), to accept an increased role in self-care and to respond positively to prevention initiatives. Will the local population be amenable to such a substantial degree of behaviour change?

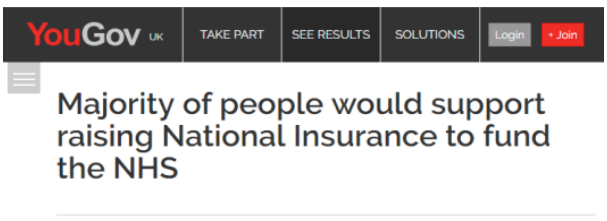
   The most recent national GP Survey reports that only 50% of Dudley patients needing out-of-hours care contacted an NHS out-of-hours service by telephone (61% nationally) whilst

41% went to A&E (34% nationally). One fifth of patients in Dudley (19% nationally) reported that they were not able to get a convenient appointment.[23] One interviewee noted:

> *Many of the services will be closer to them in a local sense. They'll be provided in their area rather than people having to travel long distances. So I think that may be easy to sell but may take a while to get there because people continue to behave like they've always behaved until they understand and appreciate that there's something else that is available that is more convenient to them. [Interviewee]*

c) Since the initiation of the NHS and the Welfare State, the scope of provision has generally been extended in response to evolving challenges and opportunities, and there is evidence of a substantial degree of national pride in this evolution. But the NHS' place in national affections may not be impregnable: what if people take against the fruits of STPs and new models of care? Or if, instead of continuing to support additional resource, start to demand constraints on provision (e.g. for treatments judged to be the result of lifestyle choices)?

King's Fund research suggests that though the NHS continues to be highly valued, expectations continue to rise and, whilst there is support for maintaining NHS expenditure (less so for social care and benefits spending), younger generations are less supportive of welfare investment.[24]



[23] https://www.gp-patient.co.uk/slidepacks2017

[24] https://www.kingsfund.org.uk/projects/time-think-differently/trends-public-attitudes-expectations. See also *Social Attitudes of Young People: A Horizon Scanning Research Paper by the Social Attitudes of Young People Community of*

d) There is a critical place for national and local Third Sector organisations within the MCP model and a certain dependency on community resilience - counteracting social isolation and loneliness, creating opportunities for social prescribing, etc. If economic pressures and/or public attitudes do not provide the financial or voluntary human resource required to build and sustain resilience then some of the key outcomes of the MCP may not be achieved and demand on public sector services could increase rather than reduce.

Lack of services to support this e.g. befriending is full to capacity. Nobody can take referrals, (there are) not enough volunteers. [Interviewee]

Not only does voluntary social activity by some have the potential to increase health and wellbeing for others but, conversely, increased isolation and loneliness are themselves health risk factors – e.g. for coronary heart disease and stroke.[25]

e) Another critical dimension of social attitudes relates to workforce supply and culture. Will there be the volume and quality of people willing to train and to serve as nurses, doctors, care assistants or the new roles that may be devised? Will they welcome or resist increased team working and the softening of professional boundaries? A number of interviewees commented on this.

We have to manage workforce in a different way as opposed to the historical GP sitting down seeing patients. How is the culture going to change so people work differently e.g. is the consultant working in the community just changing where they work or are they working closer with GPs. How do we know we've changed siloed working? [Interviewee]

The workforce is the big issue because staff don't like change. [Interviewee]

The workforce will respond to the change – we have already started to see the change over the 2-3 years we have been doing the vanguard. MDT meetings are not just focused on MH, community health etc. but talk about the patients and family as a whole. [Interviewee]

Interest, (HM Government Horizon Scanning Programme, December 2014) - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389086/Horizon_Scanning_-_Social_Attutudes_of_Young_People_report.pdf.

[25] *Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies*, BMJ 102.13. http://heart.bmj.com/content/102/13/1009

4.2.2 Technological and clinical innovation

Digital advancements are often slow to be diffused through the NHS[26] but the increasing prevalence of digital solutions in many aspects of life plus the focused action of new models of care may change this.

a) Shared care records are a critical enabler of integrated care and multidisciplinary working. Solutions are available and continue to be developed although there are issues to be overcome re: interoperability, patient permissions and clinician compliance.

We've had a big debate about the interoperability of various systems ….. If we don't crack that, we risk losing a major plank in terms of the benefit of the MCP. [Interviewee]

b) Patients who are in employment and those with caring commitments can find it difficult to attend healthcare appointments for themselves or for those they care for, as these typically occur during the working day. The NHS could therefore offer services that are more convenient for people in employment by changing forms of access (e.g. increased use of telephone or video for GP consultations) or using more convenient locations (e.g. providing outpatient appointments in GP practices).

Studies that have so far looked at effectiveness of telemedicine have not generally found it to be all that it's cracked up to be for a variety of reasons- flags up false positives etc. We need to iron out how to maximise potential of telemedicine in a cost-effective way. [Interviewee]

[26] Innovation, Health & Wealth – DH, 2011

HIMSS 2017: The connected healthcare revolution has started—but there are obstacles

Mar 01, 2017 | Cara Livernois

Connected health using technologies has improved care delivery across the healthcare continuum. In a presentation at HIMSS 2017 in Orlando, Jeroen Tas, chief innovation and strategy officer at Royal Philips, examined the role of technology and barriers organizations may face in implementing connected health technology.

He described how digital technologies assist the transition into personalized healthcare delivery and how healthcare alliances improve quality and efficiency. In this changing industry, Tas reiterated the effects of connected care and health informatics. Prevention, diagnosis and treatment can be improved with innovations such as artificial intelligence, virtual care networks, cybersecurity and precision medicine.

"In order to have continuous care for patients, you need to start looking at virtual care networks," said Tas. "It means you have to find different ways to connect and meeting people at the right time. Technology drives this. The Internet of Things gives us the opportunity to stream data and track subtle changes the naked eye cannot see and see onsets 10 years in advance. Looking at therapy a different way means we have the opportunity to create better outcomes."

Recent work for the Black Country STP by ICR International with the Strategy Unit has estimated that, for an investment of around £1 million, increasing access to remote appointments could make better use of NHS resources and also generate a productivity benefit for the local economy of £10 million, as workers are enabled to reduce time away from work to attend appointments. The scalability of this is untested as yet, however, and there would be issues of acceptability to clinicians and patients.

c) Robotic solutions have begun to impact health mostly in relation to the acute sector – for example, specialist surgery or pharmacy systems. The potential in relation to primary and community services is also now beginning to emerge.

Artificial Intelligence may also be substantially advanced in 15 years' time, the recruitment crisis may be tackled by a host of robot care home workers. There is a huge market for artificial intelligence in healthcare and there is opportunity for elderly sick patients who may benefit from intelligent machine care as oppose to face to face care. [Interviewee]

The

Start-up company doc.ai has been working with university researchers to create a platform on the block chain where patients can discuss their medical data with an advanced artificial intelligence "doctor"..... According to the World Health Organization, there is a shortage of seven million healthcare professionals globally, and that number is on the rise. There is increasing pressure on doctors who are faced with meeting the challenging needs of the population and keeping up with the latest developments in healthcare and medicine. Furthermore, the training of healthcare professionals takes years of education and experience. With the help of AI, doc.ai aims to address such challenges while improving the patient care and providing a better healthcare experience.[27]

> *In the next decade or so we will start to see more autonomous machines collecting and sorting data, freeing up medical staff to do their clinical jobs. For example, voice recognition paired with a clinical coding algorithm has the potential to document consultations without the need for notetaking. Remote patient monitoring could automatically record our vital signs. Robots that can take blood and other physiological measurements are already being developed. Once the automatisation of data collection is solved, the path to a true artificial intelligence will be exponential. Thousands of companies around the world are working to train machines in pattern recognition, deep learning algorithms, natural language processing, remote patient monitoring, visual image analysis and processing of medical data. A cornucopia of solutions is being built, and at its nexus a three stage awakening will occur: scattered systems will be connected via a common language; There will be an abundance of labelled, curated clinical data; And artificial intelligence will be allowed to grow its neural connections. The results will transform frontline health care.*[28]

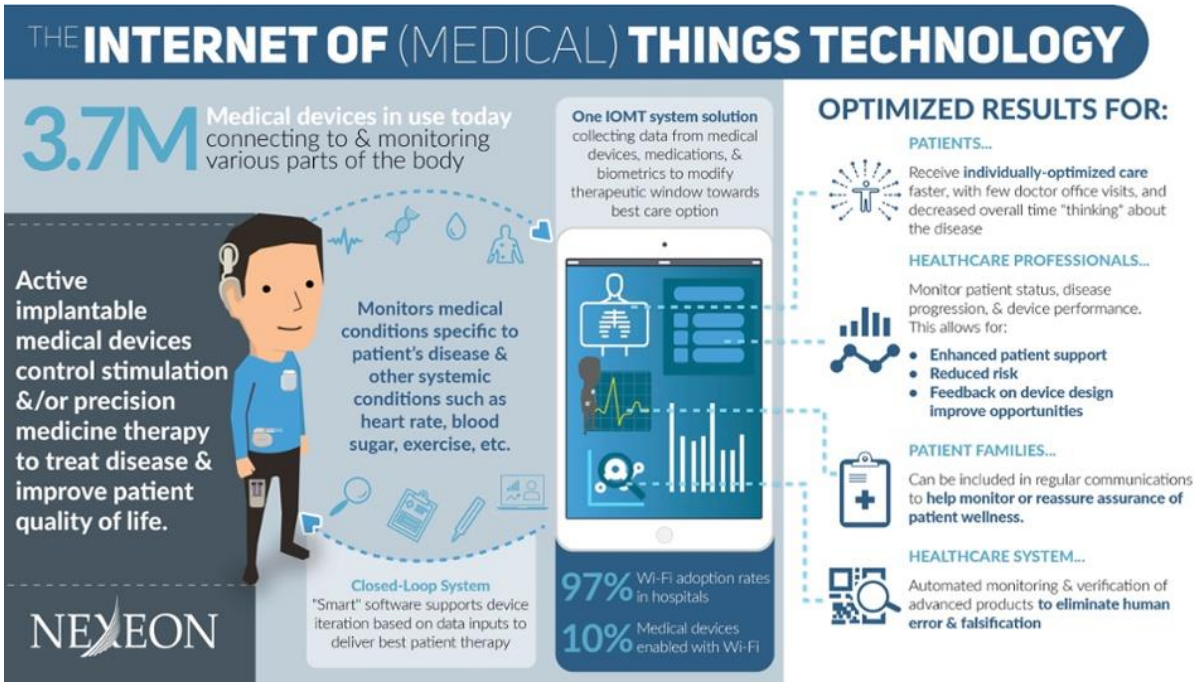
Whilst this suggests clear potential to relieve elements of the workforce supply challenge, clinician and patient confidence in AI solutions would need to be developed and could be adversely affected by any reported incidents.

Some specific examples of AI relevant to the MCP are highlighted in an interviewee with Matt Fenech of *Future Advocacy* conducted for this project, covering diagnostic and triaging solutions. Further detail is provided in Appendix 2 – AI and the MCP.

[27] http://www.nasdaq.com/article/the-next-doctor-you-consult-could-be-a-robot-healthcare-meets-ai-and-the-blockchain-cm837366

[28] Hugh Harvey (August, 2017) - https://www.kingsfund.org.uk/blog/2017/08/clinicalartificialintelligence

d) Whereas patients may be reluctant to submit to the 'care' of artificial intelligence solutions, the public has clearly embraced the use of devices and applications that are (largely) within their own control. Sales figures for 2016 indicated 25% market growth year-on-year[29], and further stages of development are feasible through connection to cellular networks and as part of the 'Internet of Medical Things'.[30]



[29] http://www.bbc.co.uk/news/technology-39101872
[30] https://www.nexeonmed.com/press/why-the-internet-of-medical-things-is-the-future-of-healthcare

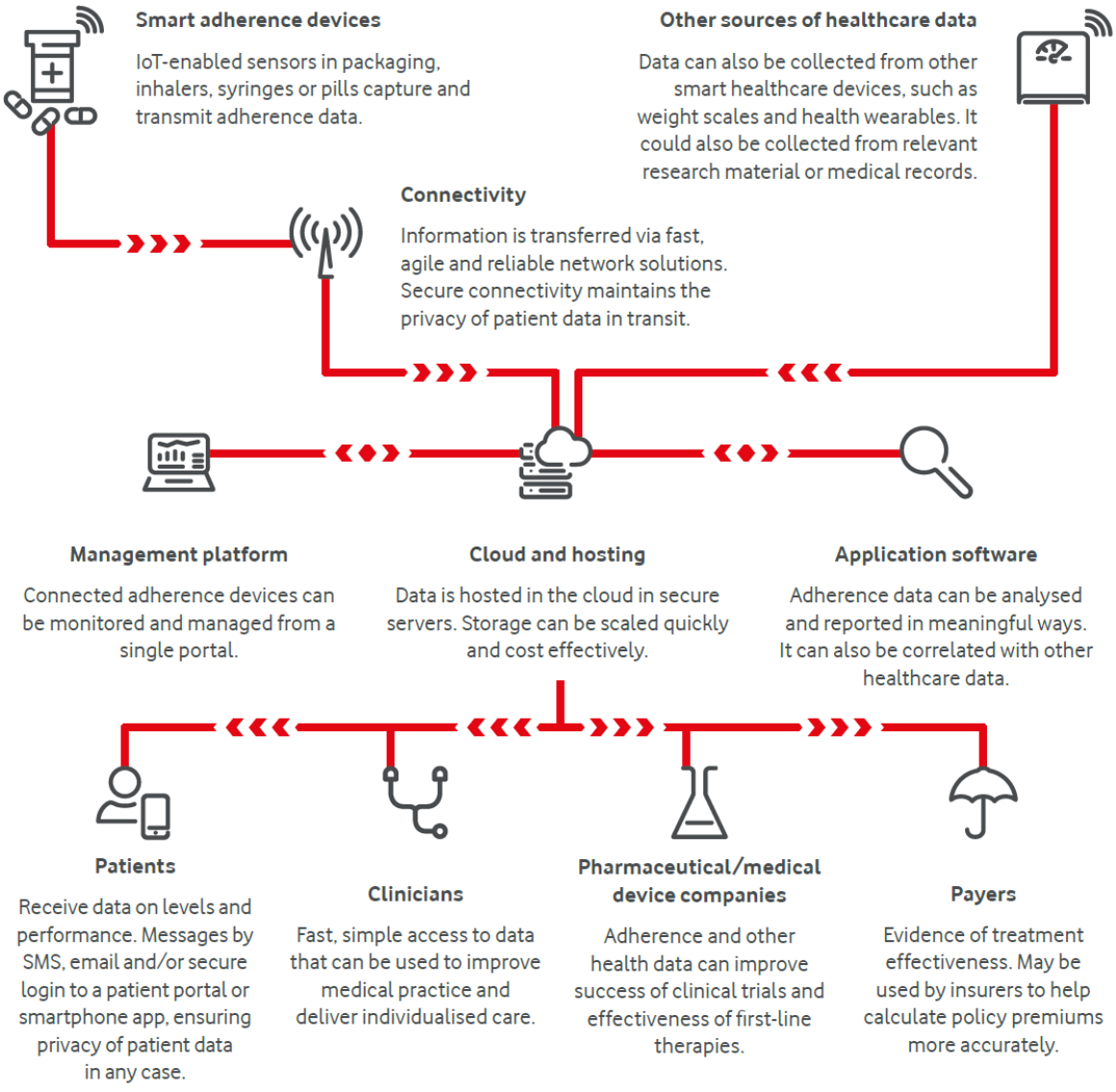
Figure 8 - Vodafone Internet of Things

The Internet of Things: providing a platform for change

The technology is here to make smarter adherence a reality and deliver better patient outcomes. Here's how it works.

Communication service providers, like Vodafone, offer a managed IoT platform that provides the secure and reliable connectivity, storage and compute to handle data from vast numbers of devices and scale up to much larger entities. And they provide management portals that give oversight of all connected assets. That means smart adherence programmes can be rolled out securely, reliably and cost-effectively for IoT projects of any size.

IoT-enabled adherence solution



What is not clear, however, is the extent to which this growth will continue or what its impact will be:

- Will we be happy for devices to share our sensitive personal (and biological) data with other devices?[31] Who will own this data and what might they do with it? Might insurance companies start to require access, for example, and make premiums responsive to health and fitness?
- What if devices and other digital information sources provide false assurances, resulting in patients not seeking medical advice until a condition is much further advanced, with the resulting outcomes impact for the patient and cost impact for health and care services (an unintended 'right-shift')?
- Will increased monitoring through devices create new demand for assurance and/or further investigation through health services that they would struggle to meet?
- Will such technological aids reduce or increase health inequalities?
- Along with new technologies goes the potential for business model innovation. If people increasingly adopt convenient standalone solutions to access care, how will a clinical model based on integration, continuity and coordination be sustained?

[31] *An Intelligent Future: Maximising the opportunities and minimising the risks of artificial intelligence in the UK* (Future Advocacy, 2016). https://static1.squarespace.com/static/5621e990e4b07de840c6ea69/t/580f8f6cb8a79b1ed436ebe3/1477414774159/An+intelligent+future-3.pdf

We're seeing an explosion in wearable technology and fitness apps, and we'll all be monitoring our health by some form of virtual online platform. These things- if they work and prove to be effective in helping people to e.g. manage their weight or give up smoking - could significantly improve the health of the population. It tends to be the early adopters who pick them up and are tech savvy, who are well connected and may be in good health. The challenge is how do you cascade these down to people who are less technologically advance and who are less minded about taking responsibility for their own health. [Interviewee]

e) In addition to developments in technology that may have health applications, there will also continue to be clinical innovations including new treatments, novel devices, etc. Deployment of these innovations will be impacted by the availability of funding and their net impact on demand and the overall costs of treatment. Some will be incremental developments; others will be disruptive clinical innovations.[32]

Health

Spending on the National Health Service has reached £120 billion in 2016-17.[18] The costs of social and private care are also rising. With a growing as well as ageing population, with poor diet and physical inactivity stressing the system, disruptive technologies offer partial solutions in combination with efficiency programmes and behavioural insights.

Synthetic biology seeks to treat biology as a world of standardised parts – offering reliable and reproducible materials for the first time to create novel devices and systems as well as to redesign existing, natural systems. The related discipline of regenerative medicine may one day revolutionise the treatment of heart disease and neurodegenerative disorders, solve the shortage of organ donors and completely restore damaged tissues. These areas of research hold out the prospect of helping us to stay healthy and of treating disease more effectively. Moreover, new opportunities are coming from the convergence of synthetic materials, automation and manipulation of genetic data.

4.2.3 Policy changes

There are multiple policy domains that may have a bearing on the course of the MCP. The following areas are highlighted as potentially having the greatest impact:

a) Funding allocations to health, social care and voluntary sector services.

Funding decisions reflect (at least in part) underlying policy positions and ideologies. Governments will differ in the extent to which they wish to promote or tolerate state intervention, and there is clearly an interaction with social attitudes here. Aspects of the 2017

[32] Technology and Innovation Futures 2017 (Government Office for Science, 2017).

General Election indicated the much greater policy divergence in this respect than has been the case for a number of decades. This inevitably increases uncertainty. One interviewee commented that

> *…we have to get the right settlement with government around the money that's needed otherwise this could potentially fail.* [The MCP] *will be significantly dependent upon the money that is still available to the NHS and social care and the austerity picture is quite problematic in that respect. So I think austerity and limited public resources will be around for a long time, regardless of who is in power. If the government decides that the NHS is no longer cost effective in its view and if there is a move towards saying the NHS isn't going to provide everything, therefore you take out private health insurance to cover the things NHS won't cover, we could see a gradual erosion of what's provided by the NHS, which will in turn affect what the MCP can afford to deliver because the money simply won't be there. [Interviewee]*

Ideology will only be one driver of funding decisions, however, and another critical driver is necessarily the underlying economic position of the UK (itself affected both by other policy positions and by events beyond the control of government such as the impact of Brexit).

Two general observations around funding are worth making –

- Funding decisions in different policy areas are interrelated. An increase in NHS expenditure (even in real terms) may be offset by a tightening of resource in other parts of the public sector (especially social care and public health but also police services, for example, in relation to the care of people with mental health conditions) or in support to the voluntary and community sector. Each of these sectors is material to the outcomes of the MCP – for example, the extent to which demand is reduced through prevention activities or through enabling more effective discharge from hospital.

> *There is an expectation that voluntary services are going to be a key player within the MCP but they are struggling to cope with the demand with reduced capacity*

and lack of investment in the sector….. There is an assumption that voluntary services will be there and picking things up but at a time when organisations are closing and making staff redundant. [Interviewee]

- Funding decisions have a double-effect on the healthcare workforce. The general level of funding – and the associated ability to meet patient needs – is likely to have an effect on staff morale and, consequently, recruitment and retention. This effect could be moderated or magnified by decisions about public sector pay parameters. A recent economic study of the NHS in the Black Country[33] reports that 65% of NHS Trust spending relates to employee benefits. Under more prosperous economic conditions there may be more funding available but there may also be more attractive and better paid jobs in other sectors of the economy. NHS employees in the Black Country currently have a higher average wage than employees in other sectors but what if this changed?

b) Structural reorganisation of health and care services.

Structural change in the NHS has been frequent – over 15 years there is likely to be at least three governments and multiple changes in NHS leadership (political and executive). Will local ownership, public support and political influence increase the extent to which local system solutions like the MCP are resilient against changing national dictat? The current direction of travel around STPs and new models of care is likely to increase pressure to reduce the role of competition in the NHS and could pave the wave for significant organisational change (mergers and acquisitions, repeal of 2012 Health and Social Care Act, etc.). It will be hard to estimate the degree to which such turbulence in the surrounding health and care economy might impact the existence and/or performance of the MCP. Again this may flow either from a policy priority (e.g. the formal integration of health and care services, the roll out of Accountable Care Systems) or as a consequence of funding decisions (e.g. if local providers appear to become unsustainable there could be a round of provider consolidation creating entities with less commitment to local models of care; provider power may grow in relation to commissioner/Primary Care power, and a hospital-centric model may be strengthened rather than transformed).

[33] *Economic impact of NHS spending in the Black Country* (ICF International and The Strategy Unit, 2017). http://www.strategyunitwm.nhs.uk/sites/default/files/2017-10/170728%20Final%20report%20on%20NHS%20economic%20impact%20in%20the%20Black%20Country.pdf

Every time the NHS tries to reorganise, it sets everything back by a matter of a few years and that doesn't allow things to develop. So has the government finally decided that major reorganisations from top down, don't work? [Interviewee]

c) Action on the wider determinants of health by local and central government.

A very wide range of action or inaction by local, national and international governments is able to impact population health and wellbeing in ways (and to degrees) that cannot be predicted with any certainty. The success of the MCP strategy is tied to improving health and reducing costs but the greatest influences on these things are outside the MCP's scope and control. The Health Foundation notes that only *10% of a population's health and wellbeing is linked to access to health care* rather than wider factors (see Figure 9 - Health Foundation Wider Determinants).

Will we see further policy interventions in relation to the consumption of alcohol, sugar, etc., and to what extent will such interventions prove to be effective mechanisms for improving health and wellbeing?


INDEPENDENT News InFact Politics Voices

Air pollution is the 'tobacco of the 21st century', warn experts

Bad air is the source of 'huge illness which is entirely preventable if we take the issue seriously', IPPR researcher says

Will there be an increased focus on addressing climate change and decreasing pollution?

Costs of air pollution

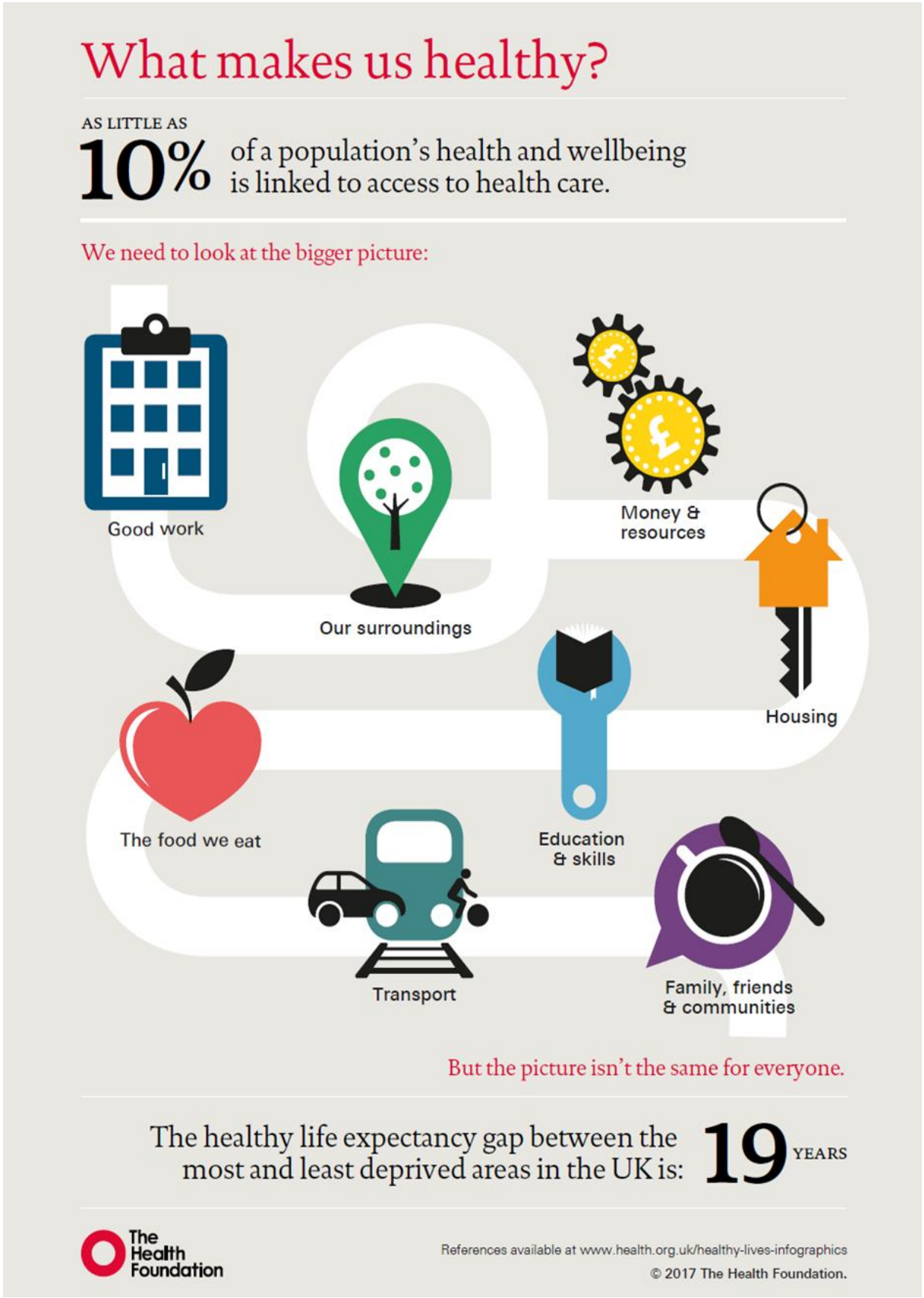
The annual mortality burden in the UK from exposure to outdoor air pollution is equivalent to around 40,000 deaths. To this can be added further impacts from exposure to indoor air pollutants such as radon and second-hand smoke.

The health problems resulting from exposure to air pollution also have a high cost to society and business, our health services, and people who suffer from illness and premature death. In the UK, these costs add up to more than £20 billion every year.

Vulnerable people are prisoners of air pollution, having to stay indoors and limit their activity when pollution levels are high. This is not only unjust; it carries a cost to these individuals and the community from missed work and school, from more health problems due to lack of exercise, and from social isolation.

Taking action will reduce pain, suffering and demands on the NHS, while getting people back to work, learning, and an active life. The value of these benefits far exceeds the cost of reducing emissions.

Figure 9 - Health Foundation Wider Determinants



A very specific local example was helpfully provided by one interviewee.

> *Possibly the biggest economic improvement to Dudley which will then lead to improvement in health outcomes is the announcement that the Metro is going to be extended into Brierley Hill. In order to minimise the number of years at the end of life that you are poorly and consuming the number of NHS resources, you need to maximise number of years of good health. So how do you do that? Well one of the biggest determinants of your healthy life expectancy is your economic position and therefore the wealthier you are within society, the healthier you live, for longer. So anything that can be done to help particularly people in poorer areas of Dudley, to live more financially secure lives with financially rewarding jobs, will then lead to their health improvement, which will then in turn lead to fewer years of poorer health and NHS care at the end of life. [Interviewee]*

d) Post-Brexit policy.

Assuming that the UK leaves the EU in March 2019, the Government will, in principle, be free to determine a wider range of policy matters than is currently the case. This would include matters relating to trade and competition, and immigration.

- Trade and Competition. The terms of the new trade deals that a post-EU UK could enter may lead to the altering of existing standards – for example, in relation to food and product safety, workplace health and safety and the environment.[34] In addition, the current trend towards greater integration of services could be undermined by increased openness of competition. Could a different competitive environment start to eat away at the edges of the MCP and to threaten the sustainability of its partners?

  Even if the MCP is successful in aligning the incentives of public sector organisations, it may find itself vulnerable to the misaligned incentives of pharmaceutical suppliers and private medical providers.

There's nothing per se to guarantee that future trade agreements that the UK secures won't open up the NHS markets to non-UK providers, whereas the EU had secured such an opt-out for health services for (the now defunct) TTIP.[35]

- Immigration. The King's Fund reports that 5% of the NHS workforce and 7% of the adult social care workforce comes from other EU countries but that, since the EU

[34] Nuffield Trust (2017) 'Why Brexit is bad for our health'. Nuffield Trust comment, 1 February 2017. https://www.nuffieldtrust.org.uk/news-item/why-brexit-is-bad-for-our-health
[35] https://www.nuffieldtrust.org.uk/news-item/why-brexit-is-bad-for-our-health#public-health

referendum, the numbers registering as nurses has fallen by 96%. [36] Is this a hiccup relating to present uncertainties or will the UK no longer be an attractive destination for skilled EU professionals? What will the new immigration regime permit or encourage? If not from the EU, can the recruitment crisis be addressed by home-grown training and, for example, a points-based immigration system? The FT reports that "*If the migration of nurses from the EEA were shut off completely, the Department of Health predicts the UK would have a shortage of 20,000 nurses by 2025-26*".[37]


Brexit Opinion

The Brexit leak shows a government on collision course with the NHS

Ben Howlett

The scheme to cut immigration is at odds with the need to fill 176,000 health and care vacancies. For the sector to survive, its workers must be given special status

With the shortage of GPs which we have in Dudley, we're not going to resolve that tomorrow unless you can suddenly shift 500 GPs in from another country, which is unlikely with Brexit. And you can't just train people up - they have to go through 7-12 years of training. So could we change the model, could there be a more nursing led aspect of the service? [Interviewee]

4.2.4 Demography

The Dudley population is expected to grow by just over 4% by 2032. This includes increases of c.11,000 and c.14,000 in the populations aged over 75 and 65 years, respectively. As high users of health and care services, not least those services within the scope of the MCP, this 21% increase in over 65s and 34% increase in over 75s adds to the challenge facing the MCP.

Over the same period, reductions are expected in both the birth rate (0.24%) and the working age population (net 1.28% over 15-64-year olds with the biggest reductions in the 45-59 age groups). So, at the same time as demand pressures are expected to grow, local workforce supply pressures are expected to tighten (see Figure 10 - ONS Projections).

The demographic characteristics of the local workforce are also material. Dudley has 168 whole time equivalent GPs: this represents 5.22 GPs per 10,000 population. NHS Improvement rates this as being between median and the quartile with the most risk.

[36] https://www.kingsfund.org.uk/publications/articles/big-election-questions-brexit-workforce
[37] https://www.ft.com/content/7658ec98-202f-11e7-b7d3-163f5a7f229c

Figure 10 - ONS Projections[38]

2014-based Subnational population projections
Table 3: 2014-based Subnational Population Projections for Clinical Commissioning Groups in England
Persons by 5 year age groups

Figures in thousands (to one decimal place)

AGE GROUP	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
0-4	19.2	19.1	19.3	19.4	19.4	19.4	19.4	19.4	19.4	19.4	19.3	19.3	19.2	19.2	19.2
5-9	19.8	20.1	20.0	19.9	19.7	19.6	19.6	19.7	19.8	19.9	19.9	19.9	19.9	19.9	19.9
10-14	19.0	19.2	19.4	19.6	20.0	20.1	20.3	20.2	20.2	20.0	19.9	19.9	20.0	20.1	20.2
15-19	17.2	17.2	17.4	17.7	17.9	18.4	18.6	18.9	19.0	19.4	19.6	19.8	19.7	19.6	19.4
20-24	17.1	16.6	16.3	15.9	15.6	15.3	15.3	15.4	15.7	15.9	16.4	16.6	16.9	17.1	17.4
25-29	19.9	20.0	19.9	19.6	19.3	19.1	18.7	18.3	18.0	17.6	17.4	17.3	17.5	17.8	18.1
30-34	19.7	19.9	20.1	20.2	20.4	20.5	20.6	20.5	20.2	20.0	19.7	19.4	19.0	18.7	18.3
35-39	19.4	19.4	19.4	19.6	19.8	19.9	20.1	20.2	20.4	20.6	20.7	20.8	20.7	20.4	20.2
40-44	17.7	17.7	18.1	18.4	18.9	19.4	19.4	19.4	19.6	19.8	19.9	20.1	20.2	20.4	20.7
45-49	22.5	21.5	20.5	19.3	18.3	17.7	17.7	18.1	18.5	19.0	19.4	19.5	19.5	19.7	19.8
50-54	23.2	23.2	23.1	23.2	22.8	22.1	21.2	20.2	19.1	18.1	17.6	17.6	18.0	18.4	18.9
55-59	20.5	21.2	21.9	22.2	22.4	22.6	22.6	22.5	22.6	22.3	21.6	20.8	19.8	18.8	17.9
60-64	17.7	17.9	18.2	18.6	19.3	19.9	20.5	21.3	21.6	21.7	22.0	22.0	21.9	22.0	21.7
65-69	17.5	17.1	17.0	16.9	17.0	17.0	17.2	17.5	17.9	18.6	19.1	19.8	20.5	20.8	21.0
70-74	17.2	17.2	17.1	17.2	16.5	16.3	16.0	15.9	15.8	15.9	16.0	16.2	16.5	16.9	17.5
75-79	12.9	13.5	13.9	14.3	15.2	15.4	15.4	15.4	15.5	14.9	14.8	14.5	14.4	14.4	14.5
80-84	9.7	10.1	10.2	10.1	10.3	10.6	11.2	11.6	11.9	12.7	12.9	13.0	13.0	13.1	12.6
85-89	5.7	5.8	6.0	6.2	6.5	6.7	7.0	7.2	7.2	7.3	7.6	8.1	8.4	8.7	9.3
90+	2.8	2.9	3.1	3.2	3.4	3.5	3.6	3.8	4.0	4.3	4.5	4.8	5.0	5.1	5.3
All ages	**318.7**	**319.7**	**320.7**	**321.7**	**322.7**	**323.7**	**324.6**	**325.6**	**326.5**	**327.4**	**328.3**	**329.2**	**330.1**	**331.0**	**331.9**
	0.28%	0.31%	0.31%	0.31%	0.31%	0.31%	0.28%	0.31%	0.28%	0.28%	0.27%	0.27%	0.27%	0.27%	0.27%
															4.14%

It is also reported that 20.9% of those GPs are over 55 years old, and 3.7% are over 65, both of which place Dudley in the quartile with the most risk.[39]

The projected demographic trends are clear but are also, of course, subject to other external factors. For example:

- Will conceivable changes to immigration policy (and/or the decisions of current EU migrants – especially those of working age) materially alter the projections?
- If the Dudley economy were to grow (for example, in response to post-Brexit trade opportunities or as a result of coordinated investment via the West Midlands Combined Authority), might the working age population and the birth rate increase over the contract period?

Interviewees made a number of observations relating to demography, including:

> *We've got too few people earning money and paying tax on that compared to the dependent population and that situation over the next 15 years gets worse. I think it starts to ease towards the end of the 15 years because of the high birth rate in*

[38] ONS 2014-based Subnational Population Projections for Clinical Commissioning Groups in England
[39] *The Black Country STP Data Pack - Q2 FY16/17 Operational update v1.01* (Strategic Finance, Health Economy Intelligence, February 2017)

some communities, which means that group starts to come into work, as long as the economy thrives. [Interviewee]

Key Facts and Figures

Population: The latest estimates from 2013 show that Dudley Borough has a population of around 314,400. The population has been growing at a modest but sustained rate in recent years, with 9,300 more people in the borough now compared to the 2001 estimate. Dudley is the third largest local authority district in the West Midlands Region based on population. 19% of people are aged under 16 and 19.5% are 65 and over.

Ethnicity: According to the 2011 Census 88.5% of the borough population are White British. Dudley has become more ethnically diverse since 2001 when the figure was 92.5%. Asian groups constitute 6.1% of the ethnic minority population, with the largest individual groups in the borough being Pakistani (3.3%) and Indian (1.8%). 1.8% of people are from mixed ethnic groups, 1.5% Black ethnic groups and a further 1.5% from White groups other than British.

Health: Life expectancy at birth for men in Dudley is 79.2 years, marginally below the England figure of 79.4 years. For women in Dudley the life expectancy is 83.2 years, just greater than the national figure of 83.1 (2011-13 three-year average). The 2011 Census shows that 78.2% of the borough population consider themselves to be in 'Good' or 'Very Good' health. The corresponding figures for males and females are 79.5% and 76.9% respectively.

Economy: In November 2014 5,880 people in Dudley Borough were claiming Jobseeker's Allowance (JSA), which is equivalent to 3.0% of the working age (16-64) population. The proportion of working age men claiming (3.9%) is greater than for women (2.2%). Although the claimant rate in Dudley has been on a downward trends since February 2013, it is still above the regional (2.5%) and England (1.9%) figures. The annual average wage for Dudley residents working full-time was £24,455 in 2013, below the national figure of £27,375.

Housing: According to council records there were 135,445 residential properties in the borough in March 2014. Of the 129,867 households occupied at the time of the 2011 Census 68.7% were in owner-occupation, 16.8% were rented from the council, 9.2% were private renting and 3% were rented from other social landlords. Almost half (48.4%) of accommodation is semi-detached, with 21.5% detached, 16.1% terraced and 11.7% flats.

Environment: The borough covers 38 square miles / 98 square kilometres. Though predominantly an urban area 25-30% is 'green' space, 17% designated green belt and 14% categorised as publicly accessible green spaces. There are eight Sites Of Special Scientific Interest, of national importance for their geology and/or biodiversity, and seven Local Nature Reserves, plus the river Stour and 16 miles of canal network. The borough has an extensive road infrastructure and access to the motorway near Dudley and Halesowen. A train line links Stourbridge to Birmingham and the national rail network. 75.4% of borough residents in employment travel to work by car, 7.9% walk, 7.3% take a bus and 3% a train. 3.5% work mainly from home (2011 Census).

Deprivation: Dudley is ranked as the 104th most deprived of the 326 local authority districts in England (where 1 is most deprived), a lower ranking than five of the other six districts in the West Midlands conurbation. While this suggests Dudley is relatively affluent, it masks the disparity in levels of deprivation across the borough. The latest deprivation indices from 2010 showed that 23.9% of the population live in areas in the 20% most deprived in England. These are principally found in a zone covering Dudley, Pensnett, Netherton and Brierley Hill, but also include parts of Coseley, Lye, Halesowen and Stourbridge.

The number of available carers and the proportion of the population, who are working and can afford to pay for that service, is at risk of declining relative to the increasing number of people requiring care. [Interviewee]

80 year olds are healthier than 20 years ago but we have far more of them. [Interviewee]

I don't think there will be massive shift in the life expectancy over the next 10-15 years. It's going to be quite modest, we know where that is going and we know other population trends during that time. So those issues would be an ageing population, atomisation of families but you will get a growth in number of people coming through to working age, particularly in BAME communities. So I think you can probably predict demographic trends and then think what the health and social care implications are of those trends during that fifteen year period, not with absolute accuracy but I think with a degree of certainty. [Interviewee]

4.2.5 Population health status

The latter comments highlight potential changes (or lack of change) in population health status in Dudley, as well as its size and age profile. The uncertainties that arise include potential impacts from:

- Changing patterns of migration with associated differential disease prevalence and healthcare expectations[40];
- Declining antimicrobial resistance – a particular morbidity and mortality risk for vulnerable elderly patients[41];

> *Resistance to current antibiotics has increased steadily since they were introduced in the 1930s and 1940s, while the development of new antibiotics has stalled. This poses a real and significant threat to patients, and our health services. If these trends continue, it is likely that this will have a profound impact upon both the nature and severity of infections that health services will be required to treat in future, and the skills and competencies that the future healthcare workforce will need to treat them.*[42]

[40] *Health Consequences of Current Immigration Policy* (Migration Watch, 2003). https://www.migrationwatchuk.org/briefing-paper/42

[41] *Strategic Research Agenda: Joint Programming Initiative on Antimicrobial Resistance* (JPIAMR, December 2013). http://www.jpiamr.eu/wp-content/uploads/2014/05/SRA1_JPIAMR.pdf

[42] *Framework 15 – Health Education England Strategic Framework* 2014-2029 (HEE, 2015). https://hee.nhs.uk/sites/default/files/documents/HEE%20Strategic%20Framework%20-%20Framework%2015.pdf

- Deteriorating climatic conditions (impacting on respiratory illnesses and increasing the 'Winter pressures' felt by services);
- Variation in life expectancy trends (both in absolute terms and relatively between population segments);

> *The long-term implications of a decade of austerity, job losses and people being financially insecure- We've seen increases in suicide rates. Clearly the fact that we have had many years of reduced financial growth will have an impact on life expectancy, just as we're starting to see life expectancy tail off in the elderly in the last 2-3 years, and the increase in life expectancy we've become used to over the last decade or so is starting to wear off. …. So the long-term health implications of the recession are not yet really working their way through but over the next 15 years of the MCP, we will start to see any areas and populations in Dudley that have been particularly adversely affected, we will start to see those negative health impacts. [Interviewee]*

- Declining morbidity compression (the duration of increased ill-health prior to death);

> *It's all well and good for partners to sign up to the table and say that population health is a good thing but actually trying to implement that at scale, if in reality it proves to be a harder slog than we think to turn around population health of Dudley, it would be quite easy to go back into patient treatment mode as opposed to disease prevention mode. And if financial incentives are not aligned towards rewarding health promotion then we won't have any levers to improve population health and we'll be stuck with a 15-year contract that delivers more of the same. [Interviewee]*

- Clinical innovations (e.g. the development of cures for conditions that currently consume significant resource).

4.2.6 Economy

Policy factors relating to health and care services, including in respect of funding levels, have been addressed above, so here we simply highlight some of the underlying economic factors that may impact funding decisions.

In the short term, a common view[43] is that there will be constrained investment and growth in the UK whilst uncertainties linked to Brexit are resolved but that there may then be a return towards trend growth.

[43] For example, Aengus Collins - Chief EU Analyst at The Economist Intelligence Unit
https://www.chathamhouse.org/system/files/publications/twt/Brace%20yourself%20for%20the%20future.pdf

Long term projections by PwC[44] suggest that:

- *The UK could be the fastest growing economy in the G7 to 2050, with average annual growth of 1.9%*
- *Remaining open to talented workers and developing successful trade links with fast-growing emerging economies will be critical to realising the UK's long-term growth potential*
- *The world economy is projected to double in size by 2042, growing at average annual rate of 2.5% to 2050*
- *Six of the seven largest economies in the world are expected to be emerging markets by 2050, led by China*
- *India could overtake the US as world's second largest economy in PPP terms by 2050, with Indonesia rising to fourth place*
- *The EU27's share of world GDP could fall to below 10% by 2050, with France out of the top 10 and Italy out of the top 20.*

What might be the impact of above average growth in emerging economies? Their increased wealth may lead to increased demand for UK products and services; it may also slow emigration, adding to workforce shortages in the UK. If growth in other countries has an adverse impact on UK manufacturing industry, this could be felt especially strongly in Dudley (14.4% of Black Country jobs are in manufacturing compared with 8.1% nationally[45]).

> *If the Brexiteers have got it right, then maybe the country will boom but if not, we may find ourselves more like Greece, where we're impoverished by leaving rather than enriched by it. So I think the outcome is difficult but I definitely think we'll have uncertainty. [Interviewee]*

Data on jobs by sector in Dudley[46] also shows the significance of the health sector. By contrast, Dudley has lower rates of employment in professional, scientific, technical and financial sectors compared with the West Midlands Combined Authority (WMCA) average, sectors that are conceivably better placed to benefit from new trade agreements and growth in emerging economies. Business, professional and financial services sectors produce 25.4% of WMCA Gross Value Added (GVA).[47] Training and productivity are likely to be key issues, and these would need to be underpinned by a healthy population.

[44] *The World in 2050* (PwC, February 2017). http://www.pwc.com/gx/en/world-2050/assets/pwc-the-world-in-2050-full-report-feb-2017.pdf
[45] https://www.the-blackcountry.com/economic-intelligence-unit/black-country-economy
[46] https://www.the-blackcountry.com/economic-intelligence-unit/black-country-data-sets/data
[47] https://www.wmca.org.uk/media/1396/annex-1-wmca-productivity-commision-intelligence-pack-08122016.pdf

	Sector	Dudley	Black Country	WMCA
2015	1 : Agriculture, forestry & fishing (A)	0.1%	0.0%	0.0%
	2 : Mining, quarrying & utilities (B,D and E)	0.7%	2.0%	1.3%
	3 : Manufacturing (C)	14.4%	14.8%	11.3%
	4 : Construction (F)	6.3%	5.4%	4.8%
	5 : Motor trades (Part G)	2.7%	2.2%	1.9%
	6 : Wholesale (Part G)	7.2%	6.5%	5.2%
	7 : Retail (Part G)	11.7%	9.9%	8.9%
	8 : Transport & storage (inc postal) (H)	3.2%	6.7%	5.7%
	9 : Accommodation & food services (I)	5.4%	4.5%	5.5%
	10 : Information & communication (J)	1.6%	1.3%	2.4%
	11 : Financial & insurance (K)	1.6%	2.0%	3.4%
	12 : Property (L)	0.9%	1.6%	1.6%
	13 : Professional, scientific & technical (M)	5.4%	4.9%	7.2%
	14 : Business administration & support services (N)	9.0%	8.5%	9.3%
	15 : Public administration & defence (O)	4.1%	3.1%	4.1%
	16 : Education (P)	9.9%	9.2%	10.6%
	17 : Health (Q)	13.5%	13.0%	12.7%
	18 : Arts, entertainment, recreation & other services (R,S,T and U)	3.6%	4.5%	4.1%
		100.0%	100.0%	100.0%

Analysis by ICF International and the Strategy Unit for the Black Country and West Birmingham Sustainability and Transformation Partnership suggests that productivity-related GVA increases of £25m could be achievable through focused NHS action on improving access to appointments and enhancing support for people with common mental health problems and for those who provide informal care.

4.2.7 Summary of key factors

The factors described above are clearly not exclusive and, equally clearly, overlap and interact in terms of their potential impact on the MCP and its transactional environment. Nevertheless, it is possible to distil a set of factors under the main themes above that can be used in the development of a range of plausible scenarios.

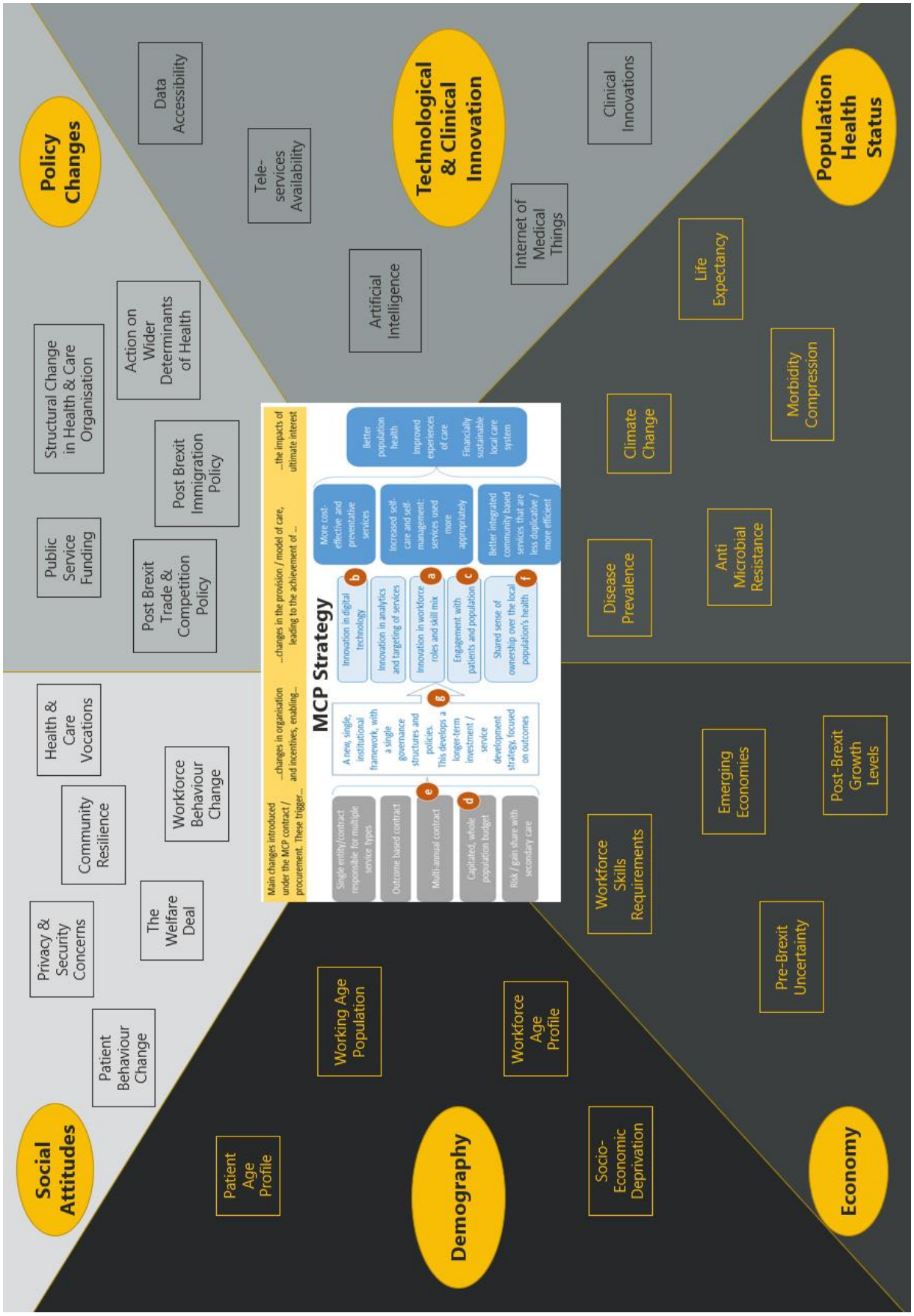


Figure 11 - Summary of Key Factors

5. Future Scenarios

5.1 Scenario development

Following our analysis of the MCP's strategy and evolving contextual environment, a full day workshop was held to begin shaping a set of scenarios that would be useful for Dudley MCP. That workshop involved a core team from the Strategy Unit plus a number of external participants who were either expert in healthcare issues and/or experienced in the Oxford Scenario Planning Approach (OSPA). This approach[48] seeks to assist organisations to make strategic decisions in uncertain, novel, turbulent or ambiguous circumstances by creating and reflecting on a diverse set of plausible narratives about how the organisation's wider contextual environment might evolve over a given period.

In the scenario development workshop conducted by the Strategy Unit, the identified contextual factors were reviewed, revised and, where necessary, expanded before the construction of the scenarios was commenced. Following the initial construction of the scenarios in the workshop, more detailed narratives were developed subsequently, and these continued to be refined ahead of their deployment with Dudley stakeholders. Additional audio and visual materials were also developed to help participants immerse themselves in each scenario. By their nature, the scenarios can continue to be revised and refreshed, as required, informed by these and/or other factors. The scenario method provides an open framework for ongoing collaborative learning.

5.2 Scenario framework

The scenarios for Dudley were developed using an approach within the 'intuitive logic' school of scenario planning known as the inductive method. Whereas the deductive method begins with a structured framework (often a two-by-two matrix formed of critical uncertainties in the contextual environment), here we have created a comparative framework post hoc to highlight key differences between the scenarios.

The framework used (see Figure 12 - Scenario Framework) reflects a number of key features that are relevant to all the scenarios but in different ways. These features are closely related to the key assumptions within the MCP strategy that were identified in the research phase. Each scenario also reflects other critical factors that may affect the MCP going forward – some potentially more significant than those used in the framework.

- In the **State Supreme** scenario, the effects of enduring austerity have led to a desire for much greater state control over national life, especially the determinants of public health, wealth and wellbeing.

[48] https://sloanreview.mit.edu/article/using-scenario-planning-to-reshape-strategy/

- In the **Community Resilience** scenario, there has been a loss of public trust in the ability of both private and state bodies to address the nation's needs, leading to the resurgence of local community groups, both established charities and informal collectives, as one of the prime drivers in national life.
- In the **Corporate Rules** scenario, the agreement of new trade deals with global partners introduces increased competition into English health and care services, leading to a large-scale move towards insurance-based provision with a minimal state safety net.

Figure 12 - Scenario Framework

Key Uncertainties			
1. Responsibility for Health What is the societal view of where the prime responsibility lies for health, care and wellbeing?	**Individual prevention /management**	**Shared responsibility**	**Institutional cure/ management**
2. Control of Care Where does the balance of control sit for publicly funded health and care services?	**Place-based**	**(Sub) Regional**	**National**
3. Size of the State What is the scope of the 'social contract' – the extent to which public needs are met by public means (including regulation)?	**Emerging economy level** (c.25% GDP)	**USA level** (c.35% GDP)	**EU level** (c.45% GDP)
4. Health of the Economy How does the real economic growth of the UK (allowing for inflation) compare with historic trends?	**Weak net growth** (0% Real GDP average)	**Average net growth** (2% Real GDP average)	**Strong net growth** (4% Real GDP average)
5. Take Up of Technology To what extent are people willing to trade potential risks to privacy, security and human interaction to access the capabilities of digital technologies?	**Low take-up**	**Moderate take-up**	**High take-up**
6. Supply of Workforce How readily can the workforce required for health and care be recruited?	**Low availability** (15% vacancy rate)	**Moderate availability** (10% vacancy rate)	**High availability** (5% vacancy rate)

In the table that follows (Figure 13 - Scenario Synopsis), the three scenarios we have developed are mapped against these key features alongside an 'official future' that represents what we take to be the default assumptions for the MCP. For the other scenarios, the key features are intended to reflect the end position of each scenario in 2033 (clearly these are unlikely to be static over a fifteen-year period).

Figure 13 - Scenario Synopsis

SCENARIO SYNOPSIS	Official Future	State Supreme	Community Resilience	Corporate Rules
KEY FEATURES	*In this scenario, the letting of a long term, outcomes-based contract to a single entity, delivering services against a new model of care, takes place against a broadly stable external environment.*	*In this scenario, the effects of enduring austerity have led to a desire for much greater state control over national life, especially the determinants of public health, wealth and wellbeing.*	*In this scenario, there has been a loss of public trust in the ability of both private and state bodies to address the nation's needs, leading to the resurgence of local community groups, both established charities and informal collectives, as one of the prime drivers in national life.*	*In this scenario, the agreement of new trade deals with global partners introduces increased competition into English health and care services, leading to a large-scale move towards insurance-based provision with a minimal state safety net.*
1. Responsibility for Health	Individual prevention /management	Institutional cure/ management	Shared responsibility	Individual prevention /management
2. Control of Care	Place-based	National	Place-based	National
3. Size of the State	USA level (c.35% GDP)	EU level (c.45% GDP)	USA level (c.35% GDP)	USA level (c.35% GDP)
4. Health of the Economy	Average net growth (2% Real GDP average)	Weak net growth (0% Real GDP average)	Average net growth (2% Real GDP average)	Average net growth (2% Real GDP average)
5. Take Up of Technology	Moderate take-up	High take-up	Moderate take-up	High take-up
6. Supply of Workforce	Moderate availability (10% vacancy rate)	High availability (5% vacancy rate)	Moderate availability (10% vacancy rate)	Low availability (15% vacancy rate)

6. Dudley Learning

6.1 Stakeholder workshop

In advance of the half-day workshop in January 2018, participants were provided with a summary of the research phase of the project (sections 2 to 4 of this report) and asked to read it in preparation. Over 30 participants attended in total, representing the senior leadership of all local NHS organisations along with representatives of Dudley Metropolitan Borough Council and the local voluntary and community sector.

On the day, the purpose of the project and the potential value for Dudley of using scenarios were highlighted with participants being invited to reflect on examples from their own experience of when organisations have suffered through not being adequately alert to future eventualities and what they might have done to be more agile or resilient in the face of uncertainty. Participants were asked to leave behind organisational perspectives as far as possible and to consider the potential impact of the scenarios on the whole health and care system in Dudley and what practical actions or mitigations the system might want to consider in response.

After an introduction to the nature of the scenarios and how they should be used, participants divided into three groups to separately consider each scenario. It is important to note that the value of the scenarios lies as much in how they can help participants to reframe current perspectives and priorities, regardless of how the future actually evolves, as in how they might respond to a particular scenario should it materialise. In their respective groups, participants were gradually immersed in a scenario through audio and visual aids, through a summary of the core logic of the scenario and finally through an individual reading of the full scenario narrative. They were then asked to consider and discuss a set of structured questions, and to prepare a presentation for the subsequent plenary session on the nature of their scenario and their reflections on it. The key questions considered were:

- *What is your gut reaction to this scenario in one brief phrase?*
- *Thinking of the scenario narrative itself (not its impact on the MCP), identify two questions that are unanswered.*
- *Thinking now of current MCP plans and assumptions, list the main challenges/ opportunities created by this scenario.*
- *What does the scenario make you think the MCP/other stakeholders should do more of, do less of or do differently*?

In the plenary session, participants questioned each other about what they reported and began to identify common themes. Those reflections are summarised in the sections below. In addition to drawing on participants' own notes from group discussions, they also reflect the content of plenary discussions and comments made in a follow-up survey completed within 10 days of the event.

There was lively discussion throughout the workshop, evidencing the extent to which participants were fully engaged in the process. Their perspectives on the workshop were subsequently explored in an anonymous survey to which 13 participants responded. This revealed that:

- Participants felt very strongly that the workshop provided safe space for expressing divergent views in a way that did not lead to fragmentation (despite the wide range of personality types and backgrounds, and the different underlying organisational allegiances). Instead they felt equally strongly the scenarios led to fruitful conversations within an approach that they would recommend to other organisations. In free response, participants described the approach as a *highly developed piece of innovative work that was thought provoking* and provided *an opportunity to engage with people in a different way*. Others commented that it broadened their thinking, clarified their priorities and helped them to see that *nothing is implausible and such massive change is difficult.*

- Other factors that were very strongly associated with the success of the workshop were the clarity of executive support for the event, the memorable and contrasting narratives that had been prepared and the way that the process helped to make key issues explicit.

- It is generally assumed that the potential impact of scenario work increases when participants are directly involved in developing the scenarios not just reflecting on them. Respondents did not feel their lack of involvement in the development phase had adversely affected their use of them (although they clearly lacked a comparator experience).

- Participants also responded positively to statements about the uncertain nature of the environment facing the MCP, the learning culture of local organisations, the role of the method in uncovering assumptions and the impact of the detailed contextual analysis on their thinking.

- Whilst there were strong responses in terms of the extent to which the scenario workshop affected participant views about the future environment of the MCP and/or what local partners should do in response, there were also indications that they felt there was inadequate time in one half-day to fully explore future uncertainties and potential responses, neither were they convinced of the likelihood of the work being continued in the MCP or its partner organisations (whereas the research evidence suggests that this is necessary if such a workshop is to avoid being an island experience).

- In free text responses, participants noted the value of surprising yet plausible narratives, of the variety of perspectives shared in discussions and of using uncertainty as a means of identifying opportunities and threats.

6.2 State Supreme scenario

6.2.1 Group summary

Several participants expressed initial scepticism about the plausibility of this scenario[49], and they clearly found the enforced and, as one person put it, *totalitarian* nature of public health measures it described to be unpalatable. Whilst the majority of responses were negative as to the desirability of this scenario, positive comments were made about the role played by young people and what was described as the *sensible* nature of some elements described (such as employer's granting employees time for exercise). In considering the scenario in itself, participants commonly found themselves wondering about the following issues:

- How far the population would have been willing participants in the changes described;
- What the impact of these changes might have been on mental health and wellbeing;
- Whether leaders had displayed a lack of foresight in not seeing this scenario coming, whether an increasing gap between generations might have contributed to this, and what leaders might have done to try and solve emerging issues;
- How the economics of this scenario would work and whether there was any room for the private sector in it; and
- How traditional education, family and community networks might have changed.

When participants turned to considering the challenges and opportunities that current plans for the MCP might encounter under this scenario, it was felt that it could have a fundamental impact on the MCP model, with Public Health responsibilities moving to the new 'Public Wellbeing Service' (along with health and education), organisational boundaries such as between acute and primary care being removed, and increased resources being allocated towards mental health and wellbeing services. The changing workforce requirement of the MCP model was seen to be a challenge, with respondents noting the MCP's need to be a leading employer in workplace wellbeing and

[49] There is evidence of the potential public acceptability of such an approach: https://ems.ipsos-mori.com/Assets/Docs/Publications/sri-ipsos-mori-acceptable-behaviour-january-2012.pdf

questioning the extent to which the workforce would be amenable to the significant changes in working practices that the MCP would require of them. There was also concern about how the nature and level of demand could challenge existing forecasts. Another, more fundamental challenge to the MCP model was seen to come from the loss of local autonomy in this scenario, given that the model is predicated on empowering communities rather than reducing personal choice and placing decision-making in the hands of others.

In terms of opportunities, those highlighted by participants included:

- Adapting healthcare delivery to innovations in information technology;
- Reallocating potential energy cost savings to service delivery;
- Engaging in health education differently, and thinking what kind of health culture we want; and
- Considering the services that wrap-around health rather than maintaining a narrower health-only focus.

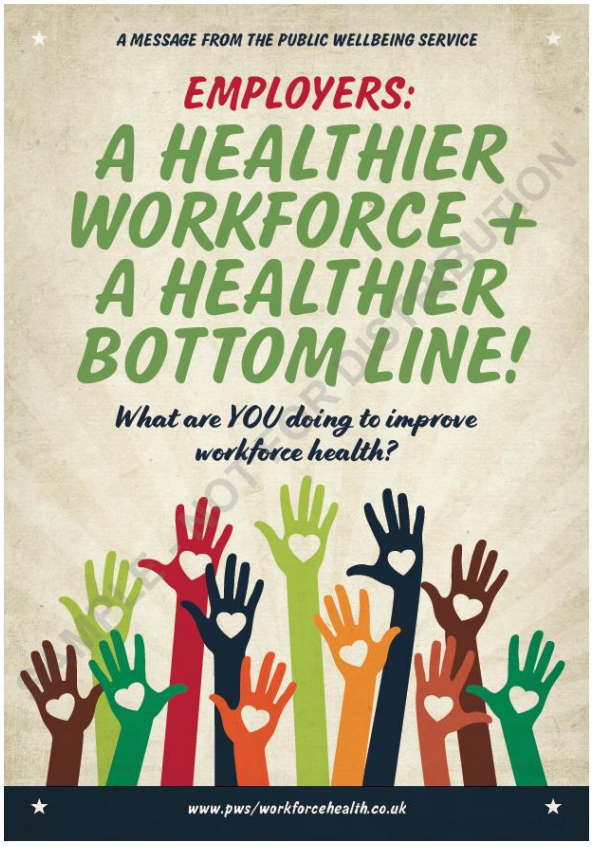
In response to being asked how current plans should be enhanced as a result of considering this scenario, participants recorded the following suggestions:

Local partners should consider:
More
• Being more adaptable, including accepting a future without all existing partners; • Understanding more about health inequalities; • Increasing health promotion activities that enable individual choices, particularly for un-engaged groups; • Co-producing clinical models; • Understanding the potential impact of demographic change on health needs; and • Increasing the focus on the mental health and wellbeing offer.
Less
• Not letting national targets dominate their thinking and planning.
Differently
• Thinking more about themes than structures; • Developing clinical models that deliver change rather than just more for less; • Building the local system on an agreed desired health culture; • Working with non-traditional partners and though non-traditional networks to increase health education; • Encouraging employers to take responsibility for health and wellbeing; • Developing a flexible and agile workforce;

- Flexible outcomes framework
- Being ambitious and taking risks in relation to the opportunities presented by technological developments;
- Considering the role and impact of health on the Black Country economy, and vice versa
- Recognising the diversity in health needs across Dudley.

6.2.2 Plenary

The group reported that the MCP concept and strategy cannot be separated from the social culture in which it will operate. The MCP may have opportunities to influence that culture but it will also need to work with it and to be aware of emerging changes in that culture over time. In particular, the MCP will need to ensure that it is effective in impacting groups that are described as 'under served' or 'hard to reach'. The MCP might also consider a differentiated approach for impacting the diverse communities of Dudley rather than assuming that a 'one size fits all' approach will be effective.



School nursing and CAMHS services are within the scope of the MCP but, rather than simply providing discrete services, the MCP should consider how it can best influence the lives and healthy development of children and young people. This was described as a challenge to see 'the bigger picture' and to work with young people as drivers of change in both health outcomes (physical and mental) and wider life outcomes.

Greater national control of health and care services would be a real challenge to the MCP and this could include the re-introduction of perverse incentives through national target setting and performance management. The MCP should maintain a clear, shared system narrative for what it is trying to achieve locally but also be ready to adapt, where possible, to drivers from regional and/or national systems.

Technology represents a massive opportunity for the MCP – not least in terms of driving better lifestyle behaviours (reference was made to the success of the *Pokemon Go* app amongst poorer children). The MCP should ensure that it continues to think how it can harvest the benefits of current and emerging technologies over the next 15 years, and avoids the risk of limiting technological developments to achieving the interoperability of existing systems.

If the MCP is really to deliver a transformed model in which services are wrapped around the population (rather than simply maintain the status quo), it will need to ensure that public/patient empowerment is key to the model that is operationalised. It was recognised, however, that a context of increasing state control/direction could be disempowering for individuals and communities. Some people prefer to have great individual choice; others prefer to be told what to do. The MCP has the potential to implement a model of genuine co-production of health and wellbeing.

The scale, culture and behaviours of the MCP workforce will clearly be critical to its impact. There is real potential for the workforce to benefit from additional technological aids but a linked risk to personal patient contact and to team cohesiveness where tasks are automated and/or digitised. There is also real opportunity for the MCP to develop a significant focus on workforce wellbeing – both to make that workforce more resilient and effective, and also to be exemplars for the wider population.

6.3 Community Resilience scenario

6.3.1 Group summary

Several respondents highlighted the geographic inequity evident in this scenario - largely assumed to be linked to social-economic conditions. Whilst there was concern about the risks arising from a potential lack of regulation of services provided by local communities, there was also a sense that communities taking responsibility in this way might be possible in the right circumstances.

In considering the scenario in itself, participants commonly found themselves wondering about the following issues:

- How equipped communities might be for dealing with the challenges of delivering health services;
- What the impact has been on vulnerable groups and individuals;
- How public and private resources have been distributed to support this model of care financial and other, such as technology, data and intelligence resources;
- What has happened to clinical science;
- How demographic change has influenced the model;
- Whether enough priority had been given to mental health and wellbeing
- How resilient such a system would be and whether it had replaced primary care as the first contact point;
- Whether leaders had displayed a lack of foresight in not seeing this scenario coming and what leaders might have done to try and solve emerging issues; and

- Who the decision-makers were in such a scenario.

When participants turned to considering the challenges and opportunities that the current plans for the MCP might encounter under this scenario, it was felt that it could adversely impact funding for statutory services such as those commissioned from the MCP and that the resulting competing for the remaining public resources could lead to fragmentation in health economy, to the detriment of patient outcomes including through making it more challenging for acute care providers to continue providing more complex care. There were also concerns that workforce planning could become even more difficult given the diversity of service delivery mechanisms in this scenario. It was recognised, however, that these same challenges could also act as spurs to innovation, and that the reduced dependence on public sector funding could allow for more freedom in local decision-making (subject to whatever regulatory regime was in place).


Anytown Weekly

FREE

24 January 2033

www.anytown.co.uk

Community spirit ensures it is not just survival of the fittest

Anytown Community Health and Wellbeing Centre has played a crucial part in the survival of residents since opening its doors a year ago.

With public services failing and private companies growing too big to address local needs, Anytown Neighbourhood Forum listened to the community and began plans for a community health centre back in 2030.

Steve Newton who Chairs the forum reminds us:

"Thank goodness we had the foresight to do this. The centre has proved vital for not only local residents but also the thousands from further afield who have turned to it.

None of this would have been possible without the community pulling together to give their time and money to get the centre open. Thanks to local trades and generous donations, Anytown residents can access the health and wellbeing services at a time and place that suits them."

The founding members' vision was for a modern, fit-for-purpose building in the heart of Anytown with the flexibility to offer everything from urgent care support to mental health clinics. The centre also hosts a popular weekly Zumba class which is free for diabetic patients, and Anyshire Housing Association also holds a monthly surgery for local tenants.

The figures speak for themselves – more than 10,000 appointments have been filled in the last 12 months, with the added inconvenience of having further to travel and expensive car parking charges. Meanwhile, Anyshire Hospital Trust hit the headlines again only last week for having to cancel a number of non-urgent procedures due to winter pressures.

Continues on page 4

Allotment Swap Shop

Every Saturday from 9am | Market Square

Bring your freshly-picked fruit, veg and eggs to the market square. Share with your neighbours to make healthy, balanced meals for the week.


Anytown Weekly

24 January 2033

Looking after their elders

Sixth-form students from Anytown Academy have been giving up their time to check on elderly neighbours this winter.

Many older people are determined to remain living in their own homes for as long as possible, but are particularly vulnerable in the cold weather.

Seventeen-year-old Lottie Jones was inspired to get her friends involved when her grandmother asked for help.

"My Granny needed some groceries but was anxious about falling over on the icy pavements. I realised that there would be many more people like her who might not have anyone to ask for help, so we've been calling and visiting older people in the town every week over the winter to check on them."

The students also found that these visits were often the only interaction that some of the older people had from one week to the next, so have also started to look for social activities that can be organised to bring older people together.

If anyone is able to host an event or arrange to drive people to an event, please contact Lottie via the receptionist at Anytown Academy.

Unlikely housemates: Young and old share accommodation to look out for one another. > See page 11

FREE

Healthy Cooking Class

Tuesday evening at Molly's Café

Drop in to view the full schedule and reserve a place.

Book early to avoid disappointment

You asked, we listened:

Free flu jab clinics throughout February

GET YOUR FREE FLU JAB

Flu can be particularly dangerous for the most vulnerable people in our community such as the elderly and people with long-term conditions.

By popular request, free flu jab clinics have been arranged by Anytown Community Centre every Monday in February – simply drop in any time between 9am and 11am.

Women's Institute February Meeting

Sandra will give a talk on homeopathy and herbal treatments.

Wednesday 7 February at the Church hall from 7pm – all welcome.

Geoff Matthews, who manages the Community Centre said:

"Once again we have acted swiftly in response to the needs of the people of Anytown by arranging for Nurse Laura to run these clinics. So I urge everyone to take up this opportunity to get the jab."

In terms of opportunities, those highlighted by participants included:

- Encouraging personal responsibility for health and care, and empowering communities to change behaviours;
- Encouraging joint working across economic, geographical, community boundaries;
- Engaging the voluntary sector to support it in its increasingly important role;

- Making better use of community facilities for delivering care with communities becoming recognised 'places' where care is delivered rather than acute settings;
- Primary care clinicians becoming 'community' physicians, delivering continuity of care for patients; and
- The MCP gaining autonomy from current statutory regulation and control mechanisms.

In response to being asked how current plans should be enhanced as a result of considering this scenario, participants recorded the following suggestions:

Local partners should consider:
More
• Taking more positive risks and making braver decisions over stopping what doesn't work; • Focusing more on prevention and public health; • Thinking local/act personal; • Increasing workforce planning and engagement; • Challenging national policy; • Acting as a system leader and having clear strategy for system change; • Working with community leaders to create community resilience; and • Creating greater alignment between clinical and non-clinical services.
Less
• Reducing access to inappropriate services; and • Scaling back hospital services in favour of more community-based care.
Differently
• Redirecting funds to community assets; • Understanding what communities want from healthcare and build it around their needs and ideas, not just the health providers. Make them aware of financial limitations within which they must make decisions through working through real scenarios; • Playing a more extensive role in the economy via greater influence over the supply chain, for example. • Drawing clear boundaries between planned and non-planned care; • Distinguishing priority services from others where communities can decide what else they need and how it should be delivered; and • Seeking funding from alternate (non-NHS) sources.

6.3.2 Plenary

The group reported that this scenario highlighted the need for the voluntary and community sector to be adequately resourced in order to play an effective role in the MCP, including as an integral

part of locality multi-disciplinary teams (MDTs). This resourcing – supported by more joined up health and care commissioning - should be part of a stronger focus on community engagement that includes seeking our and taking up community-generated ideas. The economic challenges in this were observed.

In particular, the MCP workforce will need to be mindful that 'one size does not fit all', to be responsive to the distinct needs and preferences of each locality and to positively nurture the influence of the local community on MCP provision. The MCP should remove barriers, shift power and take local communities seriously. Dudley's diverse communities have different levels of resilience, so the MCP will need different approaches appropriate to each community as opposed to deploying a simplistic franchise model of provision.

The opportunity for the MCP to become an effective system leader was highlighted, bridging the public, private and third sectors. Organisations should consider the potential to 'merge to serve; a manufacturing/commercial arm of the MCP could be considered to contribute to local growth; and social care should be part of the integrated MCP offer. The value of MCP staff living and working locally was also proposed.

Challenges will be faced in delivering an organisation that embraces a real focus on the needs of each local community but which also has to comply with the requirements of a regulated, top-down system.

6.4 Corporate Rules scenario

6.4.1 Group summary

Several respondents commented that this scenario could incentivise people to self-manage their care needs but that there would be a risk of care becoming differentiated and inconsistent *at the expense of a smaller group left behind*. Overall there was a feeling that this was an entirely plausible scenario.

In considering the scenario in itself, participants commonly found themselves wondering about the following issues:

- How local populations had adapted to the changes and whether a two-tiered system accounts for variation in utilisation rates;
- What the scale of change in 'lifestyles diseases' has been;
- How health education has changed;
- How workforce planning is managed;
- Who the insurers are and whether they are Accountable Care Organisations;

- Whether there is a minimum standard of care and, if so, how this is regulated;
- What the extent of cultural resistance to these changes there has been;
- How health inequity has been impacted; and
- How other public services interface with this model.

When participants turned to considering the challenges that might be encountered under this scenario, it was felt that there would be tensions between individual and population health, and between competition and collaboration. There would also be a lack of clarity over the responsibility for workforce planning and in relation to oversight and improvement. Participants also saw a challenge in respect of the market positioning of the MCP: where should it place itself on the care provision axis (from safety net to full spectrum health provider) and how would it differentiate itself from private providers (who might cherry-pick the most profitable services) if it chose to compete with them?

In terms of opportunities, those highlighted by participants included:

- Expansion into new areas, encouraging innovation in prevention and education to keep down costs whilst sharing responsibility for service delivery;

- Using the MCP's role as a major employer to influence approaches to tackling inequalities, and its economic scale to drive down costs, focusing the benefits on those with greatest need;
- The development of the MCP's own research and development function to unlock technological opportunities;
- The 'market' may be able to flex more easily to population change.
- Commoditising the data, information and knowledge generated in the MCP, especially through its centralised business intelligence function.

In response to being asked how current plans should be enhanced as a result of considering this scenario, participants recorded the following suggestions:

Local partners should consider:
More

• Increased investment in –
  ○ the workforce (including volunteers)
  ○ technology
  ○ infrastructure
  ○ community engagement to build social capital; and
• Greater focus on marginalised groups with poor outcomes.

Less
• Reduced concentration on regulatory compliance.
Differently
• Defining our values and what we offer so we have an organisational confidence that can help us position ourselves in a changed landscape; • Education and engagement – discussing the responsibilities of individuals in an insurance-based health economy; • Prioritising the development of an agile workforce; • Encouraging shared responsibility as a way of working; and • Differentiating routes of access for different population segments, avoiding a 'one-size fits all' approach to any aspect of health and care.

6.4.2 Plenary

The group reported that, in this scenario, the MCP could be a business that considers merging with and/or acquiring similar organisations in order to compete in an insurance-based health and care market. It could also brand itself as a test bed for different ways of working and use this as one way

of making Dudley a more attractive economy to work in. There is a real opportunity for the MCP to be clear about the distinctiveness of its offer and to use this as a tool for differentiating itself from other providers but it will need to be good at explaining this.

In a world of increasing private sector involvement, there could be a fragmentation of training (including uncertainty around the funding model for training) and a loss of national standards. Where public resources remain highly constrained, and the scope of services is reduced, the MCP will need to consider how to address the associated inequality challenges.

An increased use of technology, especially automation and artificial intelligence, could have an adverse human impact, leading to greater loneliness and isolation and to poorer mental health. The MCP should consider ways of mitigating that impact.

The MCP should invest in its workforce: train to understand its values; equip to utilise technology; have an individual focus on the future; invest in leadership; think long and hard about the identify o the organisation; and define and differentiate the MCP offer for the workforce and the population.

6.5 Common themes

Although the scenarios present divergent futures, none of which may materialise during the coming 15 years, they each provoked new perspectives on the actions and mitigations that the MCP and wider Dudley partners might prioritise in order to increase the agility, resilience and effectiveness of local health and care services. It is possible to identify a number of common themes across participants' responses to each scenario:

6.5.1 A genuinely transformational focus on responding holistically to the needs of Dudley's neighbourhoods

This was the most consistent theme across responses to all three scenarios. It contains a number of points of emphasis:

a) Breadth of vision and action

The MCP is being created to respond to local need in a more holistic and long-term manner. Participants recognised that, notwithstanding this fundamental intention, there remained a danger that the organisational vehicle being created to deliver the local model of care could too easily default to the siloed, dis-integrating behaviours customary in much of the NHS. There was some sense expressed that, perversely, the requirements of the procurement process may unwittingly have increased that danger. Transforming experience and outcomes has had to compete with issues of organisational form and governance. An example of this emerged in relation to the MCP and local schools: school nursing services are included within the scope of the MCP contract but will the MCP provider, once

commissioned, look narrowly at how best to provide that single service line or will it take a broader view about how to maximise the interaction of health and education in Dudley?

Participant responses to all three scenarios indicated the need to develop a more robust approach to the prevention of ill health, including how the MCP and its partners can positively impact the wider determinants of health, not least through fostering greater community resilience. One participant was struck by

> *the realisation that much of the determinants of health outcome lies outside the remit of the NHS.*

To achieve this, local partners would need to be prepared to build collaborative relationships with non-traditional partners and actively seek out new networks so that the MCP is able to respond quickly to change and to see opportunity, as much as challenge, within that change.

b) Active listening

There is a recognised need to clearly communicate the MCP's role so that local communities are helped to understand what it is and what it does, particularly in relation to shifting care from acute settings and to engaging the population around issues of prevention and appropriate self-management.

Whilst there has been extensive engagement to date by the CCG in developing the MCP model, the nature of the transformation proposed here does not appear to be one that public bodies can consult the public on once and then proceed to implement and adapt as they see fit. Rather this is a model that will require the breaking down of barriers between 'service provider' and 'service recipient'. So, the MCP, along with other local partners, should be prepared to evolve and change in response to 'the voice of the community'. In the post-workshop survey, one person observed that

> *Because the MCP has a community empowerment workstream, I assumed that MCP partners would have a shared understanding of what it means and why it is important, but that clearly is not the case.*

Another commented that

> *We need to do more work together to understand what we mean by community empowerment across the MCP and its implications for how the MCP needs to operate.*

The MCP strategy focuses on the things that are expected to derive long term outcome benefits for the health and wellbeing of the local population. To achieve those benefits it will need a lively, open and non-paternalistic relationship with each of Dudley's local communities. As one person observed after the workshop,

As it is a new entity the MCP is missing its leader who needs to engage differently with Dudley residents/communities than standard NHS CEOs.

Participants recognised the need to listen to voices other than simply those of public service regulators (which themselves mediate the public voice in specific ways). This will be a substantial challenge, particularly in relation to reaching beyond established patient groups or specific interest groups, and finding a wider range of voices that can continuously influence how the health and wellbeing of the local population is the shaping and delivery of services. It should also include a particular attentiveness to marginalised, under-served and 'hard to reach' groups.

Building social capital should be a priority for the MCP, not least to support the expectation of a more active and integral role for the voluntary and community sector within the MCP. An added value of this approach might be to increase the sense of community ownership of the MCP, making it more resilient to wider political, social or economic dynamics.

6.5.2 A strengthened focus on the critical enablers of the MCP strategy's success

Whilst it was not suggested that the following two enablers should be the only ones receiving increased attention, they did stand out in participant responses.

a) Workforce

The MCP will not be able to deliver the desired transformation in healthcare outputs and outcomes without a workforce of the requisite scale and characteristics. It was suggested that the MCP should position itself as one of the region's best employers, regularly reviewing roles and responsibilities and focus on attracting and retaining staff who can adapt to change as well as provide quality services. That adaptability is likely to be critical: the context of the MCP will, in some ways, be more akin to that of the community worker than the specialist clinician so its workforce will need the culture and competencies to bridge these worlds. Professional boundaries will need to be porous (without undermining adequate clinical governance): there will need to be a strong underlying culture of an integrated 'team Dudley', sharing responsibility to ensure that individual needs are met holistically through co-production with patients and service users. One survey respondent observed that the MCP

must break down organisational barriers (not only within the NHS).

Another noted that

Further work is needed across MCP partners to be clear about how we can contribute to the culture we want to see in Dudley.

Although it was not specifically highlighted by participants, it may also be necessary for the MCP to engage proactively with training providers (or even to consider moving into that space itself) and professional bodies to ensure that there is a flow of staff with the right combination of skills as well as an appropriate set of values.

b) Technology and innovation

The ability of both the workforce and local communities to support the success realisation of intended MCP outcomes can be significantly enhanced by the appropriate deployment of existing and emerging technologies.

A fundamental part of being able to adapt to change will be investment in technology and innovation in relation to all aspects of the model from method of delivery, to workforce and infrastructure.

Again, this is not simply a task that requires specialist expertise which can be determined remotely but one that needs to be explored and negotiated with local communities and with the MCP workforce. There do appear to be real opportunities to improve and simplify healthcare through assistive technologies, artificial intelligence, interconnected devices and the like. None of these things will realise their potential, however, without adequate public and professional buy-in.

7. Next Steps

Participants highlighted the value of exploring these plausible alternative scenarios in a safe environment, away from day to day transactional considerations. They concluded that the MCP Partnership Board and others should reflect on the outputs of the scenario work to date and agree how to progress the work further, although they were uncertain that this would take place.

Since the value of scenario work is so critically linked to engagement and participation – and because the research evidence indicates that standalone workshops are often of limited value when detached from ongoing processes[50] – we recommend that partners consider:

a) Holding similar exercises within their own organisations, using a common framework and agreeing to share the outputs of such exercises to increase collaborative system learning;

b) Identifying a process for how priority actions for refining and enhancing the current approach to delivering the MCP will be determined, particularly in relation to the scope of the MCP's vision, its interface with the local community (both in development and in implementation) and its critical enablers. This could be undertaken in a further collaborative workshop that consolidates the insights gained from additional reflection on the scenarios by partner organisations;

c) Using the insights from this work to drive specific practical actions that could include

    i) The reprioritisation of system focus on key areas of MCP development to ensure its maximal effectiveness (Appendix 3 – Summary of Actions);

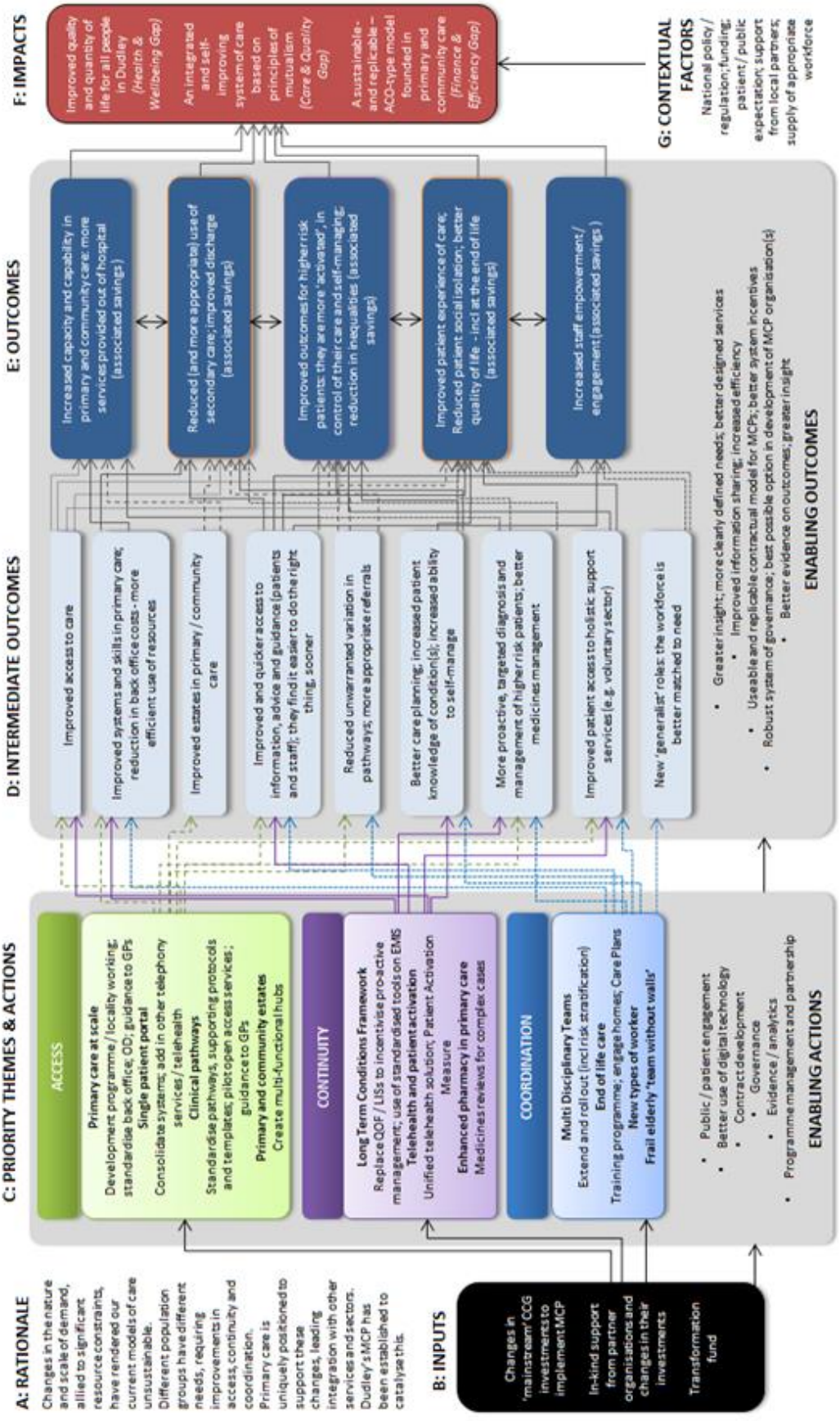
    ii) The development of targeted mitigation plans linked to potential future eventualities; and

    iii) The development of a means of identifying emerging changes in the MCP's contextual environment so as to increase its agility and resilience throughout the 15-year duration of the contract.

d) Promoting the scenarios and the insights generated through NHS England and other appropriate mechanisms, in line with the aim of the *New Models of Care* programme to share learning from vanguard sites nationally.

[50] Off to Plan or Out to Lunch? Relationships between Design Characteristics and Outcomes of Strategy Workshops, Healey, M. et al, *British Journal of Management, Vol. 26, 507–528 (2015)*. DOI: 10.1111/1467-8551.12038
The Ritualization of Strategy Workshops, Johnson, G. et al, *Organization Studies* 31(12): 1589–1618

Appendix 1 – MCP Logic Model



Appendix 2 – AI and the MCP

This is a note of an interview with Matt Fenech of *Future Advocacy*, a UK think tank. We interviewed Matt in relation to a scenario planning project the Strategy Unit is currently undertaking for a programme that is seeking to transform how population health is managed at a local level, improving patient outcomes and making more efficient use of resource.

Matt worked as an NHS doctor for 10 years. This experience helped him understand the value of large-scale, ambitious advocacy projects in improving societal well-being. He now works on Future Advocacy's Artificial Intelligence project[51], advocating for policies that will maximise its benefits while mitigating its potential risks.

We asked Matt about developments in Artificial Intelligence (AI) that might support the delivery of better care and better outcomes in a local health system. We were also interested in the wider factors that might impact the diffusion of these developments, not least their acceptability to patients. Matt highlighted two solutions that already exist and which give a flavour of the potential impact of AI on local health services. These related to clinical diagnostics and to the triaging of patient needs.

1. **Automated Image Processing[52]**

   Diagnostic capacity often causes delay in the instigation of treatment; there is a shortage of Radiologists in the NHS; and the interpretation of diagnostic tests is unavoidably subject to human error. Solutions already exist that can take images from investigations such as X-rays, CT scans and more basic imaging available to GPs. Matt says that early research evidence suggests that these automated processes, drawing on thousands of comparator images, outperforms human doctors and gets it wrong fewer times. In the diagnosis of melanoma, for example, this can be done by the GP without further initial referral (and the associated delay, inconvenience and cost). Matt says

   You can see it as freeing up capacity for hospital radiologists.

   He highlights two key enablers for diffusing this technology: first, the need to train GPs in the limitations of algorithmic decision making; and, second, establishing the acceptability to patients of both the use of AI in decision making concerning their health and the use of their images to support machine learning. A recent Information Commissioner ruling against the

[51] http://futureadvocacy.com/artificial-intelligence
[52] For an example of research in this area see: http://jamanetwork.com/journals/jamadermatology/fullarticle/400665 http://onlinelibrary.wiley.com/doi/10.1111/j.1365-4632.2006.02726.x/full

Royal Free NHS Foundation Trust's use of Google's Deep Mind related to a failure to secure adequate patient consent.[53]

2. Babylon Triage App[54]

Babylon is an example of a health tech start-up. Its triage app currently uses Chatbot technology that is becoming more advanced with the use of AI, particularly natural language processing. Matt is confident that such technologies will continue to improve, highlighting how far common applications such as Apple's Siri and Amazon's Alexa have come. He says that

When paired with diagnostic models there is huge potential for this technology to take off in the health sector.

The Babylon App, as an example, currently offers two levels of service: a free service that enables patients to chat to the app and get advice; and a paid-for service that adds direct contact through to a Doctor or Specialist.

Matt sees real potential for this kind of technology to free up clinician capacity and enable speedy referrals to the appropriate service or Multi-Disciplinary Team, and he is confident that it will be able to play a part in a transformed health system over the next 15 years.

As with the use of AI in diagnostics, however, Matt is concerned that patients are adequately engaged in understanding and consenting to the use of this technology. He says,

We can't assume that people will be willing to share their data. They probably will but, as in clinical trials, they need to be asked!

Future Advocacy is working to secure funding for a project that will explore the issues around patient acceptability through round table discussions and patient engagement.

There are clearly real opportunities and real risks in relation to AI for local health systems looking to transform how they provide care. It is possible to paint a picture of a rosy future in which AI provides solutions to workforce shortages (enabling clinicians to target their skills where they are most valuable), improves the speed and convenience care for patients and support the realisation of improved outcomes and more sustainable services. Without adequate public and patient engagement, however – or through just one or two high-profile problems with the technology or data security – those opportunities may not be realisable.

[53] https://ico.org.uk/about-the-ico/news-and-events/news-and-blogs/2017/07/royal-free-google-deepmind-trial-failed-to-comply-with-data-protection-law/
[54] https://www.babylonhealth.com/

Appendix 3 – Summary of Actions

Local partners should consider:
More

• Understanding more about health inequalities;
• Greater focus on marginalised groups with poor outcomes;
• Understanding the potential impact of demographic change on health needs;
• Increasing health promotion activities that enable individual choices, particularly for un-engaged groups/Focusing more on prevention and public health;
• Increasing the focus on the mental health and wellbeing offer;
• Being more adaptable, including accepting a future without all existing partners;
• Co-producing clinical models;
• Acting as a system leader and having clear strategy for system change;
• Working with community leaders to create community resilience;
• Challenging national policy;
• Taking more positive risks and making braver decisions over stopping what doesn't work;
• Thinking local/act personal;
• Increasing workforce planning and engagement;
• Creating greater alignment between clinical and non-clinical services;
• Increased investment in –
  ○ the workforce (including volunteers)
  ○ technology
  ○ infrastructure
  ○ community engagement to build social capital.

Less
• Reducing access to inappropriate services; • Scaling back hospital services in favour of more community-based care; • Not letting national targets dominate their thinking and planning; • Reduced concentration on regulatory compliance.
Differently
• Developing clinical models that deliver change rather than just more for less; • Thinking more about themes than structures; • Building the local system on an agreed desired health culture; • Recognising the diversity in health needs across Dudley; • Differentiating routes of access for different population segments, avoiding a 'one-size fits all' approach to any aspect of health and care; • Understanding what communities want from healthcare and build it around their needs and ideas, not just the health providers. Make them aware of financial limitations within which they must make decisions through working through real scenarios;

- Defining our values and what we offer so we have an organisational confidence that can help us position ourselves in a changed landscape;
- Distinguishing priority services from others where communities can decide what else they need and how it should be delivered;
- Redirecting funds to community assets;
- Working with non-traditional partners and though non-traditional networks to increase health education;
- Encouraging employers to take responsibility for health and wellbeing;
- Considering the role and impact of health on the Black Country economy, and vice versa;
- Playing a more extensive role in the economy via greater influence over the supply chain, for example.
- Developing a flexible and agile workforce;
- Prioritising the development of an agile workforce;
- Encouraging shared responsibility as a way of working;
- Flexible outcomes framework;
- Being ambitious and taking risks in relation to the opportunities presented by technological developments;
- Drawing clear boundaries between planned and non-planned care;
- Seeking funding from alternate (non-NHS) sources;
- Education and engagement – discussing the responsibilities of individuals in an insurance-based health economy.

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