Dudley Multi-Speciality Community Provider

Public Consultation and Equalities Impact Assessment Report

20 September 2016

Dudley Multi-Speciality Community Provider: Public Consultation and Equalities Impact Assessment Report

A report submitted by ICF Consulting Services

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ICF Consulting Services Limited
Watling House
33 Cannon Street
London
EC4M 5SB
T +44 (0)20 3096 4800
F +44 (0)20 3368 6960
www.icfi.com

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Job No.	30301035
Prepared by	Tim Knight, Peter Farrar and Colin Howat
Checked by	Colin Howat
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Executive summary

Dudley Clinical Commissioning Group (CCG) carried out a public consultation on its proposal to develop a Multi-Speciality Community Provider (MCP) from the 15th July to the 9th September, 2016. This independent report presents the findings from the public consultation and from the exploratory equalities impact assessment undertaken alongside it.

The MCP

The MCP will fundamentally change the way non-acute healthcare is organised and delivered in Dudley. A single provider, with an annual budget of over £200m, will be commissioned to deliver all non-acute healthcare in the borough. The selected provider will be awarded a long-term contract (over 10-15 years) and its performance will be measured primarily on the basis of the health outcomes it achieves for patients and the local population as a whole. A proportion of the funding it receives will also be dependent on these outcomes. This will replace the current situation in which the CCG has individual contracts of 1-2 years with 177 local providers, which are primarily based on the delivery of activities rather than outcomes.

The MCP model has been developed as part of the national NHS 'New Care Models' programme in response to a need to manage the challenges posed by people living longer and with more complex health issues, and at a time when there are constraints on future NHS spending. It has also been designed to address the main issues that local people report with current provision: access to care; continuity or care; and communication and coordination. The MCP will bring together local GP practices, nurses, physical and mental health services, community-based services, relevant hospital specialists and others to provide care that is joined up and puts patients at the centre. Different healthcare providers will work together in Multi-Disciplinary Teams (MDTs) organised around local GP practices, and more services will be delivered in community settings rather than in hospital.

The Public Consultation

This formal public consultation is the latest stage of an on-going dialogue with local people around new care models and the development of an MCP. The consultation was built on the listening exercise which took place earlier this year to help shape the themes of the MCP – access, continuity and co-ordination, and to understand what was really important locally.

Explaining something as new and complex as the MCP, and gaining meaningful feedback from a large and diverse population, is not easy. Nonetheless, by giving people a range of ways to input and carefully communicating information about the key proposed features of the MCP, the consultation reached several thousand people and received over 800 contributions. These contributions were also rich in detail. Some confirm and reinforce the plans for the MCP. Others challenge aspects of these plans and highlight additional concerns that will merit further consideration by the CCG.

861,597 **#MCPconsult impressions on Twitter**

8,910 **reaches on Facebook**

374 **completed surveys**

347 **attendees at 21 public events**

80 **attendees at 7 events for staff**

80 **recorded video diaries**

30+ **written submissions, by email and letter**

The Equalities Impact Assessment

The exploratory Equalities Impact Assessment (EqIA) was undertaken in order to identify any potential ways in which the MCP could have a disproportionate or differential effect on specific groups in the local population. Disproportionate equality effects arise when a specific group comprises a high proportion of the users of the service or services that are being changed. Differential equality effects arise when a specific group is impacted in a different way to other users by the changes being made.

The 2010 Equality Act places a legal duty on public bodies to have due regard to advancing equality of opportunity for nine protected characteristic groups, relating to: age; disability; gender reassignment;

marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and sexual orientation. A tenth characteristic, deprivation, was also considered in this EqIA.

The Dudley Population

Dudley has an estimated population of 316,464, which is projected to increase to around 338,000 by 2039[1]. Overall, the population has a slightly older age profile than the West Midlands and national average. It also contains a higher proportion of people with a disability. Over 1 in 10 residents are in groups other than "White British".

The average income of Dudley's residents is comparatively low and the borough contains some areas of that are among the 10 per cent most deprived nationally.

Based on the available local and national data, the groups likely to comprise a disproportionately high proportion of the users of services potentially affected by the MCP are set out in the accompanying table.

Is this group likely to have a disproportionately high level of need for the kinds of care within the MCP?	
Older people	Yes
Children	Yes
Men	No
Women	Yes
Marriage and civil partnership	No
Religion or belief	No
Race	Yes
Disability	Yes
Sexual orientation	Possible
Gender reassignment	Possible
Pregnancy and maternity	Possible
Deprivation	Yes

Findings: Dudley-wide themes

The comments, concerns and questions raised throughout the consultation were wide-ranging, but mainly fell under the five themes identified by the CCG in advance:

- The priorities the MCP should address
- The scope of the MCP
- The characteristics of the MCP
- The outcomes the MCP will be expected to achieve
- The potential impacts of the MCP

One additional theme emerging unprompted from the consultation as a key area of concern: the identity and accountability of the MCP provider.

Priorities

People in Dudley understand why there is a need for the MCP and agree on the local priorities it needs to address: access, continuity of care, and communication and coordination.

Local residents described the difficulties they and their families currently experience in getting GP appointments, disjointed care when dealing with more than one professional or provider, and a perceived lack of information sharing between different parts of the system. The main questions raised concerned how the MCP would offer a solution to these challenges. There were very positive reactions to the proposal to have MDTs at the heart of the MCP when information was provided about this in the consultation. People could easily see how it offered a potential solution to the current issues relating to communication and co-ordination.

Which of these do you think it is important the MCP improves?

66% access to services

55% continuity

66% communication & coordination

[1] Office for National Statistics (2015) Subnational Population Projections for Local Authorities.

Scope

Overall, people expressed satisfaction with the provisional list of services proposed for inclusion in the MCP. Most comments and questions revolved around why certain other services were not planned to be part of the MCP, and whether more services could be included.

Several queries were raised about why only some adult social care services would be included in the MCP, given the overlaps between social and health outcomes. Clarification was also sought as to whether certain specialist services would be included in the MCP. Local residents, volunteers and professionals also wanted reassurances that the MCP would involve and support community and voluntary services. This was underpinned by concerns about the future sustainability of these services in the light of reduced local authority funding.

The CCG confirmed that some adult social care services would be part of the MCP, with the possibility of more being incorporated over time. It is also exploring opportunities for adult social care staff to be seconded into the MCP. The inclusion of specialist services will be decided on a case-by-case basis, but the priority will be to ensure that existing care pathways are not broken up. The CCG sees the community and voluntary sector as central to the MCP model. Existing CCG funding for the sector will be maintained under the MCP and groups will also potentially be able to benefit from longer-term funding through the MCP.

Characteristics

The majority of survey respondents reacted positively to the proposal for the MCP to have a single integrated telephone and online system for patients to access care. This reflected the common difficulties people report with access and the potential advantages they could foresee in a single system providing, in terms of convenience, speed and simplicity. Equally, it was felt that such a system would require certain features in order to deliver these advantages for all. It would have to be equally accessible by telephone and online, have the capacity to deal quickly with large numbers of patients at any given time, be simple to use and be staffed by people qualified to address the needs of all patient types.

Views on the MCP having a single integrated telephone and online system to access care:

67% **agree**

21% **disagree**

12% **don't know**

The proposal for more services to be delivered in community settings under the MCP was occasionally a source of confusion in the consultation, with some people envisaging all services being delivered from one or a small number of MCP buildings. Where the proposal was understood, it was generally welcomed, on the basis that it would potentially make services more convenient to access. However, this was contingent on exactly where services would be located.

Identity and accountability

There was a degree of anxiety expressed by local residents, professionals and stakeholders about the possibility of a private sector organisation bidding for and winning the MCP contract. Questions were asked about whether this could happen, what basis the selected provider could operate on, and what safeguards would be in place to ensure it met its obligations under the contract. The CCG confirmed that there was no legal barrier to private sector organisations bidding for the contract, but emphasised that any bidder would have to have the support of local GP practices to be considered. The expectation is that profits would be reinvested in patient services. The performance of the provider will also be closely monitored by the CCG, which would be able to impose sanctions and fines, and could ultimately choose to terminate the contract.

The consultation feedback also highlighted a strong desire for members of the public to be represented in the procurement and operation of the MCP, in order to ensure it is publicly accountable. The CCG confirmed that plans for involving and engaging the local community will be key criteria that bids for the MCP contract are judged against. No plans have yet been made for representing the public in the procurement process, but the CCG will explore options for doing this.

Outcomes

The intention that the MCP contract will be outcomes-based rather than events-based met with widespread approval. It was seen as being important to ensuring that resources were focused on bringing about meaningful improvements for local people and pre-empted some concerns that the MCP provider might artificially generate additional referrals and activities to access more funding.

Views on linking the funding the MCP provider receives with outcomes:

53% **agree**

24% **disagree**

23% **don't know**

Questions were asked about the types of outcomes that the MCP would be expected to achieve and when people were prompted with further information in the survey or at events, it attracted contrasting reactions. For example, reactions were very positive to the idea of patient-reported outcomes; but, at the same time, doubts were raised about how such outcomes could be reliably measured. There were also queries raised about the relationship between the MCP outcomes and existing public health targets, and about how the proposed outcomes would meaningfully reflect specific health conditions. This comparatively mixed response reflected two competing viewpoints. The main perceived advantage was that it would incentivise the provider to achieve better outcomes for patients. The main concern was that it could lead to reductions in services if the provider did not perform well and received less funding.

Impacts

Just under half of survey respondents thought the MCP would have a positive impact on themselves and others. The positive impacts most widely reported were improved access, the integration of services and better communication between providers. Some respondents thought the MCP would have a negative impact. The most common concern was that it could lead to reduced levels of service delivery – either resulting from poor performance leading to reduced funding, or from resources being diverted from service provision to administration.

Having heard a little about the MCP, how do you think it may affect you and others in Dudley?

46% **positive impact**

19% **negative impact**

35% **don't know**

Concerns were also voiced about the potential impacts of the MCP on local staff and the healthcare sector in Dudley as a whole. These included concerns that it could lead to frontline jobs being cut, create stress and uncertainty, divert funding away from existing local providers, and increase overall complexity and management costs in the system. The CCG responded that the MCP is not being introduced to cut funding for frontline staff or services - but rather to create efficiencies by integrating services. Staff will be supported during the transition to the MCP. The CCG is also in dialogue with local providers to plan for and mitigate any risks, and it will be in the interests of the MCP provider to develop ways of reducing complexity and management costs in the system rather than increasing them.

Findings: Themes for specific groups in the Dudley population

The existing literature and the various, complementary consultation inputs provide a steer towards *potential* equalities-related challenges that the MCP should take into account. In most areas, there is no clear pattern of views according to the protected groups for which evidence is available.

It is worth noting that support for the proposed integrated telephone and online system was stronger amongst older people, people with disabilities, and particular Black, Asian and Minority Ethnic (BAME) groups. This appeared reflect some negative experiences in accessing and navigating current care services. The proposal to deliver more services in community settings could potentially create equality effects, positive or negative, depending on where these settings are in relation to the geographical distribution of different groups within Dudley. For example, some residents could experience quicker and easier access to certain services as a result, while others could feasibly experience the reverse.

Certain groups (those aged 65 and over, from a BAME group, and those with a more serious disability) were more likely than average to expect the impacts of the MCP to be positive. Equally, there were concerns that the MCP could lead to some negative equality effects. For example, if some GP practices did not sign up to the MCP, there was a concern that the local population they served could lose out on

access to MCP services. The CCG confirmed that if a GP practice did not sign-up to the MCP, then it is anticipated it would still host a multi-disciplinary team, and processes would be put in place to facilitate communication and co-ordination with MCP services.

Recommendations

Although some elements of the MCP, such as the identity of the provider, are necessarily unconfirmed at this point in time, there other areas of concern that the CCG could usefully address now – either by providing further information on plans that have already been developed, or by developing plans now with the involvement of local people, staff and stakeholders:

1. The CCG should consider contractual requirements, or "minimum standards", for the single integrated access system, to include maximum waiting times, adequate staff resourcing, suitably qualified staff, and industry best-practice design and usability.

2. There is a need for further development of the MCP outcomes (building on the work that ICF, the Strategy Unit and the CCG have already undertaken to identify meaningful and relevant patient-reported outcome measures). While this is likely to develop iteratively as part of the competitive dialogue, it will be important to draw on national and international best-practice and potentially to incorporate deliberative work with patients.

3. The CCG should explore potential mechanisms for the representation of members of the public in the procurement and subsequent monitoring and governance of the MCP. There is a strong appetite for and expectation about on-going public involvement. It will be important that whatever approach is followed, this is widely-communicated and clearly signalled within future communications to the public about the development of the MCP.

4. There may also be value in sharing the findings from this report with other CCGs participating in the NHS England 'New Care Models' programme and others considering the adoption of an MCP.

5. Equalities impact assessment should be embedded within the competitive dialogue process. Identified themes with potential equalities impacts should be used as a checklist on an on-going basis to inform the competitive dialogue.

6. A formal equalities impact assessment should take place towards the end of the competitive dialogue process, but sufficiently in advance of contracts being signed in order to enable any identified impacts based on the actual design of the MCP to be addressed. Beyond this, the selected provider should also be required to make provision for any further equalities work required during the MCP contract.

7. While there are a number of issues that the CCG and its partners will need to be mindful of from a equalities perspective, there are two areas that relate directly to the design of the MCP that are likely to be the source of any significant equalities effects and which should, therefore, be areas of further focus in the next phase:

- Ensuring that the single integrated access system guarantees equal quality of access both online and by telephone, and exploring realistic ways to ensure that non-English speakers and people with sensory, mental and learning disabilities are equally able to access the system.
- Undertaking further exploratory work on the relative accessibility (by car and public transport) of potential community venues for MCP services in relation to different local areas and populations within Dudley, including a requirement that bidders provide detailed analysis (e.g. GIS mapping) of this as part of their proposals.

1 Introduction

This independent report presents the findings from the Public Consultation on the proposed Multi-Speciality Community Provider (MCP) in Dudley as well as the exploratory Equalities Impact Assessment (EqIA) that was undertaken alongside it. The report has been produced by ICF as part of a broader package of work with the Strategy Unit to support Dudley CCG. This first chapter provides an introduction to the MCP, the public consultation and the EqIA.

1.1 The Multi-Speciality Community Provider (MCP)

NHS England's recent Five-Year Forward View[2] highlighted that the NHS must continue to change and develop 'new models of care' if it is going to be able to provide the services that people need within the resources that are available. Dudley CCG is responding to this by developing, with local partners, a new model of care that will significantly change the way that non-acute healthcare is organised and delivered in Dudley. This new model of care is known as the MCP, and is one of several models currently being developed as part of the NHS England 'New Care Models' programme[3].

1.1.1 Why the MCP is needed

The CCG is currently responsible for planning and buying services from healthcare providers for people registered with one of the 46 GP practices in Dudley. Services are delivered by a range of providers, all working to different contracts and different objectives. In total, there are currently 177 such contracts. These are typically 1-2 years in duration and most do not link the funding that providers receive with the outcomes they achieve.

The key issues that patients have identified with this current provision relate to:

- **Access** to GPs and other non-acute healthcare services.
- **Continuity** of care, particularly for patients with long-term conditions.
- **Co-ordination** of care for patients, particularly older people, with multiple needs.
- **Communication** between different healthcare providers.

There are also other drivers for changing the way that primary healthcare and community care is organised and delivered in Dudley. These include constraints on future NHS spending, coupled with an ageing population containing more people with complex long-term health needs, and additional costs (alongside potentially benefits) associated with new technology. In addition, there is a recognised local need to reconfigure services so that they are more centred on patients rather than organisations, to keep people out of hospital and move care into the community wherever possible, and to empower people to have more responsibility for their own health and wellbeing.

1.1.2 Key Features of the MCP

The CCG will have a **single contract** with one lead organisation, the MCP provider, that brings together GP practices, nurses, community health and mental health services, community-based services, relevant hospital specialists and others to provide **care that is joined up** and **puts patients at the centre**. Under the MCP, different **healthcare providers will work together** in community teams organised around local GP practices.

As far as possible, services will be **delivered within the community** rather than in hospital. The MCP will be commissioned by the CCG and receive a capitated budget for meeting the non-acute healthcare needs of the whole population of Dudley. The contract will be for **10-15**

[2] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[3] https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/

years, significantly longer than current contracts, in order to enable **long-term planning and investment** to support changes to the way in which care is delivered. A proportion of the funding that the MCP provider receives will be **based on the outcomes it achieves**.

The proposed features of the MCP, on which views were sought through the public consultation from July to September, 2016, are as follows:

Scope

The following services will be part of the MCP:

- Community-based physical health services for adults and children.
- Some existing out-patient services for adults and children.
- Urgent care centre and primary care out of hours service.
- Primary care services (i.e. GP services) provided under existing contracts.
- Mental health and learning disability services.
- Intermediate care services and services for people with continuing healthcare needs.
- End of life services.
- Voluntary and community sector services.

Characteristics

The MCP will:

- Have strong links to the community and voluntary sector.
- Be based on the GP-registered population and be focused around community and primary care delivery.
- Be outcomes focused.
- Develop its workforce and be a great place to work.
- Use technology to improve access to services.

Outcomes

The MCP will have a proportion of its funding based on achievement against outcome measures for:

- Access.
- Continuity.
- Co-ordination.
- Population health.
- Patient satisfaction.
- Patient-reported outcomes.
- Staff satisfaction.

Access

The MCP will include:

- A single telephony and online digital point of access for patients, and health and social care professionals.
- Seamless and immediate navigation to appropriate professionals within the MCP - for patients to clinicians, and clinicians to clinicians.
- Systems that reduce the number of repeat assessments that patients experience.

1.1.3 The aims of the MCP

The MCP aims to achieve the following benefits for Dudley people, its health and care professionals, and the local health and care economy[4]:

For Dudley people:

- Easier access to a wider range of care via people's local GP practice.
- Better outcomes based on what is important to people.
- Fewer trips to hospital as more services will be available in the community.
- More advice and guidance to help people make the right choices and manage their own health.
- Better access to local voluntary and community groups.
- More involvement in the design of care services near where people live.
- Support from community and voluntary services when people need them.

For health and care professionals:

- Being part of developing new services that better meet the needs of local people.
- Working together as one team.
- Improved communication between services and mobile technology to make working lives easier and more efficient.
- More time to support people who need professionals' specific expertise.
- Access to people who understand the diverse community and voluntary sector services to help signpost people to the right services.
- A health and care system that has the skills and knowledge to look at the whole person and recognises the power of a strong community.

For the health and care economy:

- Personalised, better-value services co-produced by the people who use them.
- Reduced acute hospital activity (admissions and A&E attendance).
- More sustainable services (especially general practice).

1.1.4 What happens next

The intention is that the MCP contract will be put out to tender by the end of 2016 and that a contract in place with a provider by the 1st April, 2017 following a competitive dialogue process. A detailed mobilisation process will then be required due to the complexity of the changes involved, but it is expected that the MCP will become operational by the 1st April, 2018.

1.2 The public consultation

Dudley CCG launched the public consultation on 15th July, 2016 to help shape the development of the MCP. It closed on 9th September, and the outputs from the consultation will now be used to inform the requirements specified by the CCG when the MCP contract is put out to tender. The results will also be shared with potential bidders for the contract so that they can develop plans based on detailed insights into what is most important to local people.

The consultation was widely publicised through the local press, the CCG website, the CCG newsletter, Facebook and Twitter. Local press coverage included stories by the Wolverhampton Express and Star, Dudley News, Stourbridge News, Halesowen News, and the Health Service Journal. It reached an audience of 8,910 on Facebook. There were also a

[4] Dudley Clinical Commissioning Group (2016) Prospectus for the Procurement and Commissioning of a Multi-Specialty Community Provider (MCP).

total of 465 tweets using the #mcpconsult hashtag over the course of the consultation, with an audience of 233,084 accounts and a total of 861,597 impressions. This means that the tweets using the hashtag may have been seen a total of 861,597 times by the 233,084 accounts[5].

The public consultation itself combined several elements, each of which are described below:

1.2.1 Online survey

An online survey asked people in Dudley what they thought of the MCP in terms of its proposed scope, characteristics, outcomes, and potential impacts. The survey questionnaire (provided in the annex to this report) was also appended to the MCP consultation document in paper form, which people could complete and return free by post. In total, **374 people completed the survey**. The demographic profile of respondents is displayed in Table 1.1 below.

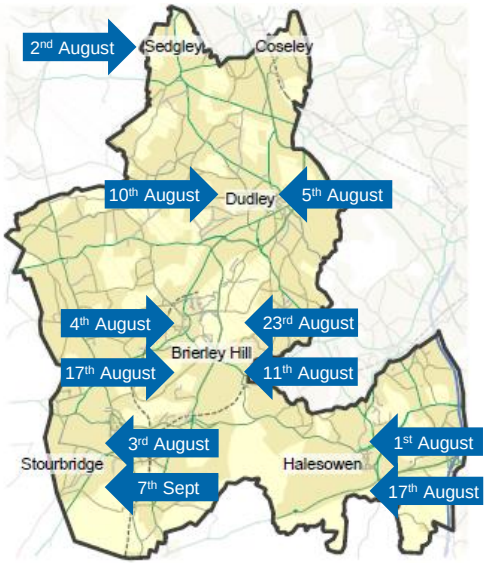
Table 1.1 Demographic profile of survey respondents

		count	%
Age	up to 17	5	1%
	18-24	14	4%
	25-34	33	9%
	35-44	85	23%
	45-54	96	26%
	55-64	65	18%
	65-74	55	15%
	75+	14	4%
	Rather not say	3	1%
Sex	Male	128	35%
	Female	230	63%
	Transgender	2	1%
	Other	3	1%
	Rather not say	5	1%
Disability or health problem limiting day-to-day activities	No	247	68%
	Yes, limited a little	75	21%
	Yes, limited a lot	43	12%
Ethnicity	White	286	81%
	Mixed/Multiple Ethnic	6	2%
	Black/African/Caribbean/Black British	28	8%
	Asian/Asian British	33	9%
	Other	20	6%
Religion	Christian	217	60%
	Muslim	18	5%
	Hindu	6	2%
	Sikh	3	1%
	Buddhist	2	1%
	Jewish	1	0%
	No religion	105	29%
	Rather not say	8	2%

[5] There is always a level of uncertainty about exactly how many people see a given tweet, which is why the word *may* is used in the above definitions. An impression is made when a user scrolls past a tweet, but they may not actually stop to read it.

1.2.2 Public meetings

Eleven public meetings were held during the consultation across Dudley. These included five one-off public meetings and six meetings hosted by existing local networks, panels and patient groups[6].



Each meeting followed a similar format:

- A four-minute doodle ad video about the MCP was played[7].
- A presentation was given by the CCG, providing more detail on the MCP.
- Comments and questions were then taken from attendees and responded to by the CCG.

In total, 209 people attended the meetings. These were predominantly local residents, but also included some volunteers and professionals working for a local health provider.

1.2.3 Focused events

Five more focused public events were also undertaken in order to collect more detailed feedback on specific aspects of the MCP. This included three deep-dive events, which focused on what the MCP may mean for patients with diabetes, primary mental health and respiratory conditions, and two events which focused specifically on the outcomes, characteristics and scope of the MCP. In total, 54 people attended the events, and, again, this included a mix of local residents, volunteers and professionals.

1.2.4 Equalities workshops

Five workshops were conducted by the Centre for Equality and Diversity (CfED) with representatives of potentially vulnerable groups in the local population, to ensure that their views of the MCP were heard. These groups were: recent migrants; Bangladeshi residents; Chinese residents; people living with HIV; and gay men. The workshops were undertaken with the assistance of a translator, when necessary, to ensure all attendees were fully able to participate and express their views. In total, 84 people attended the workshops.

A total of 347 people attended a public event of any type. All attendees were asked to complete a short questionnaire to monitor the demographic reach of the consultation, and their demographic profile is presented in Table 1.2. Not every attendee completed a questionnaire, meaning that the counts in the table are lower than the total number of attendees.

Table 1.2 Demographic profile of public consultation event attendees

		count	%
Age	up to 17	2	1%
	18-24	8	3%
	25-34	17	6%
	35-44	41	15%

[6] These were: the People's Network; Patient Opportunity Panel (POP); Vanguard Engagement Group (VEG); Dudley Carers Alliance; Dudley Voices for Choices; and Whitehouse Cancer Support Group.

[7] www.youtube.com/watch?v=c9-E3tM4Aas&feature=youtu.be.

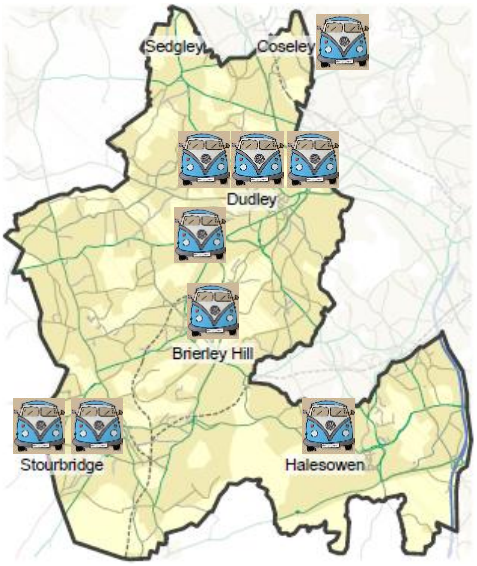
		count	%
	45-54	52	20%
	55-64	49	18%
	65-74	69	26%
	75+	26	10%
	Rather not say	3	1%
Sex	Male	112	42%
	Female	154	58%
	Transgender	1	0%
	Rather not say	0	0%
Disability or health problem limiting day-to-day activities	Yes, limited a lot	31	12%
	Yes, limited a little	75	29%
	No	157	60%
Ethnicity	White	197	74%
	Mixed/Multiple Ethnic	6	2%
	Black/African/Caribbean/Black British	26	10%
	Asian/Asian British	24	9%
	Other	12	5%
Religion	No religion	59	22%
	Christian	172	65%
	Buddhist	1	0%
	Hindu	4	2%
	Jewish	3	1%
	Muslim	17	6%
	Sikh	2	1%
	Other	5	2%
	Rather not say	3	1%

1.2.5 Video diaries

Members of the public were also able to submit their views in a video diary campervan at a range of locations around Dudley:

- 1st August: Huntingtree Park (Halesowen)
- 2nd August: Silver Jubilee Park (Coseley)
- 3rd August: Lion Health (Stourbridge)
- 4th August: Mary Stevens Park (Stourbridge); Priory Park (Dudley); and Brierley Hill Civic Hall
- 5th August: Russells Hall Hospital; DY1 Centre; and Stone Street Square (all Dudley)

In total, 80 people recorded a video diary entry, while 100s more also asked questions and shared their views with the campervan staff but preferred not to be recorded on camera.



1.2.6 Staff events

A series of events were held with professionals working for local health providers in order to ensure their perspectives on the MCP were also captured. These included sessions with staff from Dudley and Walsall Mental Health Partnership NHS Trust, governors from the Dudley Group NHS Foundation Trust, and a group of local GPs. In addition, deep-dive events (similar to those conducted with the public) were also conducted with local clinicians. In total, approximately 80 staff attended these events.

1.2.7 Written submissions

Members of the public, local staff, and local stakeholder organisations also had the option of writing or emailing the CCG to ask questions and express views about the MCP throughout the consultation period. The submissions received included a formal response to the consultation from the local authority, Dudley Metropolitan Borough Council.

1.3 The Equalities Impact Assessment

An exploratory Equalities Impact Assessment (EqIA) was also undertaken alongside the public consultation. In order to minimise the burden on the local public, the EqIA drew on largely the same sources as the consultation rather than additional primary research. Its aim was to help identify any ways in which the MCP could potentially have a disproportionate or differential effect on groups in the local population – including, but not limited to, groups protected under equalities legislation. The purpose of this assessment was to inform the future tendering, design and implementation of the MCP to ensure that any potential negative effects can be mitigated and positive effects enhanced.

1.3.1 Equalities legislation

The Equality Act (2010) consolidated previous legislation designed to prohibit discrimination on the grounds of an individual's characteristics, and identified nine protected characteristics:

Age: This refers to persons defined by either a particular age or a range of ages.

Disability: A person with a disability is defined as someone who has a physical or mental impairment that has a substantial long-term adverse effect on their ability to carry out normal day-to-day activities.

Gender reassignment: This refers to people who are proposing to undergo, are undergoing, or have undergone a process of reassigning their gender identity.

Marriage and Civil Partnership: Marriage is no longer restricted to a union between a man and a woman but now includes a marriage between a same-sex couple, and same-sex couples can also have their relationships legally-recognised as civil partnerships.

Pregnancy and maternity: Pregnancy is the condition of being pregnant or expecting a baby and maternity refers to the period after the birth.

Race: The Equality Act defines race as encompassing colour, nationality (including citizenship) and ethnic or national origins.

Religion or belief: Religion means any religion a person follows and belief means any religious or philosophical belief, and includes those who have no formal religion or belief.

Sex: This refers to a man or to a woman or a group of people of the same sex.

Sexual orientation: A person's sexual orientation relates to their emotional, physical and/or sexual attraction and the expression of that attraction.

Under the Act, all public bodies are required to have due regard to three aims: eliminating discrimination, harassment and victimisation of people with a protected characteristic;

advancing equality of opportunity between people who share a protected characteristic and people who do not share it; and fostering good relations between people who share a protected characteristic and those who do not share it.

1.3.2 Types of equality effects

Equality effects are defined as being either disproportionate or differential effects on groups of people on the grounds of their protected characteristics. A **disproportionate effect** arises when an impact has a proportionately greater effect on protected characteristic groups than on other members of the general population. This can be because protected characteristic groups make up a greater proportion of the affected population or because an impact affects a service predominantly or heavily used by protected characteristic groups. A **differential effect** is one which affects members of a protected characteristic group differently from the rest of the general population, because of specific needs, or a recognised sensitivity or vulnerability associated with their protected characteristic.

The Equality Act does not set out a particular methodology for assessing the equality effects of new policies and programmes, and EqIAs are not a statutory requirement in and of themselves. However, they are a recommended tool for public bodies to inform and enable their compliance with the Equality Act. EqIAs are intended to be iterative. They can assist public bodies in understanding potential equality effects and inform how policies and programmes can be designed to mitigate any such effects.

1.3.3 This Equalities Impact Assessment

This EqIA was exploratory in nature. It was undertaken at a point in time when many of the features of the MCP have not yet been finalised or developed into detailed plans. Consequently, it was not feasible to comprehensively and quantitatively assess its future equality effects. Instead, the focus of the EqIA was on providing a baseline assessment of equalities groups in Dudley. It sought to identify and qualitatively describe possible equality effects in order to provide a framework that can be used in the future to assess equality effects more fully when the plans for the design of the MCP have been finalised.

The methodology for the EqIA combined the following:

- An initial review of MCP programme documentation and the outputs from previous engagement activities with the public undertaken prior to the formal consultation.
- Desk research to identify and analyse relevant data on the size and healthcare needs of specific groups in the Dudley population.
- The collection of qualitative evidence from the public consultation, through the attendance of researchers at the events and the analysis of email, letter, and video diary submissions.
- Analysis of the quantitative and qualitative results from the public consultation survey.

1.4 Report Structure

The remainder of this report is structured as follows:

- **Chapter 2** provides an overview of the Dudley population and the health characteristics and needs of specific groups within it.
- **Chapter 3** presents the findings from the publication consultation on the key Dudley-wide themes that emerged.
- **Chapter 4** presents the findings on the themes that emerged for specific groups within the Dudley population.
- **Chapter 5** synthesises the key findings from the public consultation, considers the implications of these from an equalities perspective, and provides recommendations for the future commissioning, design and implementation of the MCP.

2 The Dudley Population

2.1 Overview

Dudley is a large metropolitan borough within the West Midlands region. It is predominantly urban, containing four main town centres (Stourbridge, Brierley Hill, Halesowen and Dudley), plus several smaller towns and urban villages. It had an estimated population of 316,464[8] in 2015, which is projected to increase to around 338,000 by 2039[9]. Table 2.1 illustrates the overall characteristics of Dudley's population in comparison to regional and national averages.

Table 2.1 Overview of the Dudley Population

		Dudley	West Midlands	England
Age (%)	0-14	17.68	18.26	17.68
	15-29	18.20	19.88	19.97
	30-44	19.71	19.81	20.64
	45-59	19.56	19.19	19.39
	60-74	16.31	15.01	14.57
	75+	8.53	7.86	7.75
Sex (%)	Male	49.16	49.33	49.18
	Female	50.84	50.67	50.82
Ethnicity (%)	White British	88.54	79.16	79.75
	White other	1.46	3.56	5.66
	Bangladeshi	0.13	0.94	0.82
	Indian	1.83	3.90	2.63
	Pakistani	3.30	4.06	2.10
	Asian other	0.79	1.90	2.26
	Black Caribbean	0.85	1.55	1.11
	Black African	0.45	1.15	1.84
	Black other	0.20	0.55	0.52
	Mixed	1.84	2.35	2.25
	Other	0.62	0.89	1.03
Disability[10] (%)		19.97	17.60	17.45
Marriage & civil partnership (%)	Single	31.20	34.64	34.57
	Married	50.18	46.59	46.59
	In civil partnership	0.12	0.23	0.23
	Separated	10.74	11.63	11.64
	Widowed / surviving partner	7.75	6.91	6.97
Sexual orientation (%)	Heterosexual / straight	97.69	97.18	96.94
	Gay / lesbian	1.40	1.35	1.63
	Bisexual	0.36	0.70	0.77
	Other	0.56	0.77	0.67
Pregnant / mother of young child[11]		64.3	67.1	61.5
Religion (%)	Christian	69.63	64.46	63.97

[8] Office for National Statistics (2015) Mid-2015 Population Estimates for UK.

[9] Office for National Statistics (2015) Subnational Population Projections for Local Authorities.

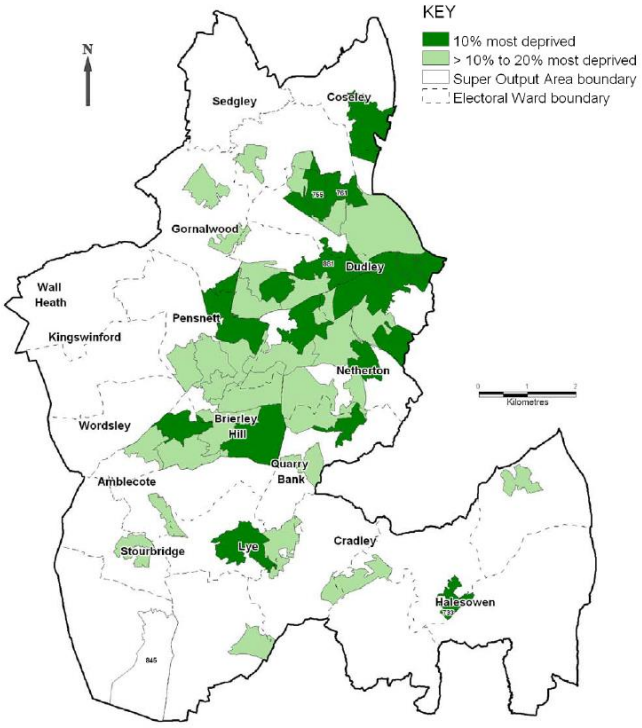
[10] Day-to-day activities are limited because of a disability or health problem.

[11] Maternities per 1,000 women aged 15-44.

		Dudley	West Midlands	England
	Muslim	4.40	7.19	5.41
	Sikh	1.26	2.55	0.85
	Hindu	0.65	1.38	1.64
	Buddhist	0.22	0.32	0.48
	Jewish	0.03	0.09	0.53
	Other Religion	0.35	0.49	0.46
	No Religion	23.46	23.52	26.65
Net weekly income (£)		471.20	486.20	551.15
Deprivation (%)[12]		61.76	60.07	57.46

Overall, the population of Dudley has a slightly older age profile than the West Midlands and national average. It also contains a higher proportion of people with a disability. It is less ethnically diverse than the regional and national average, but more than one in ten residents are still in groups other than "White British". In most other respects, the area's socio-demographic profile is comparable with regional and national averages. However, the average income of Dudley's residents is lower than regional and national averages and, as illustrated below, it contains areas that are amongst the 10 per cent most deprived nationally.

Figure 2.1 Areas of high deprivation in Dudley



Source: DCLG (2011) Indices of Multiple Deprivation

It is also known that people with higher levels of deprivation have generally poorer levels of health than other groups[13]. For this reason, this group has been included for consideration in the EqIA in addition to the protected characteristic groups defined under the Equality Act.

[12] Defined as the proportion of households deprived in at least one of the following four areas: employment; education; health and disability; and household overcrowding

[13] See, for example: The King's Fund (2015) Inequalities in life expectancy: Changes over time and implications for policy.

2.2 Groups within the Dudley population

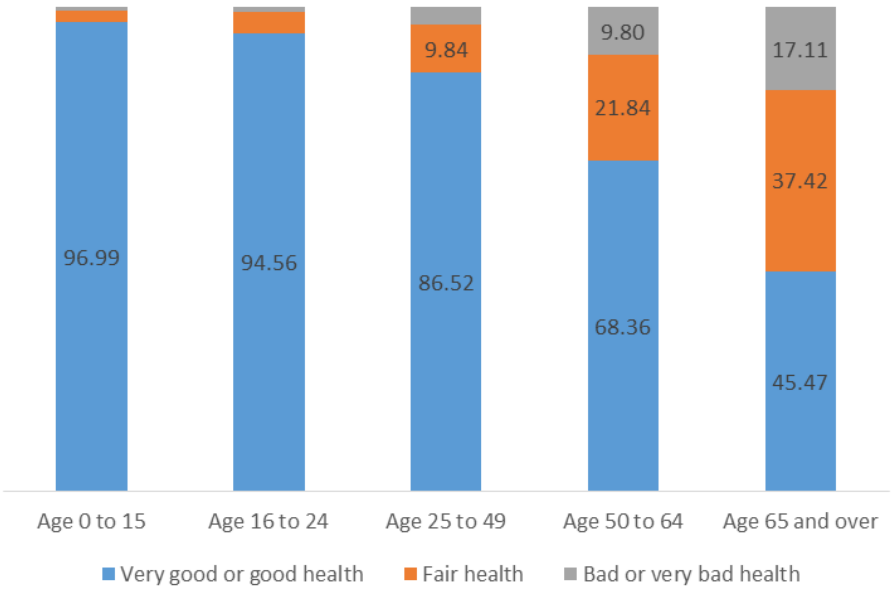
The following sections present evidence on the health characteristics and needs of specific groups within the Dudley population. The relevance of this from an equalities perspective is that groups with poorer health and high levels of need for primary and other non-acute healthcare services could potentially be disproportionately affected by changes to these services under the MCP.

2.2.1 Age

Older people

Older residents of Dudley give lower self-assessments of their own state of health than younger residents, most noticeably in the 65+ age group. Only 46 per cent of those over 65 years consider their health to be 'good' or 'very good', compared to almost all children and young adults (97 per cent and 95 per cent respectively). It is also lower than the national average, with 51 per cent of over 65s rating their health as 'good' or 'very good' across all of England.

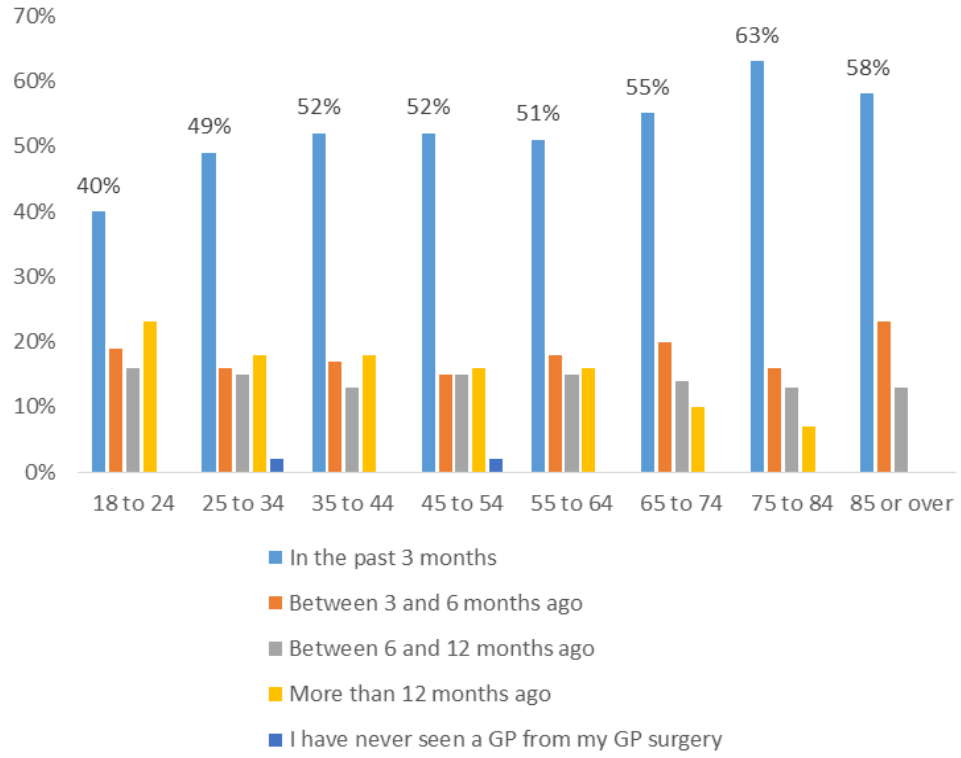
Figure 2.2 Self-assessed state of health by Age



Source: Office for National Statistics (2011) UK Census

GP Patient Survey data show that older people in Dudley are significantly more likely to have a long-term medical condition than other age groups. 87 per cent of over 65s have at least one long-term health condition, compared to 23 per cent of young adults. In keeping with this, older age groups are significantly more likely to have visited their GP recently than younger age groups. Trends in GP visitation frequency over time are not available, but it is likely that older people consistently utilise primary care more frequently than younger people.

Figure 2.3 Time since last GP visit by Age



Source: NHS England (2016) GP Patient Survey

Children

Evidence on how much children in Dudley currently use primary care provision was not identified in this initial review. However, data on their general health suggests that they may have above average primary healthcare needs. On several indicators, infant/child health in Dudley is statistically worse than national and regional averages. For example, Dudley has a higher rate of term babies[14] born with a low birth weight (less than 2,500 grams), as well as greater prevalence of overweight young children.

Figure 2.4 Overweight and obesity in children

	Dudley	West Midlands	England
Excess weight in 4-5 year olds (%)	26.10	23.06	21.89
Excess weight in 10-11 year olds (%)	39.05	35.79	33.24

Source: Public Health England (2015) Public Health Outcomes Framework

Levels of teenage pregnancy, breastfeeding and smoking at time of delivery in Dudley are also worse than West Midlands and England averages[15].

2.2.2 Sex

Men

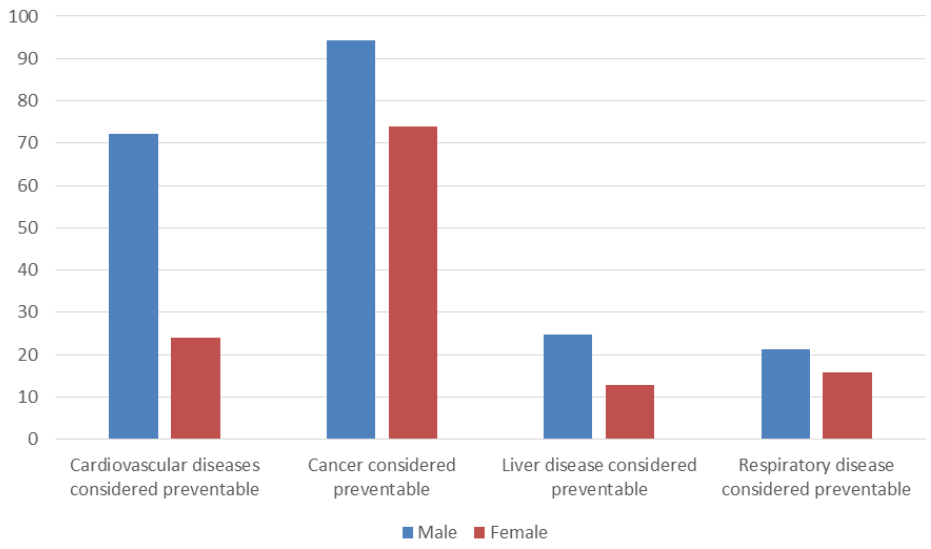
As in the rest of the country, men in Dudley generally fare worse than women on a variety of different health indicators. At the time of birth, men in Dudley have a life expectancy 3.9 years

[14] Those born after at least 37 weeks of pregnancy

[15] Public Health England (2016) Dudley Child Health Profile 2016

lower than the life expectancy of women[16]. Nationally, the difference in life expectancy at birth between men and women is 3.65 years[17]. Men in Dudley are more likely than women to die from cardiovascular diseases, cancers, liver diseases and respiratory diseases that are considered to be preventable. This is especially true of preventable cardiovascular diseases, from which men in Dudley are almost three times as likely to die as women.

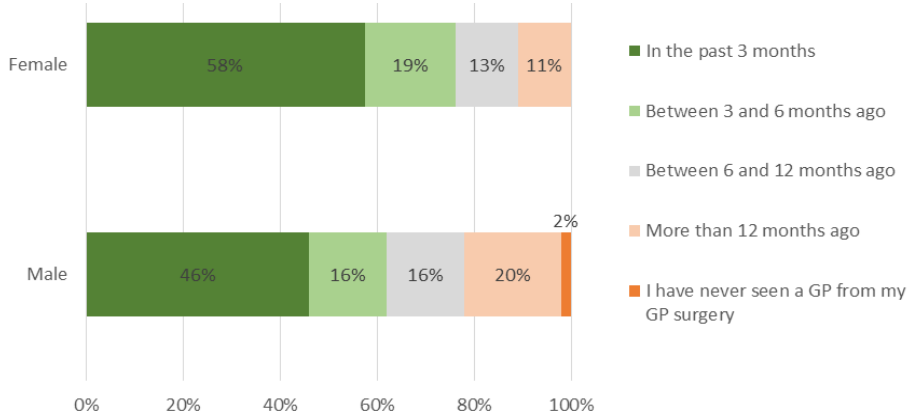
Figure 2.5 Under 75 mortality rate (per 100,000) by Gender



Source: Public Health England (2015) Public Health Outcomes Framework

However, this does not directly translate into greater use of primary care services. Men in Dudley access GP services with less frequency than women – just over 60 per cent of men have accessed their GP within the past 6 months, compared to nearly 80 per cent of women.

Figure 2.6 Last seen or spoke to a GP by Gender



Source: NHS England (2016) GP Patient Survey

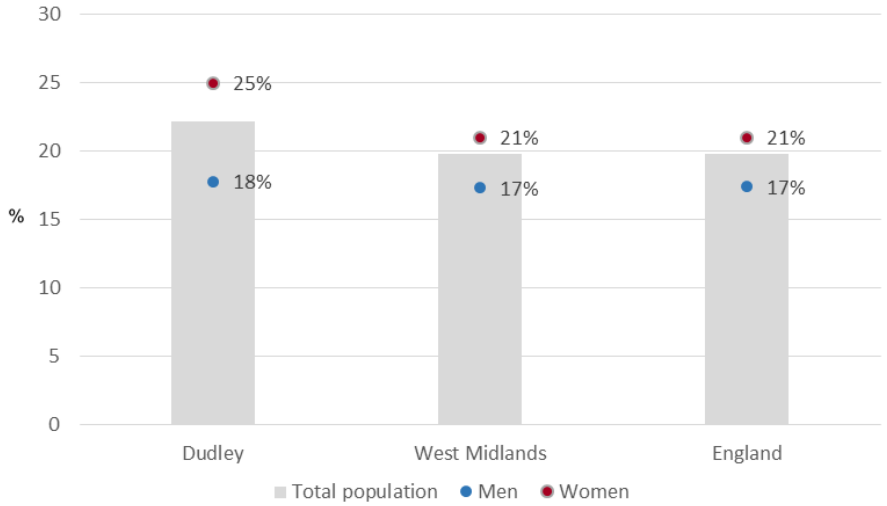
Women

While women fare better than men on most health indicators, they are more likely than men to have a disability which limits their ability to work or to go about their day-to-day activities. The difference between the proportion of women and men who have a disability is, at seven percentage points, considerably larger in Dudley than either the West Midlands or England.

[16] Public Heath England (2015) Public Health Outcomes Framework

[17] Office for National Statistics (2015) Life Expectancy at Birth and at Age 65 in England and Wales: 2012 to 2014

Figure 2.7 Proportion population with a disability by Gender



Source: Office for National Statistics (2016) Annual Population Survey

As highlighted in the previous section, women in Dudley are also more likely to visit their local GP regularly than men.

2.2.3 Marriage and civil partnership

No evidence was identified to indicate that couples who are married or in a civil partnership in Dudley have particular health needs or patterns of primary care access, either when compared to each other or to the rest of the population. There is also little to indicate that this group has substantially different health characteristics and needs in relation to primary healthcare from national evidence sources.

2.2.4 Religion or belief

No evidence was identified to indicate that people with a particular religion or belief have substantially different health characteristics or healthcare needs to other groups in Dudley. There is international evidence that people with religious beliefs report better health than average[18] but, at least in the UK, this is offset by the greater likelihood of certain groups (e.g. Muslim and Hindu) of living in deprivation, which is strong associated with poorer health outcomes (see section 2.2.10).

2.2.5 Race

Overall, White British people in Dudley are more likely to report being limited in their day-to-day activities by a disability than any other ethnic group[19]. However, this difference largely reflects the older age profile of the White British cohort in comparison to other ethnic groups in Dudley, rather than systematically worse patterns of health. Research indicates that Black, Asian and Minority Ethnic (BAME) groups are, in fact, at greater risk of certain health problems than White groups. For example, the Department of Health reports that: *"some conditions and diseases are particularly prevalent among certain ethnic groups, for example coronary heart disease among South Asians, and diabetes among South Asians (prevalence five times higher than the general population) and people from African and Caribbean backgrounds (three times higher)"*[20].

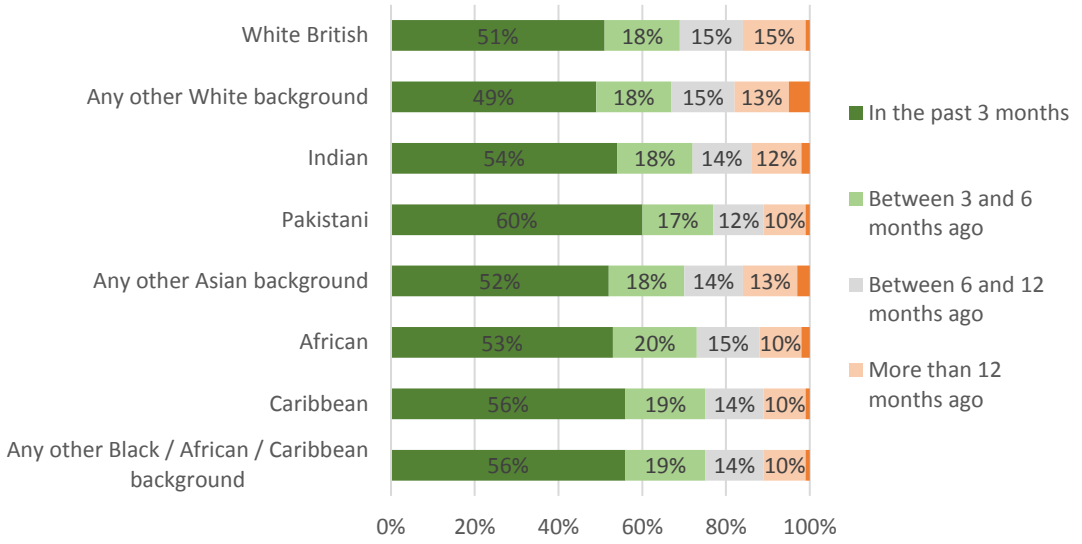
[18] Deaton, A. (2009) Aging, Religion and Health, Working Paper 15271

[19] Office for National Statistics (2011) National Census

[20] Department of Health (2005) Promoting Equality and Human Rights in the NHS: A guide for non-executive directors of NHS Boards

National data also illustrates that BAME groups are more likely to have accessed GP services in the previous three months than White groups (see Figure 2.8).

Figure 2.8 Last seen or spoke to a GP by Ethnicity



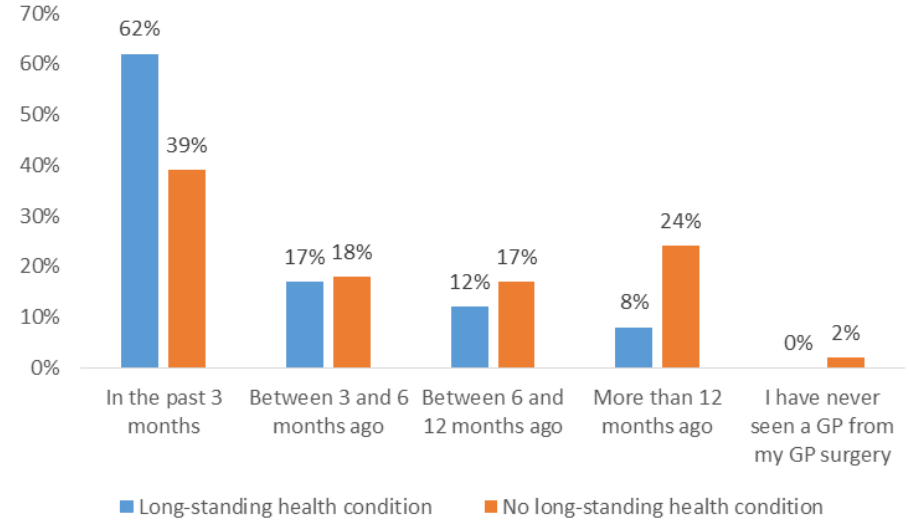
Source: NHS England (2016) GP Patient Survey

Language can act as barriers for BAME groups accessing health services[21]. There is also local evidence suggesting that a lack of awareness may act as a barrier - particularly for recent migrants. Recent research in Dudley highlighted that a disproportionately high proportion of BAME attendees at A&E were not registered with a local GP[22].

2.2.6 Disability

Dudley residents with disabilities and long-term health conditions (LTCs) are significantly more likely to make frequent use of their local GP surgeries than other residents (see Figure 2.9).

Figure 2.9 Last seen or spoke to GP by disability



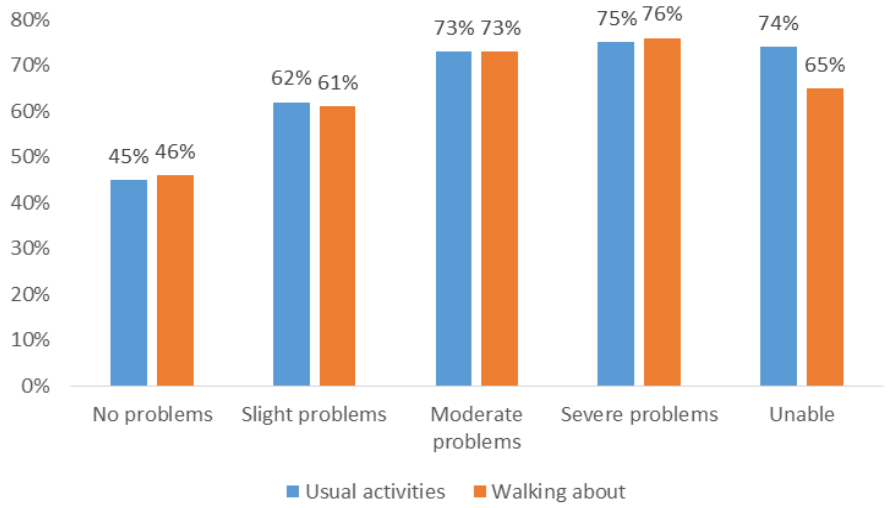
Source: NHS England (2016) GP Patient Survey

[21] Afiya Trust (2010) Achieving Equality in Health and Social Care

[22] Dudley Metropolitan Borough Council (2015) Dudley Migrant Health Needs Assessment: An initial qualitative health needs assessment of migrant communities in the borough of Dudley

The same data also show that people who have a greater level of physical impairment are more likely to see their GP more frequently than those with a lower level of impairment.

Figure 2.10 Last seen or spoke to GP within the last three months by level of impairment



Source: NHS England (2016) GP Patient Survey

2.2.7 Sexual orientation

Robust data is not available on levels of access to primary healthcare by sexual orientation specifically in Dudley. Nationally, levels of access are broadly consistent by group. Overall, 51 per cent of heterosexual respondents to the GP survey (who describe their sexual orientation as 'straight') have seen a GP within the last three months, compared to 48 per cent of gay and lesbian respondents, and 56 per cent of bisexual respondents[23].

Equally, there is evidence from a major recent UK study that lesbian, gay and bisexual men and women are statistically more likely to report having a longstanding psychological or emotional problem than their heterosexual counterparts, while on average they also report poorer levels of general health[24]. In addition, research indicates that, on average, they have more negative experiences of accessing healthcare. Lesbian, gay and bisexual men and women are up to 50 per cent more likely than heterosexuals to report negative experiences with primary care services, including trust and confidence with their GP, communication with both doctors and nurses, and overall satisfaction[25].

2.2.8 Gender Reassignment

Data collection on the UK's transsexual population is still very rudimentary, and evidence is not readily available, either locally or nationally, on the health profile of the transsexual population or their use of primary healthcare services.

Wider evidence on transgender individuals' experiences of accessing health services has identified barriers such as lack of access to knowledgeable, competent, and trans-friendly providers[26]. Transgender individuals are also more likely to experience certain mental health

[23] NHS England (2016) GP Patient Survey

[24] Elliot M N, et al (2015) Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey, Journal of General Internal Medicine, January 2015, Volume 30, Issue 1, pp 9–16

[25] ibid

[26] Taylor, E. T. (2013). Transmen's health care experiences: Ethical social work practice beyond the binary. Journal of Gay and Lesbian Social Services, 25

problems than the general population, which could bring them into greater contact with primary care[27].

2.2.9 Pregnancy and Maternity

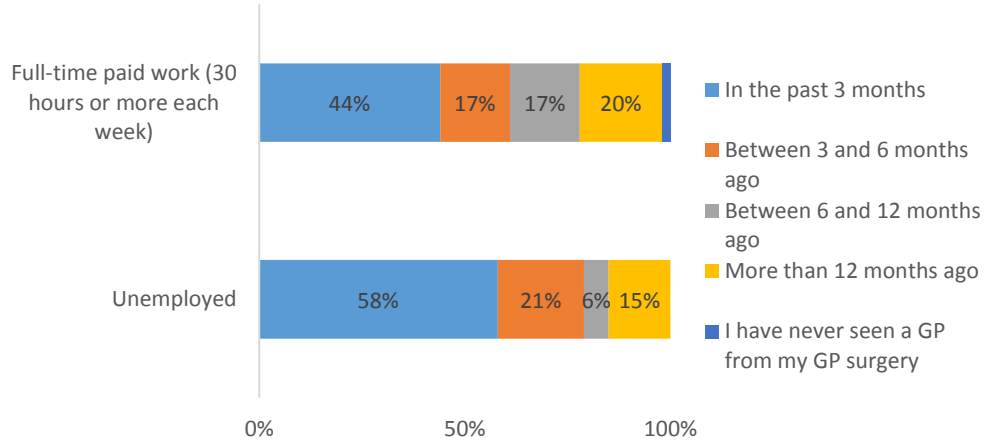
There were 3,758 births in Dudley in 2014[28]. Data is not readily available on the health characteristics and needs of pregnant women and mothers of new-born babies in relation to the services that are proposed to be part of the MCP. However, if these include local midwifery services then this group are highly likely to be affected by any subsequent impacts on these services (positive or negative) when the MCP is introduced.

The King's Fund has also highlighted the potential benefits of GPs performing an active role in supporting ante and postnatal care provision in the community[29], which again indicates that there are equality effects potentially arising from the MCP for this group.

2.2.10 Deprivation

Data is not routinely collected on the income or level of deprivation of people who access primary healthcare. However, data on working status is collected through the GP survey, and the findings from this illustrate that unemployed people in Dudley are significantly more likely to have seen or spoken to a GP in the last three months than those in paid employment (see Figure 2.11).

Figure 2.11 Last seen or spoke to GP by employment status



Source: NHS England (2016) GP Patient Survey

This reflects the strong association between low income, deprivation and health - both in Dudley and nationally. For example, the 2010 Marmot Review concluded that people living in the poorest neighbourhoods in England will, on average, die seven years earlier than people living in the richest neighbourhoods[30]. They are also more likely to live in overcrowded and unsuitable housing, have more than one concurrent illness or condition, and have a disability[31].

2.2.11 Summary of potential disproportionate equality effects by group

Figure 2.12 provides a summary assessment of whether the available evidence suggests each group has a disproportionately high level of need for the kinds of care that will be affected by

[27] Department of Health (2011) Consultation on preventing suicide in England: a cross-government outcomes strategy to save lives

[28] Office for National Statistics (2015) Births by area of usual residence of mother, UK, 2014

[29] The King's Fund (2010) The role of GPs in maternity care – what does the future hold?

[30] The Marmot Review (2010) Fair Society, Health Lives

[31] Royal College of General Practitioners (2015) Health Inequalities

the MCP. This provides a starting point for considering the potential equality effects of the MCP. However, it is worth noting that the subsequent exploration of potential equality effects in the public consultation was not restricted to just these groups. Groups may still experience differential equality effects arising from the MCP (i.e. be affected by it in different ways to others), irrespective of whether they are affected disproportionately.

Figure 2.12 Potential disproportionate equality effects by group

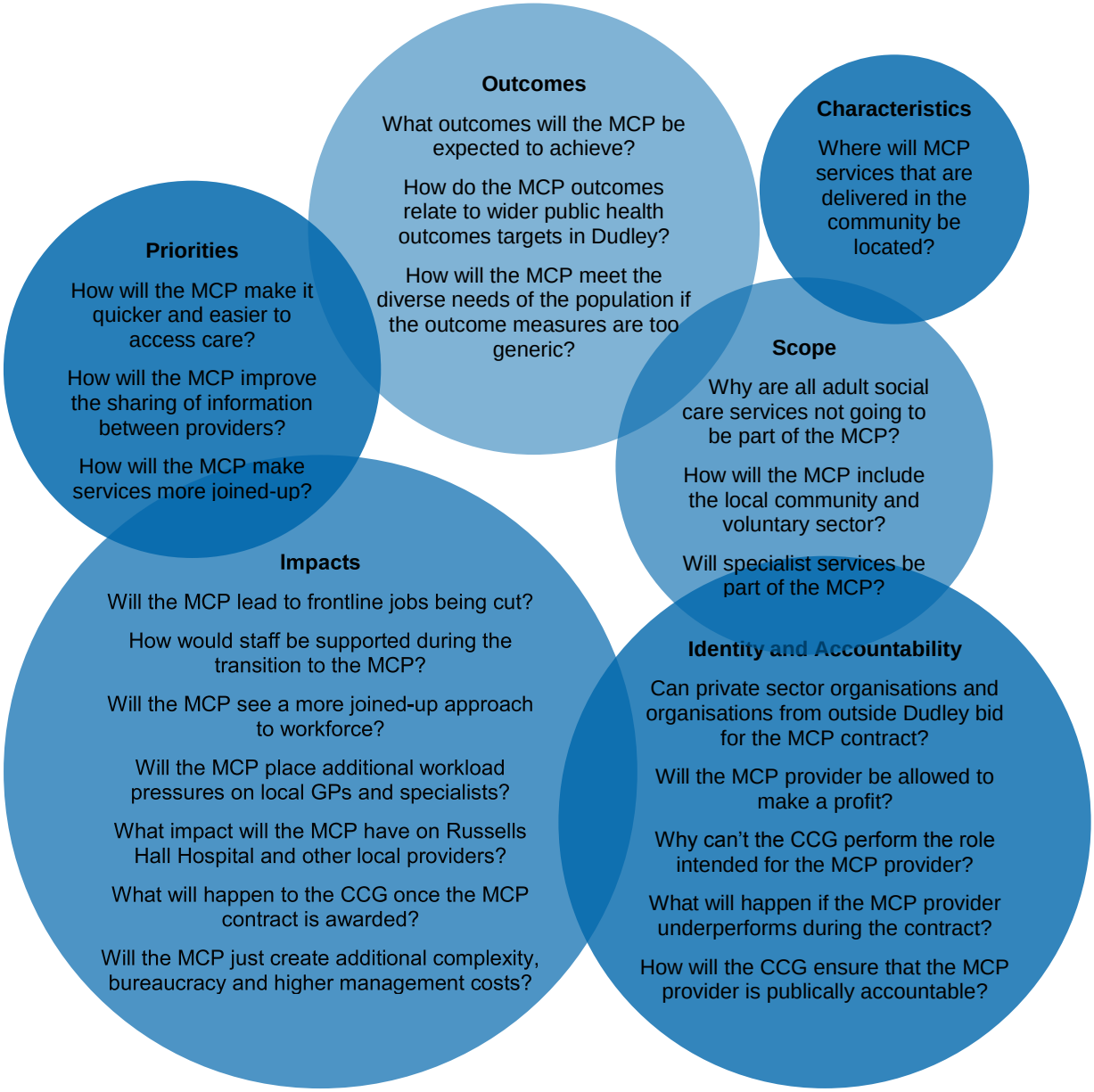
	Is this group likely to have a disproportionately high level of need for the kinds of care that will be affected by the MCP?
Older people	Yes
Children	Yes
Men	No
Women	Yes
Marriage and civil partnership	No
Religion or belief	No
Race	Yes
Disability	Yes
Sexual orientation	Possible
Gender reassignment	Possible
Pregnancy and maternity	Possible
Deprivation	Yes

3 Findings: Dudley-Wide Themes

This chapter discusses the main themes that emerged through the public consultation. The comments, concerns and questions raised throughout the consultation were wide-ranging, but the majority of points fell under the five themes identified by the CCG prior to the consultation, namely:

- The priorities the MCP should address.
- The scope of the MCP.
- The characteristics of the MCP.
- The outcomes the MCP will be expected to achieve.
- The potential impacts of the MCP.

An additional theme that emerged unprompted as a notable area of concern was: the identity and accountability of the MCP provider. Key questions from the consultation under each theme are summarised below and then discussed in more detail, including responses provided by the CCG.



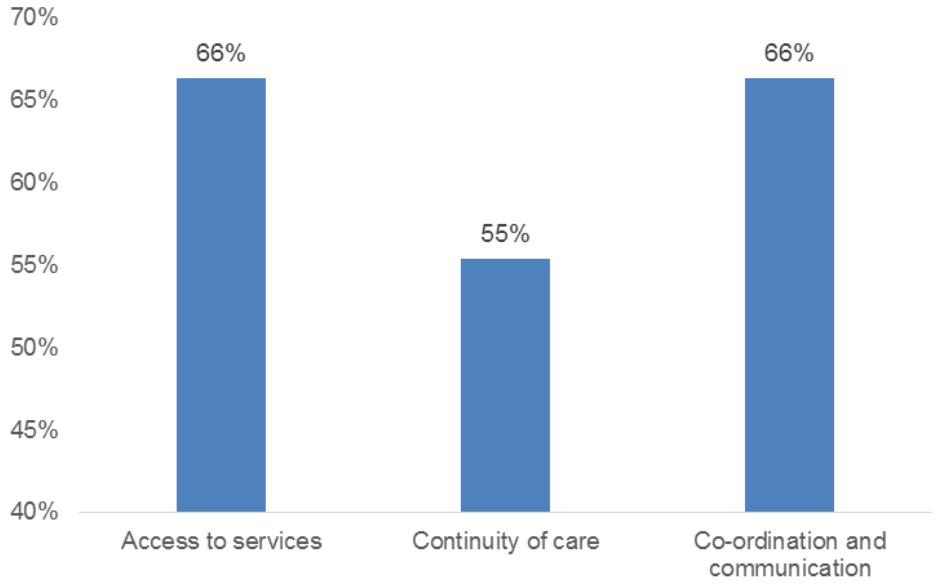
3.1 The priorities the MCP should address

Previous public engagement by the CCG has identified three key issues with existing primary healthcare provision in Dudley:

- Access
- Continuity of care
- Co-ordination and communication

The findings from the consultation survey reinforce this, with over half of respondents indicating they thought it was important that the MCP improves each priority area[32].

Figure 3.1 Which of these do you think it is important that the MCP improves?



Source: Survey (base = 374)

The findings from the consultation events and video diaries echo the survey results. Local residents talked about the difficulties they and their families sometimes currently experience in relation to access, continuity of care and co-ordination/communication. They were in favour of the MCP if it was able to improve access, continuity, and co-ordination and communication. However, there was a common desire to understand more about *how* it would do this.

3.1.2 Access

Local residents talked about problems they or family members had encountered in quickly accessing GP and other non-acute health services when they needed them.

For example, an attendee at a consultation event described how they had felt it necessary to dial 999 having tried and failed to access primary care at short notice for an elderly relative. Others talked about occasions when they had visited A&E, despite not having an emergency condition, having tried and failed to access care through their GP. Local residents felt that if the MCP could help to address these issues, it would represent a tangible improvement for them and other Dudley residents.

"Hopefully it's better than now, having to wait 48 hours to see your GP." **Video diary**

"When they can't get through to the doctors, sometimes that's the last straw for some folk." **Survey**

"If we can access them [services] more swiftly, that would be of great benefit." **Video diary**

[32] Survey respondents were able to select more than one, or all three, response options for this question.

- **Question:** How will the MCP make it quicker and easier to access care?
- **CCG response:** One direct way in which the MCP will improve access is by providing a single point of contact (telephone and website) that all patients can use to access a range of services, including their local GP. It is also intended that the greater co-ordination between providers under the MCP will reduce the need for patients to have to proactively seek access to care themselves at short notice.

3.1.3 Continuity of care

Continuity of care was raised as a particular concern for local residents with ongoing and long-term conditions that require repeated care, often from multiple providers.

They wanted to be able receive this care from the same person or, where necessary, from different providers who understood their condition and did not need this to be repeatedly explained to them by the patient or a family member. Some examples were also given of patients having to have tests undertaken a second time because the results of previous test had not been shared between providers.

"When you go to the doctors now, you find that even if you have a continuing problem and a need for a particular service to be provided to you nobody seems to know about you." **Video diary**

"I think it's a good idea because [their daughter] was very poorly when she was younger and I often found that I had to repeat ourselves over and over again. Every time you saw someone it was a 20 minute discussion on what the problem was." **Video diary**

- **Question:** How will the MCP improve the sharing of information between providers?
- **CCG response:** This is a recognised issue and one that Dudley has already made progress in addressing. All Dudley GPs are now on a single IT system that enables them to access information about any local resident's health. There are technical challenges to enabling this system to "talk to" IT systems used by other local providers, but having one single MCP provider will help and it is envisaged that a solution would be pursued for this under the MCP.

At one consultation event, a concern was voiced about potential data protection issues arising out the increased sharing of patient information. However, overall this did not come through as a widespread concern. In other events, where the issue of information sharing was raised, there was a general desire voiced for more sharing of data across local providers and even providers outside Dudley.

3.1.4 Co-ordination and communication

Local residents and people working in the local health sector perceived that there was a current lack of co-ordination and communication between providers.

This was seen to lead to disjointed services, particularly for people with complex and multiple needs. Examples given included people with physical and mental health conditions, who currently receive treatment for only one condition (or for both conditions, but in an uncoordinated, incremental way).

Concern was also voiced that some patients may currently "slip through the net" in situations where they may leave the care of one provider, but are not referred on to other providers able to address other conditions they are at risk of developing. Socially isolated older people were cited as an at-risk group in this regard.

"I think there's too many departments sort of overlapping but they don't cooperate." **Survey**

"I'd want more cohesion between the services so that everyone's singing from the same song sheet." **Video diary**

"They should all be connected, so no one gets missed off or left behind." **Video diary**

Local volunteers and professionals working in the Dudley healthcare sector fully recognised this as an issue, but also highlighted that there had been several previous attempts to resolve these kinds of issues without fully succeeding.

- **Question:** How will the MCP make services more joined-up?
- **CCG response:** Improving co-ordination and communication between providers is one of the main drivers behind the MCP. The CCG has already introduced measures to start to address this, and the intention is that the MCP will continue and build upon these. Twelve months ago, Multi-Disciplinary Teams (MDTs) were introduced at every GP practice in Dudley. These allow different healthcare professionals to share information and jointly plan care for patients with complex needs. Feedback has been positive from those involved and, under the MCP, the MDTs will be contractually formalised. The CCG has also recently supported the introduction of Community Link workers, the Integrated Plus service[33], a mental health triage car[34], and maintained its funding for district nurses. These all help to facilitate better co-ordination between providers, and the CCG envisages that all will be continued under the MCP. The MCP provider would also have the flexibility to potentially increase funding for this provision over the course of the contract.

3.2 The scope of the MCP

Overall, people expressed satisfaction with the services that are proposed to be included in the MCP. Instead, most comments and questions focused on why certain other services *were not* being proposed to be part of the MCP and whether more services could be included.

Survey respondents suggested a wide and diverse range of other services they thought should be part of the MCP. The most commonly suggested services were dentistry and charities/support groups, education, translation/interpretation services, and mental health support (which are already proposed to be part of the MCP). Further services were also suggested by respondents, but not with the same frequency.

In addition to the services suggested through the survey, attendees at some consultation events said they thought all adult social care services should be part of the MCP. Adult social care was felt to be an important part of local care provision in Dudley and there were concerns voiced about the level of funding the local authority would be able to allocate to ongoing provision. Some attendees also queried how the MCP would be able to provide genuinely joined-up care if adult social care was not fully included.

- **Question:** Why are all adult social care services not going to be part of the MCP?
- **CCG response:** The local authority does not wish all adult social care services to be part of the MCP; but, subject to certain criteria being met, it has already agreed that some adult social care services will form part of the MCP, including mental health and learning disability services and end of life services. The CCG is also in discussions with the local authority about staff in other adult social care services being seconded into the MCP to support the co-ordination of care provision for patients. In the longer term, the CCG would like to see even greater integration between adult social care and the MCP.

The local authority also clarified its position on the scope of the MCP in a written submission to the consultation:

[33] https://integratedplusblog.com/about/

[34] This has a community psychiatric nurse, police officer and paramedic, to rapidly respond to mental health crises out of hospital.

Dudley Metropolitan Borough Council, written submission, 5th September, 2016

"With regard to the proposed scope for the MCP the Council is in broad agreement."

"…The council has identified proposed public health and adult social care resources to be transferred into the MCP during the mobilisation phase. Whilst the majority of services listed pertain to care for older people and adult mental health; it is feasible that services for adults with a disability could be incorporated in due course."

"With regard to Children's Services, following the recent Ofsted report and a new DofE directive the approach is subject to a continuing improvement journey. There may be an opportunity to consider alternative models and approaches of which the MCP could be one. This could provide a stronger whole system solution whilst aimed at protecting and supporting children in the right way. This will be later in the establishment of a MCP."

There were also several comments and questions at consultation events about the inclusion of voluntary and community sector services in the MCP. Local residents and staff working for these providers wanted reassurances that they would be involved in the MCP. This was underscored by concerns several voiced about recent reductions in local authority funding for the community and voluntary sector, and the possibility of further reductions being made in the future.

- **Question:** How will the MCP involve and support the local community and voluntary sector?
- **CCG response:** Dudley currently has a vibrant community and voluntary sector, and it will be critical to the success of the MCP model. The CCG is aware of the cuts in funding the sector is facing. It is talking to local providers in the sector and has asked the local authority to share details of its future funding plans, so that it can look at ways of mitigating the effects of these budgetary changes. The CCG has maintained its funding for local community and voluntary groups and recently invested additional funding in local Community Link workers. The intention is that all the funding the CCG currently provides to the sector will be provided through the MCP. The MCP will also create opportunities for groups to access longer-term funding than is currently the case. Community and voluntary groups could enter into a partnership with other organisations that bid for the overall 10-15 year MCP contract. Alternatively, groups that currently have a contract with the CCG could benefit from longer subcontracts with the MCP provider. In addition, new groups could benefit from the MCP. The MCP contract will be reviewed every year and, as part of this process, there will be the flexibility to redirect funding towards new services and providers if this is can better meet the needs of Dudley residents.

Some consultation events attendees also wanted to know whether or not specific services would be included in the MCP.

- **Question:** Will the following specialist services be part of the MCP: speech therapy, phlebotomy, physiotherapy, district nurses, and Integrated Plus?
- **CCG response:** In line with the intention to provide more services in the community, it is planned that physiotherapy, phlebotomy, district nurses and Integrated Plus will be part of the MCP. Speech therapy is an example of a service which may have to be split between community-based MCP provision and some non-MCP hospital-based provision (e.g. specifically for acute speech therapy). However, the priority in making decisions about such services will be to protect existing care pathways. The aim is to minimise cases where such pathways have to be split between MCP and non-MCP provision.

3.3 The characteristics of the MCP

Two key proposed characteristics of the MCP that were explored in the consultation were:

- The use of technology to improve access (through a single booking system).
- The intention to deliver more services in community settings rather than in hospitals.

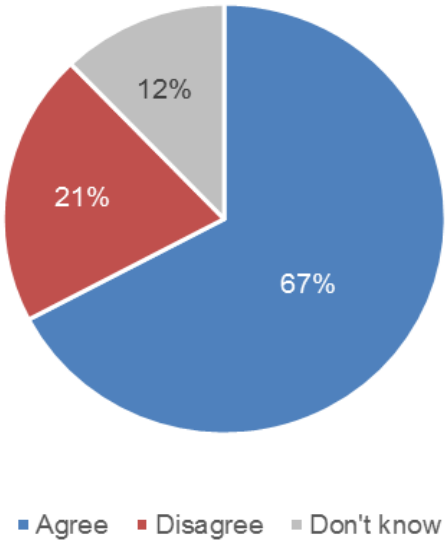
The consultation also sought views on the softer characteristics of the MCP, in terms of:

- Its "touch and feel".

3.3.1 Use of technology to improve access

Overall, the majority of survey respondents and people who engaged in the consultation in other ways were in favour of having a single integrated system to access services through the MCP. This reflected the difficulties people said they currently experience in accessing non-acute health services and the advantages they could foresee in a single integrated system.

Figure 3.2 We think the MCP should have a single telephone and online system that all patients can use to access different local services. Do you agree or disagree?



Source: Survey (base = 336)

"GP appointments particularly are hard to make if it's an emergency and you need to see someone, so yeah it would be a good idea." **Survey**

"One phone number would be brilliant, one email address or one website that would be even better." **Survey**

"Having that one single access point, that one single telephone number that people can ring will be really, really helpful." **Survey**

However, as the survey results above illustrate, not everyone was in favour of this proposed characteristic of the MCP, and amongst those who agreed with it in principle there were still certain reservations and concerns.

It was highlighted by several local residents and patient representatives that not everyone has internet access, and that many older people in particular may be unable and/or unwilling to use an online system. There was agreement that any system would have to be equally accessible by telephone and online.

Some concerns were voiced about such a system replacing face-to-face contact with healthcare providers. Although this appeared to stem from a misunderstanding of what is being proposed (it is not intended that the system would be used for the delivery of care), it suggests that this distinction should be made clear if-and-when the system is introduced.

Views on the proposed system were also partly coloured by experiences people had of other telephone call centres and booking systems, which were not always positive. People did not want to have to wait in long queues, navigate complex automated options or speak to someone who was not qualified to deal with their query. There was a common desired for any system

to be accessible via a single telephone number, be simple to use, well-staffed, and able to deal with a large volume of callers.

3.3.2 Delivery of services in the community

This proposed characteristic of the MCP attracted less comment in the consultation and was also occasionally a source of confusion when it was raised. For example, some people thought that the MCP would mean that all services would be delivered from a single MCP site for the whole of Dudley. Others imagined a network of MCP sites across Dudley with, for example, one in each of the five principal localities that comprise the borough. People could see pros and cons to having services concentrated in such sites. Having a range of services all under one roof was the seen as a potential advantage, while longer travel times to access a single site was cited as a potential disadvantage.

More generally, people seemed to understand and accept the basic idea that delivering more services in community settings rather than in hospitals would potentially make them more accessible to local residents. However, this was still seen as contingent on exactly *where* such services would be located.

- **Question:** Where will MCP services that are delivered in the community be located?
- **CCG response:** This has not been decided and it will be up to the MCP provider to determine where individual services will be delivered. However, the CCG will expect that services become more rather than less accessible to local residents under the MCP, and proposal for achieving this will be scrutinised as part of the procurement process.

Despite the relative lack of debate about this aspect of the MCP in the consultation, it does have potential implications from an equalities perspective. This point is revisited in that context to in Chapter 4.

3.3.3 "Touch and feel"

Survey respondents were asked about what kinds of things would matter to them when they come into contact with the MCP and how they would want to be treated.

Most of those who responded to this question did not make specific suggestions relating to service delivery. Instead, respondents mostly stated a more general desire to be treated well by healthcare professionals. The values that were most frequently cited were: **respect**, **dignity**, **friendliness** and **politeness**.

3.4 The identity and accountability of the MCP provider

This theme emerged out of the consultation as a key area of concern for local residents, volunteers and professionals working within the local health sector, as well as other local stakeholders. These concerns centred round:

- The types of organisation that could bid to be the MCP provider.
- What would happen if the MCP provider underperformed.
- How the MCP provider would be publically accountable.

3.4.1 The types of organisation that could bid to be the MCP provider

Concerns were expressed by attendees at consultation events and in written submissions about the possibility of a private sector organisation bidding for and becoming the MCP provider.

A common concern was that it could lead to the MCP being "profit driven rather than patient driven" - to the detriment of patients - and that staff in existing local NHS providers could also be adversely affected.

Another concern was that a private sector provider could "walk away" midway through the MCP contract, leading to negative outcomes for patients. It was suggested that there were examples of this having happened with regard to healthcare contracts in other parts of the country.

"We are concerned that the MCP could be run by the private health care sector with the potential for detriment to our NHS workforce and services." **Written submission**

"The experience of the private sector taking over NHS services has not been a happy or successful one to date." **Written submission**

Some concerns were also expressed about the possibility of a public sector provider from outside Dudley, and without any ties to the area, bidding for the MCP contract.

- **Question:** Can private sector organisations or other organisations from outside Dudley bid for the MCP contract?
- **CCG response:** The CCG does not know which organisations will bid for the MCP contract. It will be widely advertised when it goes out to tender, including in the Official Journal of the European Union (OJEU). Existing providers of primary and community care in Dudley may consider bidding individually or in partnership. Equally, there is no legal barrier to other organisations, including private sector organisations and ones from outside Dudley, bidding for the contract. However, the NHS has specified that MCPs must be list-based and, as GP practices are the only provider to maintain patient lists, any bidder for the MCP contract will require the buy-in of local GPs in order to be considered.

Further questions were asked about the basis on which the MCP provider would be permitted to operate.

- **Question:** Will the MCP provider be allowed to make a profit?
- **CCG response:** Under the terms of the MCP contract, the provider would not be permitted to make excessive profits. The expectation will be that profits (or a budget surplus for a public sector provider) would be reinvested in patient services.

Views were also expressed about the potential merits of the CCG itself performing the role intended for the MCP provider, given its detailed knowledge of local health needs, its successful recent track-record in supporting the introduction of innovative approaches and its "outstanding" rating.

- **Question:** Why can't the CCG perform the role intended for the MCP provider?
- **CCG response:** CCGs cannot legally deliver services, only commission them, meaning that Dudley CCG could not perform the role intended for the MCP itself. However, the CCG will work very closely with the MCP provider during the initial implementation period and on an ongoing basis during the contract, meaning expertise within the CCG will feed into the MCP. It is also likely that some existing CCG functions will sit better in the MCP in the future, potentially meaning some transfer of staff between the two entities.

3.4.2 What would happen if the MCP provider underperformed

People generally recognised the potential benefits of the MCP having a longer 10-15 year contract, in terms of the greater scope this would give the provider to plan and develop local service provision. Conversely, a perceived downside or risk of this longer contract was that the provider could fail to perform as expected during this period – leading to negative impacts for patients.

"I applaud the length of the contract, but what if something goes wrong?" **Consultation event**

"Is it possible to end this contract should the provider prove to be giving unsatisfactory services?" **Written submission**

- **Question:** What would happen if the MCP provider fails to deliver the expected outcomes during the contract?
- **CCG response:** The procurement process for awarding the contract will be rigorous in order to minimise the risk that the selected provider cannot perform the role effectively. After the award of the contract, the performance of the MCP reviewed by the CCG on a monthly basis and as part of the proposed annual contract review process. As with existing contracts, in any instances of underperformance the provider would be required to produce a plan for addressing this for approval by the CCG. The CCG would also be able to impose sanctions and fines, and could ultimately choose to terminate the contract if the provider is not achieving the required outcomes. These measures can already be used by the CCG on existing contracts and it has processes and contingency plans to mitigate any potential knock-on effects on patients.

3.4.3 How the MCP provider would be publically accountable

There was widespread support at consultation events for members of the public to be closely involved in the MCP, in order to ensure that the needs of the Dudley public were being represented and that the MCP was being held to account. Further, it was suggested that members of the public should be involved in the selection of the MCP provider.

In its written submission to the consultation, the local authority also voiced its concern that "it remains unclear how the new entity will be meaningfully accountable to local people and bodies" and that "in this context, the Council wishes to be engaged in the procurement process and a member of the governance and oversight of the MCP." Exceptionally, one written submission questioned whether it was appropriate for the CCG itself to be responsible for overseeing the performance of the MCP as it is not a publicly elected body. However, more generally, very high levels of trust were expressed in the CCG to perform this role.

- **Question:** How will the CCG ensure that the MCP provider is publically accountable?
- **CCG response:** Plans for involving and engaging with the local community will be one of the key criteria on which bids for the MCP contract will be assessed. The CCG envisages that meetings of the MCP board will be public and that the MCP provider will consult with the public regularly on any new proposals or service changes. It also hopes to see more innovative and co-productive approaches being used, over and above existing approaches such as public meetings. No firm decisions have yet been made for involving local residents in the selection of the MCP provider. This public consultation is giving Dudley people an opportunity to have their say and influence how this selection will be made. Two local community representatives also sit on the board that has overseen the initial development of the MCP model, and an option would be for them to be similarly involved in the MCP procurement process.

3.5 The MCP outcomes

Comments and views raised through the consultation concerning the proposed outcomes-based nature of the MCP can be divided into the following three sub-themes:

- The general focus of the MCP on outcomes.
- The outcomes the MCP should be expected to achieve.
- The link between outcomes and funding for the MCP provider.

In interpreting the findings for each of these areas, it should be noted that this was a topic of some confusion for participants in the consultation. For example, one question from a local resident at a consultation event was simply "what is an outcome?" Most consultation event attendees had also not studied the outline MCP outcomes framework published online by the CCG prior to the consultation, meaning there was little detailed discussion of specific outcome measures.

3.5.1 The general focus of the MCP on outcomes

Overall, the intention that the MCP contract will be outcomes-based rather than events-based (as most CCG contracts with local providers currently are) was welcomed.

It was seen as being important for ensuring that resources were focused on bringing about meaningful improvements for local people. It also pre-empted some concerns that were expressed that a provider could be incentivised to artificially generate more referrals and activities rather than focusing on making people better.

"This is a great step forward in increasing the health outcomes for individuals and as a whole for local health population." **Survey**

"It's important that any funding has measurable results otherwise money could just be wasted." **Survey**

"It will mean that they try harder to do things well rather than just getting paid for seeing people." **Survey**

3.5.2 The outcomes the MCP should be expected to achieve

Questions were commonly asked at the consultation events about the types of outcomes that the CGG would use to monitor the performance of the MCP and, ultimately, expect it to achieve.

- **Question:** What outcomes will the MCP be expected to achieve?
- **CCG response:** There are three broad types of outcomes being proposed: population-level outcomes (indicators of the general health of the Dudley population); condition or service-level outcomes (for example, specific indicators for the effective management of diabetes); and patient-level outcomes (to include self-reported outcomes by patients themselves).

The proposed inclusion of self-reported patient outcomes attracted significant, but contrasting, comments in the consultation.

On the one hand, the basic idea was enthusiastically received. It was seen as a very tangible way in which the intended "patient-centred" ethos of the MCP could be realised. On the other hand, doubts were expressed about how such self-reported data would be collected and how reliable it would ultimately be as an indicator of good or bad performance by the MCP provider. These viewpoints were not necessarily mutually exclusive. For example, some respondents in the consultation survey said they both welcomed the idea *and* still had some doubts about how it would work in practice.

"My opinion is that it's really good because it puts the patient at the centre." **Survey**

"The patient must be at the centre of their care. If they are not satisfied then the healthcare system is not functioning for them." **Survey**

"Patient satisfaction is questionable as an accurate measure." **Survey**

Reflecting this, there was a general sentiment that careful thought would be needed in designing data collection methods for self-reported outcomes, and, that if these were included, they should be supported by clinical outcome measures.

The other types of outcomes proposed for the MCP attracted less comment, although some further questions were asked about these at consultation events.

- **Question:** How do the proposed population-level outcomes for the MCP relate to the public health outcomes the local authority has targets for?
- **CCG response:** Representatives of the local authority have been heavily involved in the development of the outcomes to ensure that they align with its targets. Colleagues from Public Health England have also assisted with the development of the MCP outcomes framework.

One consultation event attendee also voiced a concern that the outline MCP outcomes framework did not include specific measures for long-term conditions, such as neurological

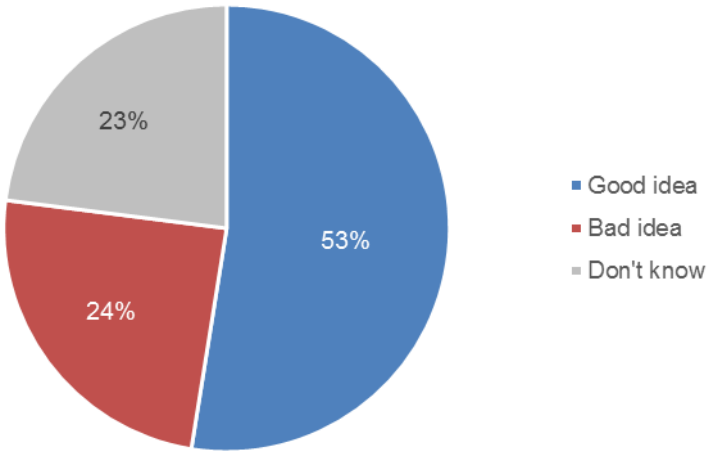
or neuromuscular conditions. This led on to a broader question about the proposed outcomes.

- **Question:** How will they ensure the MCP meets the diverse needs of their population if the outcome measures are too generic?
- **CCG response:** The development of detailed outcome measures for the MCP will be an iterative process and they may not get it right first time. The CCG will be looking at whether individual measures for neurological conditions, and other types of condition, might be included in the framework.

3.5.3 The link between outcomes and funding for the MCP provider

The CCG has proposed that a proportion of the funding the MCP provider receives is directly linked to its performance against the agreed outcome measures. Views on this were sought through the consultation survey, and the results are displayed in Figure 3.3 below.

Figure 3.3 What do you think about this approach?



Source: Survey (base = 335)

These results illustrate that just over a half of respondents thought this approach was a "good idea", while nearly a quarter of respondents expressed the opposing view.

Further responses in the survey and feedback from other elements of the consultation help to explain these mixed reactions. The main perceived advantage of linking performance to funding was that it would incentivise the provider to achieve better outcomes for patients. The main concern was that it could lead to reductions in services for patients if the provider did not perform well and received less funding as a consequence.

"It will be a huge incentive for the provider to make sure the services are successful." **Survey**

"If the targets are not met then the funding is not allocated and therefore the only people to suffer will be the patients." ***Survey***

3.6 The potential impacts of the MCP

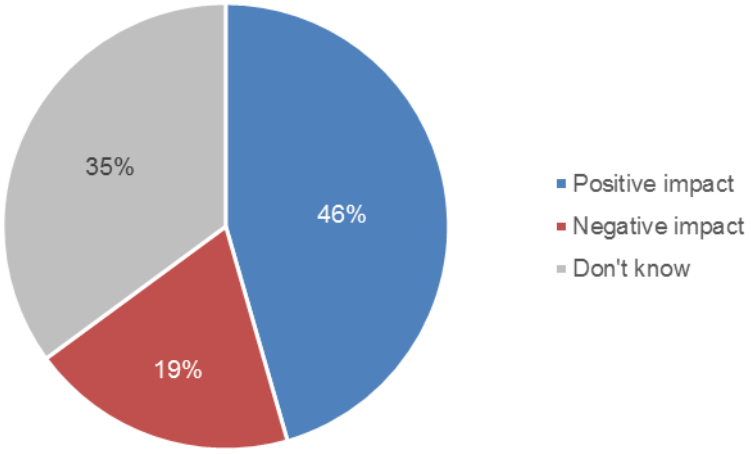
Three main types of impact were raised through the consultation:

- Impacts on the health of the Dudley population.
- Impacts on staff.
- Impacts on wider health system in Dudley.

3.6.1 Impacts on the health of the Dudley population

Just under half (46 per cent) of survey respondents felt that the MCP would have a positive impact on themselves and others in Dudley. The positive impacts most commonly reported were improved access, the integration of services and greater communication between different providers, although services delivered closer to patients was also mentioned. Those who felt the MCP would have a positive impact generally did not identify any specific patient groups who they felt would benefit, although a small proportion said it might help the elderly and people with long-term or multiple conditions, in particular.

Figure 3.4 Having heard a little about the MCP, how do you think it may affect you and others in Dudley?



Source: Survey (base = 325)

A minority of survey respondents (19 per cent) felt the MCP would have a negative impact on themselves and others. The most common concern in this regard was that the changes would lead to reduced levels of service delivery – some respondents expressed worries that linking funding to performance could lead to overall funding being reduced if targets are missed, while others were concerned that the creation of the MCP would mean resources being diverted from service provision to administration. A smaller number of respondents were worried that the changes would result in more disjointed service delivery, because of the potential disruption caused by undertaking such a system-wide change. These respondents did not consistently identify any particular groups they felt might be affected.

The relatively high proportion of respondents who answered “don’t know” to this question (35 per cent) is likely to reflect the difficulties for many people in conceptualising what the impacts may be under such a new model, and in the context of an approach that is still very much at the development stage. This appeared to be the case at the consultation events and in the video diaries, where the potential impacts of the MCP was not, in itself, a major source of discussion.

However, it was clear that this issue underpinned many of the more specific comments and questions raised. For example, comments about the possible identity of the MCP provider and the potential risks of entering into a long-term contract with an unsuitable provider, ultimately stemmed from concerns about how this could negatively affect patients. Similarly, questions about how the MCP will improve access, co-ordination and communication all related directly to a desire for the MCP to bring about positive impacts in these areas for patients.

3.6.2 Impacts on staff in the local healthcare sector

Staff working in the local healthcare sector raised some understandable issues, concerns and questions about how the introduction of the MCP could affect them and their colleagues.

"Organisational change causes a lot of stress and anxiety, how will you support us with that?" **Written submission**

- **Question:** Will the MCP lead to frontline jobs being cut?
- **CCG response:** We are not talking about cutting funding. We have not cut NHS funding in all the time that CCG has been in operation, and have increased funding in areas like mental health year-on-year. There are other parts of the system facing budgetary challenges (e.g. adult social care), but the CCG is maintaining its funding levels. The challenge is managing the money in the face of increasing need – the MCP is designed to deal with that by creating efficiencies through integrating services.
- **Question:** How would staff be supported during the transition to the MCP?
- **CCG response:** Any changes will be gradual, will take time to implement and staff will be supported throughout the journey.
- **Question:** Will the MCP see a more joined-up approach to workforce than is currently the case?
- **CCG response:** The MCP will mean a bigger and, consequently, more joined-up and resilient workforce. It will be a requirement of the MCP contract that the provider takes steps to develop its workforce and make it a great place to work. In addition, there will be outcome indicators for job satisfaction that the provider will be expected to report against.

Staff, and some local residents, also questioned whether the use of MDTs as part of the MCP, and the intention to deliver more services in community settings, would place additional time and workload pressures on certain professionals – particularly GPs and specialist consultants.

"A specialist worker will be going out into the community, surely the time and cost of coming out into the community is not worth it?" **Written submission**

- **Question:** Will the MCP place additional workload pressures on local GPs?
- **CCG response:** This is not the intention, and instead it is planned that the MCP will help GPs to spend less time on undertaking time-consuming tasks such as having to ring around for potential providers to which patients can be referred. Although GP practices will provide a central hub for different providers to come together in MDTs under the MCP, GPs themselves will not be expected to take the lead on designing joined-up packages of care for every patient. Feedback from the initial introduction of MDTs suggests that it has helped to make GPs' workloads easier rather than harder to manage.
- **Question:** Will the MCP place additional time pressures on specialists?
- **CCG response:** This will be up to the MCP provider to determine, but, as commissioner we are clear that we do not intend to create any inefficiency in the system, so we would be looking to avoid examples of senior clinical staff spending the day driving around the borough rather than seeing patients.

One event attendee questioned whether the new MCP provider could lead to higher staff costs, if staff were only offered time-limited contracts by the provider and demanded significantly higher salaries as a consequence.

- **Question:** Will the MCP lead to significantly higher staff costs?
- **CCG response:** Staff already transfer and move between local providers when services change and new contracts are awarded under the current system. This is not generally accompanied by significantly higher salary demands.

3.6.3 Impacts on the wider health system in Dudley

Staff, and some local residents, voiced concerns about the wider potential impacts of the MCP on the local healthcare sector. A common anxiety was that it could "destabilise" existing local providers by creating uncertainty and potentially reducing funding. Specific concerns were also expressed about the potential impact of the MCP on large existing local providers, such as Russells Hall Hospital. There was a concern that, with some hospital-based services moving out into the community under the MCP, the hospital could lose a significant proportion of its existing funding. Similar concerns were expressed about the potential impact on local NHS Trusts if they were to bid unsuccessfully for the MCP contract. In addition, some people questioned what would happen to the CCG itself once the MCP was in operation.

- **Question:** What impact will the MCP have on Russells Hall Hospital?
- **CCG response:** The intention is that some services will move out of the hospital, but these will not include the main services that the hospital is funded to provide – namely, acute and planned care. As mentioned elsewhere, there is also no legal barrier to the Foundation Trust bidding as part of a partnership for the MCP contract or potentially being a subcontractor to the MCP.
- **Question:** What impact will there be on other local providers if they bid for the MCP but are not successful?
- **CCG response:** The CCG is working with local providers to fully understand the risks that they have identified and how these might be mitigated. During the short term, there will also be a protection of budgets while services are given the time to transform.
- **Question:** What will happen to the CCG once the MCP contract is awarded?
- **CCG response:** Overall, the CCG will become smaller than it is now. As highlighted previously, it is envisaged that some existing CCG functions will sit better in the MCP in the future, once the MCP is fully operational. The CCG will also have considerably fewer contracts to manage than it does now. In addition to the MCP contract, it is also envisaged that, in the longer-term, acute and planned care will be brought together under one contract, meaning all healthcare in Dudley is delivered through two contracts.

Finally, there were questions relating to whether the MCP would increase or decrease the level of complexity, bureaucracy and management costs in the local healthcare sector. One concern that it could lead to complexity simply being moved from one part of the system to another if, for example, the MCP provider commissioned a large number of subcontractors to deliver different services. There was also a concern that costs could increase if there is an additional layer of management between the MCP provider and the CCG.

> *"Presumably there will be considerable cost involved in establishing these new organisations and with their ongoing existence… how will the percentage of the total amount of money available to the CCG for direct patient care change from the current system?"* **Written submission**

- **Question:** Will the MCP just create additional complexity and bureaucracy?
- **CCG response:** The MCP provider will have the flexibility to deliver some services itself and to subcontract others. The CCG has not specified what the balance should be, but this will be considered when bids for the overall MCP provider contract are assessed. It is also going to be in the interests of the MCP provider to minimise complexity and bureaucracy as far as possible.
- **Question:** Will the MCP lead to higher management costs and less funding for patient care?
- **CCG response:** Our expectation is that the amount of resource going into direct patient care remains the same as it is now under the MCP. The CCG's existing contracts with providers already include costs associated with "management" and these would be recycled in the MCP contract.

4 Findings: Themes for Specific Groups in the Dudley Population

This chapter describes the themes that emerged through the consultation for specific groups in the Dudley population (rather than themes that appeared to apply equally to all groups). The main sources of insight on these themes were the five workshops undertaken as part of the consultation with a sample of protected groups/sub-groups certain groups (recent migrants; Bangladeshi residents; Chinese residents; people living with HIV; and gay men) and the online survey. The survey included a small number of socio-demographic questions (on age, gender, ethnicity, disability and religion) enabling comparison of responses between different groups. However, due to the small number of respondents with certain characteristics, this analysis should be treated with caution, and as indicative of potential differences, rather than definitive evidence.

One important overall finding is that the views, comments and concerns that were expressed about the MCP by specific groups in the Dudley population were not fundamentally different from those expressed by all, reflecting the central role of health in everybody's lives. Nevertheless, some points did appear to be particularly amplified by certain groups, notably: people with a disability; older people; BAME groups; and people living in deprived areas. These differences and potential equality effects are discussed below, structured in terms of the same general themes used in the preceding chapter.

4.1 The priorities the MCP should address

While all groups agreed on the need for the MCP to improve access, continuity, and co-ordination and communication, these issues appeared to be even more pressing for certain groups.

In terms of accessibility, local residents from BAME groups whose first language was not English talked about the difficulties they experienced in knowing where to go to in order to access different forms of care. From their perspective, current provision is highly complex, opaque, and difficult to navigate. Some also felt that, at times, they were neglected or pushed around between providers, leading to delays in accessing the appropriate care. This may explain why over 80 per cent of Asian respondents in the survey said it was important that the MCP improve access, compared to 66 per cent across the survey sample as a whole (see Table 4.1).

The survey findings also illustrate that a higher proportion of older respondents and respondents with a disability said they thought it was important that the MCP improve continuity and/or co-ordination and communication than the survey sample as a whole. This is highly likely to reflect the higher incidences of multiple and complex conditions among older and disabled people, noted in Chapter 2.

Some participants in the workshop with local residents with HIV also had multiple health needs and said they currently experience disjointed and/or uncoordinated care to address these. From their perspective, any improvement the MCP could bring about in this respect would be welcomed.

Table 4.1 Which of these do you think it is important that the MCP improves?

		Access to services	Continuity of care	Co-ordination and communication
Age	Up to 64	64% (194)	53% (159)	64% (194)
	65 and above	74% (52)	67% (47)	76% (53)
Limiting health problem or disability	None	64% (158)	54% (133)	67% (167)
	Limited a little	74% (57)	61% (47)	66% (51)
	Limited a lot	68% (30)	57% (25)	64% (28)
Ethnicity	White	63% (179)	58% (166)	68% (195)

	Black/African/Caribbean/ Black British	64% (18)	32% (9)	57% (16)
	Asian/Asian British	82% (27)	45% (15)	45% (15)
All		66% (248)	55% (207)	66% (248)

Source: Survey

4.2 The scope of the MCP

The online survey results do not indicate major differences by group in the services that respondents expect to be included within the MCP. There were, however, some services that were more widely mentioned by particular groups. While the scale and design of the survey mean that it is not possible to draw firm conclusions about the significance of any differences between groups, this provides some intelligence about priorities for different groups.

In relation to ethnicity:

- References to children's services were especially apparent among both the White British and Black/African/Caribbean/Black British groups. It was not mentioned by Asian/Asian British respondents.
- References to interpretation and translation services were primarily focused on the 'Other' ethnicity group (and this exclusively related to Chinese respondents), as well as a small number of Black/African/Caribbean/Black British respondents.

There was no clear pattern in relation to whether individual respondents had a limiting health problem or disability. Respondents with a limiting health problem or disability arguably honed in on specialist services (both medical services and supportive services, such as advocacy and day care) to a greater degree than other respondents, although the pattern is weak. There were no discernible patterns of response by age category.

4.3 The characteristics of the MCP

The online survey findings, and those from other elements of the consultation, suggest there are certain differences and potential equality effects relating to the planned characteristics of the MCP.

4.3.1 Use of technology to improve access

In terms of the proposed integrated telephone and online system, support for this was even greater amongst certain groups than the overall respondent group. This applied to older people, Asian people, and disabled people, as illustrated in Table 4.2.

These differences appear to reflect:

- The perceived complexity and inaccessibility of current provision from the perspective of local residents from BAME groups whose first language was not English. Participants in the workshops with these groups talked about how a single point of access was appealing because of its simplicity and because it would remove the need for them to have to try to navigate the system themselves.
- The greater needs that older and disabled people have to access care, and the potential barriers they may face to physically visiting their local GP just to be referred on to access other services.

However, the potential benefits to these groups of the single integrated telephone and online system are partly contingent on this system having certain features, and without these it is possible that it could inadvertently result in negative effects for these groups. Firstly, there should be the facility to access the system by telephone and online in languages other than English. Secondly, it should also be fully accessible by telephone and online to people with disabilities, including sensory and learning disabilities.

Table 4.2 We think the MCP should have a single telephone and online system that all patients can use to access different local services. Do you agree or disagree?

		Agree	Disagree	Don't know
Age	Up to 64	64% (172)	24% (63)	12% (32)
	65 and above	77% (51)	9% (6)	14% (9)
Limiting health problem or disability	None	64% (149)	23% (50)	13% (29)
	Limited a little	70% (49)	19% (13)	11% (8)
	Limited a lot	79% (33)	12% (5)	10% (4)
Ethnicity	White	65% (165)	22% (55)	13% (33)
	Black/African/Caribbean/ Black British	61% (17)	36% (10)	4% (1)
	Asian/Asian British	86% (24)	4% (1)	11% (3)
All		67% (226)	21% (69)	12% (41)

Source: Survey

4.3.2 Delivery of services in the community

This proposed feature of the MCP was not explored in the survey, but evidence from other elements of the consultation suggest it is a source of potential equality effects. For example, participants in the workshop with members of the local Bangladeshi community (living in Halesowen) voiced the concern that if services moved out of Russells Hall hospital and into a community setting located further north in the borough, this could make them harder rather than easier to access. This same impact could also be felt by other groups in the Dudley population that have a particular geographical distribution or clustering within the borough, depending in exactly where MCP services that move out into community settings are delivered.

4.3.3 'Touch and feel'

Dignity, respect, friendliness and politeness were recurrent themes for all groups when they talked how they would like to be treated when they came into contact with the MCP. Certain groups also placed particular emphasis on empathy and understanding, reflecting the negative experiences some reported with how they were treated by healthcare staff currently. Specifically, some participants in the workshops with gay men and people with HIV felt they experienced a lack of understanding of their lifestyle and occasionally direct discrimination. Members of BAME groups did not report feeling explicitly discriminated against; but, equally, did perceive a lack of understanding and sympathy from some healthcare staff they had come into contact with.

4.4 The identity and accountability of the MCP provider

No differences or potential equality effects were identified with regard to the identity of the MCP provider. Similar concerns relating to the potential for a private sector led MCP and the desire for significant safeguards to be in place during the MCP contract were, for example, raised in the workshops with specific groups as they were in other elements of the consultation.

Views about the need for public involvement and accountability in the development, procurement and operation of the MCP were also similarly-articulated, although some potential equality effects were raised. Attendees at some of the open public consultation events commented on the under-representation of young people at the events. Others highlighted that people who are house-bound (due to a physical or mental condition) would not be able to attend events. It was also mentioned that not all older people use the internet, meaning they would not be able to input into the public consultation online. Although these concerns were voiced with regard to a small number of groups, and in the immediate context of the public consultation, they appeared to reflect a more general concern that all parts of the Dudley

population will be actively involved in the design and delivery of the MCP. Participants in the workshops with BAME groups also voiced their desire to be involved and represented in the development of the MCP.

- **Question:** What is the CCG doing to involve and represent different groups in the consultation, development, procurement and operation of the MCP?
- **CCG response:** Extensive efforts have been made by the CCG to engage with different groups in the community. During the initial development of the MCP model, they consulted with over 60 local groups, including several youth groups. The public consultation was widely publicised through the local press, the CCG website, the CCG newsletter, Facebook and Twitter. In addition, residents could input into the consultation by completing the consultation questionnaire online or by calling, emailing or writing to the CCG to give their views. A campervan also travelled throughout Dudley during consultation to give people the opportunity to express their views in the form of video diaries. Focus groups were conducted with protected characteristic groups as part of the consultation. Ordinarily, the CCG also would have run consultation events in local schools and colleges, but the public consultation period coincided with summer holidays.

  In addition, the CCG welcomed suggestions for additional steps that it could take to address the need to engage, as far as reasonably possible, with a wide cross-section of the population. In the longer-term, it also envisages that the MCP will develop closer links with local education providers and, more generally, all potential bidders for the MCP contract will partly be assessed on their plans for consulting and involving the local community.

4.5 The MCP outcomes

No obvious variations were revealed in how different groups viewed the general focus of the MCP on outcomes or the selection of outcomes currently proposed. There were some variations by group in the survey when respondents were asked about the proposal to link MCP funding to the achievement of outcomes, as illustrated below in Table 4.3.

This indicates that, if anything, respondents from BAME groups and those aged 65 and over were more positive about the outcomes-based approach than average; although it is worth noting that some respondents generally thought that the question was a little abstract. In terms of why respondents thought that this was either a good or bad idea, there is no particular pattern of response by any particular protected group. This may reflect that the sub-groups reporting the outcomes-based approach as bad idea are quite small. However, it appears that the types of concerns that are raised (practicability of implementation; impact on incentives for service providers etc.) transcend age, ethnicity or disability status.

Table 4.3 What do you think about this approach?

		Good idea	Bad idea	Don't know
Age	Up to 64	50% (135)	23% (62)	26% (71)
	65 and above	59% (38)	23% (15)	17% (11)
Limiting health problem or disability	None	55% (123)	23% (52)	22% (48)
	Limited a little	43% (29)	29% (20)	28% (19)
	Limited a lot	54% (22)	24% (10)	22% (9)
Ethnicity	White	46% (116)	23% (58)	31% (77)
	Black/African/Caribbean/ Black British	86% (24)	14% (4)	0% (0)
	Asian/Asian British	66% (19)	28% (8)	7% (1)
All		53% (176)	24% (82)	23% (77)

Source: Survey

4.6 The potential impacts of the MCP

Differences and potential equality effects were identified with regard to the expected impacts of the MCP. Firstly, certain groups (those aged 65 and over, from a BAME group, and those with a more serious disability) were more likely than average to expect these impacts to positive, as illustrated in Table 4.4 below.

This appeared to reflect the perceived potential of proposed aspects of the MCP (notably, the single integrated telephone and online system and the formal adoption of multi-disciplinary teams at every GP practice) in addressing the issues that certain groups currently experience with access, continuity and communication and co-ordination. There was also a distinctive pattern of responses in terms of perceived negative impacts according to disability status. Respondents with a limiting health condition or disability were more likely to report impacts in relation to access to services (impacts on acute care, travelling further for specialist consultations, and perceived fragmentation of acute and community links). Other respondents tended to hone in on more general issues such as perceived bureaucracy, technical deliverability (especially in relation to IT system) and the impact on jobs.

Table 4.4 Having heard a little about the MCP, how do you think it may affect you and others in Dudley?

		Positive impact	Negative impact	Don't know
Age	Up to 64	45% (117)	22% (57)	34% (88)
	65 and above	48% (29)	10% (6)	43% (26)
Limiting health problem or disability	None	46% (100)	21% (45)	33% (71)
	Limited a little	42% (28)	18% (12)	40% (27)
	Limited a lot	49% (19)	15% (6)	36% (14)
Ethnicity	White	44% (107)	24% (58)	33% (80)
	Black/African/Caribbean/ Black British	68% (19)	4% (1)	29% (8)
	Asian/Asian British	56% (15)	7% (2)	37% (10)
All		46% (148)	19% (63)	35% (114)

Source: Survey

In addition, and somewhat in contrast to the survey findings, findings from other elements of the consultation suggested ways in which certain groups could be adversely affected by the MCP. These issues were typically raised at public consultation events, which provided the CCG with the opportunity to respond:

- **Issue:** It was suggested at one public event that potential equality effects could arise if some GP practices in Dudley chose not to sign-up to the MCP. The concern was that people registered with a GP that was not part of the MCP would not being able to access the same benefits as those registered with MCP practices. This could lead to populations in different local areas of Dudley experiencing different impacts and effects.
- **CCG response:** It will not be known how many GP practices will sign-up to the MCP until bids are submitted for the contract. The expectation, based on discussions the CCG has had, is that most or all will do so. If a practice does not sign-up to the MCP, then it is anticipated it will still host an MDT, and processes would be put in place to facilitate communication and co-ordination with MCP services.
- **Issue:** There was a concern that providers of very specialist care could be spread too thinly under the MCP if they to be expected to participate in MDTs across the whole of Dudley, leading to possible knock-on impacts on the patient groups concerned. The specific example referred to when this issue was raised was paediatric physiotherapy for children

with complex needs, but this could equally apply to all population groups with a high incidence of multiple and complex health needs.

- **CCG response:** The CCG is exploring models for how best to meet the needs of these groups under the MDT model.
- **Issue:** A further equality effect, which was raised more with respect to current provision than specifically the MCP, was the location of services in more deprived areas of Dudley. Attendees suggested that some services have recently been withdrawn from such areas. They wanted reassurances that the MCP will not lead to the withdrawal of services from deprived areas.
- **CCG response:** The aim of the MCP will be to deliver more services in the community (including in deprived areas) rather than less. As part of the MCP contracting process, the CCG will require assurances from potential providers about sustaining services in such areas.
- **Issue:** A final, more general potential equality effect related to the ability of one overall MCP provider to deliver care that is tailored to the specific characteristics of the population in different parts of Dudley. For example, one attendee highlighted that Halesowen has one of the largest Yemeni populations in the UK, while others pointed to different other socio-demographic differences between local areas in Dudley.
- **CCG response:** The MCP model is about enabling local teams to determine what is needed by local communities. Despite there being one overall MCP provider, the MDTs at every GP practice will be key in ensuring that services are designed and delivered to reflect the specific needs of the local community each practice serves.

5 Conclusions and Recommendations

This final chapter provides conclusions and recommendations: firstly for the public consultation as whole; and secondly for the explorative equalities impact assessment.

5.1 Public Consultation

5.1.1 Conclusions

The various strands of the consultation can be summarised in terms of the following key Dudley-wide conclusions:

- People in Dudley understand the rationale for the proposed MCP and agree on the local priorities it needs to address: access, continuity of care, and communication and coordination.
- Some of the proposed features of the MCP make intuitive sense to people and give them confidence that the MCP would bring about tangible improvements for them and others in Dudley – most notably, the formal adoption of MDTs at every GP practice. Concerns that are raised in this area, and others, understandably tend to relate to people being unsure how the model will work in practice under the MCP.
- Other proposed features, such as the single integrated access system, have a wide appeal, but their impact will also depend heavily on how they are designed, resourced and operated. Similarly, the proposal to deliver more services in the community is generally seen as "a good thing", but its impact will depend on where services are located in the community.
- There are also proposed features that attracted strongly contrasting views. The proposal to use patient-reported outcomes and to link outcomes with funding for the MCP provider were both favoured by the majority of consultees, but were also seen to come with risks and potential downsides. Partly this reflects that the consultation was dealing with some complex aspects of MCP performance management while the model is still in the early stages of development. It is not realistic to expect the majority of respondents to have reviewed the proposed outcomes framework in detail, nor is that essential to the consultation itself.
- The potential types of bidder to run the MCP emerged as a key question and source of anxiety for many respondents. While it was accepted that the CCG is legally obliged to allow organisations from the private sector and outside the borough to bid, there was a perceived need for the performance of the selected provider to be closely monitored, safeguarded and, ultimately, held to account by the Dudley public.
- The type of organisations falling within the MCP umbrella was also a concern for many – particularly those who benefit from and work in the local community and voluntary sector. Their full inclusion and involvement in the MCP was seen as essential, while there was also an apparent appetite for more, and more diverse, services to be included.
- A key determining factor in all the views expressed through the consultation was uncertainty. Over a third of respondents in the consultation ultimately said they did not know how the MCP would affect them and others in Dudley. This reflects the planning stage that the MCP is currently at, and the attendant unknowns relating to the '*who'*, '*how'* and '*where'* of the MCP.
- There was a clear appetite among people who contributed to the consultation to learn and understand more about the MCP, and to continue this (public) dialogue on into the procurement and operational phases of the MCP.

5.1.2 Recommendations

Although some elements of the MCP, such as the identity of the provider, are necessarily unconfirmed at this point in time, there other areas of uncertainty and concern that the CCG could usefully address now – either by providing further information on plans that have already been developed, or by developing plans now with the involvement of local people, staff and stakeholders:

1. The CCG should consider contractual requirements, or "minimum standards", for the single integrated access system, to include maximum waiting times, adequate staff resourcing, suitably qualified staff, and industry best-practice design and usability.
2. There is a need for further development of the MCP outcomes (building on the work that ICF and the CCG have already undertaken to identify meaningful and relevant patient-reported outcome measures). While this is likely to develop iteratively as part of the competitive dialogue, it will be important to draw on national and international best-practice and potentially to incorporate deliberative work with patients.
3. The CCG should explore potential mechanisms for the representation of members of the public in the procurement and subsequent monitoring and governance of the MCP. There is a strong appetite for and expectation about on-going public involvement. It will be important that whatever approach is followed, this is widely-communicated and clearly signalled within future communications to the public about the development of the MCP.
4. There may also be value in sharing the findings from this report with other CCGs participating in the NHS England 'New Care Models' programme and others considering the adoption of an MCP.

5.2 Equalities Impact Assessment

5.2.1 Conclusions

The Equalities Impact Assessment (EqIA) has been undertaken at an early stage in the development of the MCP. This, in itself, indicates that equalities considerations are being considered centrally to the design of the MCP. These considerations have informed the design of the consultation process, including having multiple avenues for community involvement in the consultation, as well as having events targeted at specific groups and looking at specific health-related issues.

However, it also means that there is somewhat limited scope for drawing definitive conclusions about equalities impacts at this point in time. Much will depend on the more concrete development of MCP plans, which will emerge over the next year or so through the competitive dialogue to develop the MCP contract. As indicated above, the level and nature of any equalities impacts in reality will depend on *where* MCP services are delivered and, more importantly, *how* they are delivered.

This does not dilute the importance of considering equalities impacts at a time when the overall shape and ethos of the MCP is being discussed within Dudley. However, it emphasises the importance of recognising that equalities impacts will need to be reviewed over time as the MCP plans crystallise. This is a key recommendation, as set out below.

The existing literature and the various, complementary consultation inputs provide a steer towards *potential* equalities-related challenges that the MCP should take into account. The evidence tends towards potential consequences associated with particular groups rather than anything that is intrinsic to the design of the MCP.

A set of common themes have emerged from the consultation that provides a template for more detailed focus for the next stage of MCP development:

- **Access to specialist care:** The principles underpinning the design of the MCP (access; continuity; co-ordination) may lead to positive benefits for those protected groups more

likely to face complex or multi-faceted health/care needs (e.g. older people; people with disabilities). Questions raised during the consultation related to resourcing. It is important to be mindful of the potential perception of competing drivers between increasing efficiency and the sustainability of services on one hand, and the provision of MCP services based on accessibility, continuity and co-ordination on the other hand, specifically for groups with complex care needs (therein avoiding both disproportionate and differential equality effects).

- **The geographic location of services:** There is an association between some geographies within Dudley and certain protected groups, primarily in terms of race and age. There is a strong association between geography and poverty / deprivation. Consultation messages relate to concerns about the physical accessibility of services across the local area if these are re-organised and concentrated in a way that increases dependency on public transport. This could lead to disproportionate inequality effects on certain groups, the risk of which can be assessed once firmer plans are in place.
- **The potential change / transformation to how services are accessed:** While the focus on access could provide positive equality effects, it could lead to differential effects on groups that are less able to access an online-driven system.
- **External factors:** It is clear from the consultation that considerations relating to the MCP are not viewed by the community as necessarily separate from other, related concerns about services (especially local authority-run services) that are out with the MCP. This is partly a perception issue, and is not surprising given that the consultation itself was helping to promote a wider understanding of the MCP concept. However, from an equalities perspective, wider changes to service provision affecting particular groups may be experienced through the prism of the MCP and it will be important that the MCP design is effective in ensuring the best outcomes where non-MCP services are also changing.

5.2.2 Recommendations

1. Equalities impact assessment should be embedded within the competitive dialogue process. Identified themes with potential equalities impacts should be used as a checklist on an on-going basis to inform the competitive dialogue.
2. A formal equalities impact assessment should take place towards the end of the competitive dialogue process, but sufficiently in advance of contracts being signed in order to enable any identified impacts based on the actual design of the MCP to be addressed. Beyond this, the selected provider should also be required to make provision for any further equalities work required during the MCP contract.
3. While there are a number of issues that the CCG and its partners will need to be mindful of from a equalities perspective in the next phase, there are two areas that relate directly to the design of the MCP that are likely to be the source of any significant equalities impacts in the subsequent MCP design and which should, therefore, be areas of further focus in the next phase of service design (i.e. equalities risks):
    - Ensuring that the single integrated access system guarantees equal quality of access both online and by telephone, and exploring realistic ways to ensure that non-English speakers and people with sensory, mental and learning disabilities are able to access the system.
    - Undertaking further exploratory work on the relative accessibility (by car and public transport) of potential community venues for MCP services in relation to different local areas and populations within Dudley, including a requirement that bidders provide detailed analysis (e.g. GIS mapping) of this as part of their proposals.

Annex

Public Consultation Survey Questionnaire:

We want your views

To return your views to us free of charge, please cut along the dotted line, fold in half and place into the envelope supplied.

1. About you

   a. Choose one option that best describes your ethnic group or background:

   ☐ White ☐ Mixed / Multiple Ethnic ☐ Black / African / Caribbean / Black British
   ☐ Asian / Asian British ☐ Any other ethnic group - please state: _____

   b. What is your gender?

   ☐ Male ☐ Female ☐ Transgender ☐ Prefer not to say ☐ Other - please state: _____

   c. Are your day-to-day activities limited by a health problem or disability which has lasted or is expected to last over 12 months?

   ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No

   d. Which of the following age categories do you fit into?

   ☐ Up to 17 ☐ 18-24 ☐ 25-34 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75+
   ☐ Rather not say

2. The MCP will be a new single organisation that is responsible for bringing together local GP practices, nurses, community health and mental health services, social care, hospital specialists and others to provide integrated out of hospital healthcare. What other local services, if any, do you think are missing from the MCP and should also be included?

   Fold Fold

   _____

   _____

   _____

   _____

3. Other people in Dudley have told us the most important things they want the MCP to improve are: access to local services, continuity of care, and co-ordination and communication between different services. Which of these do you think it is important that the MCP improves? Are there any other aspects of out of hospital care you think it should also aim to improve? (please tick all that apply)

   ☐ Access to services ☐ Continuity of care ☐ Co-ordination and communication

   Other, please specify: _____

4. The MCP will have a part of its funding allocated by the CCG based on its achievement in the following areas: how satisfied patients are with MCP services, the health outcomes for patients using MCP services, and the general health of the local population. What do you think about this approach?

   ☐ Good idea ☐ Bad idea ☐ Don't know

5. If you think this is a good or bad idea, why is that?

   _____

   _____

   _____

   _____

We want your views

To return your views to us free of charge, please cut along the dotted line, fold in half and place into the envelope supplied.

6. We think the MCP should have a single telephone and online system that all patients can use to access different local services. Do you agree or disagree?

   ☐ Agree ☐ Disagree ☐ Don't know

7. Having heard a little about the MCP, how do you think it may affect you and others in Dudley?

   ☐ Positive impact ☐ Negative impact ☐ Don't know

8. If you think it may have a positive or negative impact, what are these impacts and who in Dudley do you think they will affect?

9. What do you think we can do to make sure that any impacts are positive ones?

Fold Fold

10. What kind of things will matter to you when you come into contact with the MCP or the staff? How would you want to be treated?"

Thank you!

If you would like this document in large print, audio, Braille or in a different language please contact us on 01384 322777 or email us at contact@dudleyccg.nhs.uk