MIDLANDS AND LANCASHIRE
COMMISSIONING SUPPORT UNIT
Strategy Unit

Evaluation of the Dudley New Care Model Programme: Early Findings Report

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MIDLANDS AND LANCASHIRE COMMISSIONING SUPPORT UNIT
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One page summary of the main points in this report

This is a high level summary of the main early findings from the evaluation of Dudley's New Care Model (NCM) programme. Dudley is establishing a Multi-speciality Community Provider (MCP), with the intention of enhancing and improving services provided in the community.

The report was commissioned by Dudley Clinical Commissioning Group (CCG) and produced by the Strategy Unit. The evaluation is learning oriented and this report provides early feedback, focused exclusively at a strategic level, with the aim of supporting Dudley's programme. The report draws on interviews with local senior stakeholders, undertaken in June, the main findings from which were:

On the case for change and views on the MCP model:

- There is a widely shared understanding of problems in the local system, in that:
  - Services in Dudley are too fragmented;
  - Population need and care provision are not well matched, with insufficient focus on services provided in the community;
  - Primary care is under increasing strain;
  - Care is too reactive, with too little emphasis on prevention and self-care;
  - There are perverse incentives in the system; and,
  - Dudley's current system is not financially sustainable.
- Accepting some reservation and disagreement, the MCP model is seen as an important means of addressing these problems, by:
  - Integrating the right services;
  - Creating the right incentives using a single, long-term contract, held by a single organisation, with a focus on outcomes and a capitated budget; leading to
  - More proactive and enabling care, provided in the community; supported by
  - More strategic commissioning.

On implementation of the model to date, the evaluation found that:

- Work to establish the MCP has raised inevitable organisational conflicts and system risks, which are being managed through multiple mechanisms;
- The CCG has largely driven the work to date;
- The CCG - Local Authority (LA) relationship is generally strong; further work is needed to clarify more detailed elements of the MCP model;
- More needs to be done to prepare primary care for the MCP;
- The Partnership Board that oversees the work is not realising its full value;
- Significant change in care and resulting outcomes is likely to follow only after the MCP provider is established; although,
- There are some early signs of outcomes resulting from work done to prepare the system for the MCP.

Resulting recommendations are therefore for the:

- CCG to focus on primary care development.
- CCG to define, and plan to mitigate, system risks.
- CCG and LA, supported by the Partnership Board, to design a post-procurement development programme for the MCP provider.
- Partnership Board to collectively re-confirm its function.
- CCG, LA, NHS England and NHS Improvement to stress-test the MCP contract.
- CCG and LA to describe planned changes in local commissioning function.
- NHS England to refine the approach to overseeing the programme.

Executive summary

The NHS faces a well-documented series of challenges. Fundamentally, these challenges are a corollary of a mismatch between demand for care (rising, becoming more complex) and its supply (highly constrained, not optimally arranged). The consequences of this mismatch are becoming increasingly apparent as finances and performance worsens and public concern rises.

The Five Year Forward View outlined these challenges and set out a series of responses to them. The most high profile of which was the New Care Models (NCM) programme. The programme established 50 'vanguard' sites to test different models of care. Dudley is one of 14 such sites developing the 'Multi-speciality Community Provider' (MCP) model, which – in essence – sets out to integrate and enhance services provided in community settings. This work was initiated by Dudley Clinical Commissioning Group (CCG) and is being overseen by a multi-agency Partnership Board (PB).

The Strategy Unit, working in partnership with ICF International and the Health Services Management Centre, has been appointed as Dudley's evaluation partner[1]. The evaluation is learning oriented and has been designed to track implementation and effects at strategic and operational levels of Dudley's programme.

This report provides early feedback, focused exclusively at the strategic level. It draws on in-depth, semi-structured interviews with 16 local stakeholders (predominantly Chief Executives and Directors), sampled purposively for their involvement in the programme. Interviews were undertaken in June and the report therefore provides a high level view of Dudley's programme at a specific point in time.

This summary outlines the main findings from the report. It begins by describing views in relation to the rationale for the MCP, moves on to its design and then its implementation. Recommendations follow. Readers wanting more detail on any of these topics are referred to the main body of the report.

There is a widely shared understanding of the challenges facing Dudley's health and care system

Stakeholders described a common set of issues facing the local system, perhaps all of which are also reflected in national level analysis. Problems cited included:

- The fragmentation of different parts of the system, with services not meeting the changing needs of the local population;
- An imbalance of provision (given population need), with Dudley's care economy being unbalanced in favour of hospital based services at the expense of services based in the community. Primary care was also cited as being under significant strain;
- Too little emphasis on preventive care, with a need for more community and voluntary services, more proactive care and greater use of approaches such as care planning and the promotion of self-care;
- The presence of perverse incentives facing provider organisations; and,
- The financial unsustainability of the current system. Most stakeholders considered that the system was (just about) affordable now, but that it would not remain so. 'Do Nothing' was not therefore seen as a desirable option.

[1] This report was produced solely by the Strategy Unit.

Accepting some reservation and disagreement, the MCP model is seen as having the potential to address these challenges

Interviewees were asked for their reflections on the MCP model: whether they thought it would address the problems outlined above and, if so, how. These were reflections 'in theory' given that the MCP has yet to be brought about in practice.

There was a broad (but not unanimous or unreserved) consensus that the MCP model was right given the nature of local challenges. Means by which the model is expected to work included:

- *Integrating the right services*. This was most typically described in terms of bringing currently separate services, teams and professionals together under a single (contractual / institutional) framework.
- *Creating the right incentives*. Stakeholders outlined three main features of the MCP model that they saw as having an effect on provider incentives (and so behaviour): a single, long-term contract; a focus on population level outcomes; and a capitated budget.
- *Changing the delivery of care*. Following the logic of the points above, interviewees outlined expected changes in care – to include a greater focus on prevention, integrated community based provision and patient-centred care planning.
- *More strategic commissioning*. While not seeing this as resolved, stakeholders noted that, with an MCP in place, the CCG and Local Authority (LA) would have an opportunity to concentrate on their more strategic commissioning functions, rather than day-to-day contract management.

Moving to implementation of the MCP has been complex and demanding

In large part, the CCG (as commissioner) is leading the implementation of the MCP. Multiple strands of activity are being used to bring the MCP about. They include:

- A supporting programme - focused largely on enabling measures, system and provider development - funded by NHS England (NHSE) through the NCM programme;
- The MCP procurement (specifying a contract, procuring a provider) and the mainstream work of the CCG in support of this; and,
- The PB and consequent activities of partner organisations.

This list is not exhaustive; these activities are not mutually exclusive; they are also evolving rapidly. In sum, they add up to a highly complex and large scale programme of change. As would be expected, this has been challenging work that has raised a series of issues for the local system. Stakeholders noted that:

- Work to establish the MCP has raised inevitable organisational conflicts and system risks. These are being managed through multiple mechanisms;
- The CCG - LA relationship is generally strong; further work is needed to clarify more detailed elements of the MCP model;
- More needs to be done to prepare primary care for the MCP;
- The PB is not realising its full value; and,
- Significant changes in care and resulting outcomes for the population are likely to follow only after the MCP provider is established. However, there are some early signs of outcomes resulting from work done to prepare the system for the MCP.

A series of early recommendations follow from these findings:

For the:	***To:***
CCG	*Focus on primary care*. The MCP offers an opportunity for an enhanced and improved set of services in the community, with the GP-patient relationship at the heart of it. Yet locally primary care does not appear to have kept pace with developments. A programme of support has been established by the CCG, yet more needs to be done to stimulate demand for this and to improve GP leadership in representing primary care.
CCG	*Define, and plan to mitigate, system risks*. As would be expected in a programme of large scale system change, the move to establish an MCP has created tensions and raised potential risks for different providers / parts of the local system. Some of these risks look significant; they must be clearly articulated and documented. Some risks will remain organisational, others will require system-level mitigation within Dudley and/or the Black Country Sustainability and Transformation Plan area.
CCG, LA, PB	*Design a post-procurement development programme based on 'MCP theory'*. A change in contractual form will not bring about the promises of the MCP model. Nor will aggregating services within a single institutional framework. There is therefore a need for a programme of post-procurement system and provider development. This should be based on an understanding of the ways in which MCPs are expected to work (e.g. by reducing duplication; by greater digital integration, etc).
PB	*Re-confirm the function of the Partnership Board*. There is some ambiguity the PB's function and the recommendation here is for the PB to focus on strategic system issues, rather than detailed operational oversight.
CCG, LA, NHSE, NHS Improvement	*Stress-test the MCP contract.* Locally, the MCP contract is being tested via a review process and the competitive dialogue approach to procurement. Nationally, there is scope to add value to this in developing the MCP contract – e.g. by exposing opportunities for gaming, examining trade-offs between outcomes, reviewing mechanisms for local political accountability (etc).
CCG and LA	*Describe the planned changes in commissioning function*. Once the MCP is established, the CCG will – jointly with the LA - see a change in function. Accepting that uncertainties remain, it should be possible to trace the logic of these developments such that a joint commissioning function for health and social care in Dudley can be described with reasonable precision.
NHSE	*Refine the approach to overseeing the NCM programme*. There are signs that oversight of the NCM programme is over-emphasising traditional approaches to performance management (focusing on what has been done / what has resulted); this misses the opportunity to extract and share learning, which is a core expected benefit of the programme. NHSE should reflect on whether there are opportunities to refine its approach to ensure that these benefits are also realised.

1 Introduction to the programme, the evaluation and this report

The challenges facing health and social care services are well rehearsed. Pressures created by increasing demand and highly constrained supply are becoming apparent in relation to finance, service performance (Kings Fund, 2016) and public concern (Economist/Ipsos MORI, 2016).

In October 2014, the Five Year Forward View (5YFV) was published. It articulated a series of responses to these challenges; it set a direction of travel and established a series of initiatives to exemplify this direction and to accelerate progress. The most high profile of which was the New Care Models (NCM) programme.

The NCM programme is being implemented as a set of 'Vanguard' sites, with five NCM types being tested in 50 areas across the country[2]. The programme is supported by NHS England (NHSE), in concert with other national bodies. In broad terms, the policy intention is to show:

- What these new models of care look like in practice;
- The results they can achieve (by what means and at what cost); and
- How they have been designed and implemented, such that they can be adopted more widely[3].

Dudley was successful in bidding to become a Vanguard. It is one of 14 sites developing the Multi-speciality Community Provider (MCP) care model[4]; it is also one of six sites working with NHSE to develop a contract for commissioning MCPs. Dudley's programme was initiated by the Clinical Commissioning Group (CCG) and is overseen by a multi-agency partnership from across health, social care and voluntary sector services in Dudley. The work is overseen at the most senior levels by the Partnership Board.

1.1 The evaluation is learning oriented; this report provides early feedback focused at a strategic level

Evaluation has an important function given the policy intention summarised above. It can help codify the models, examine their worth and extract their lessons. This is especially pertinent in an environment where national policy development and local implementation is contemporaneous: practical lessons from programmes may offer insights for policy.

The Strategy Unit, working in partnership with ICF International and the Health Services Management Centre (University of Birmingham), has been appointed as Dudley's evaluation partner[5].

[2] https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/ [accessed 8th July]

[3] The expectation on adoption has been formalised as a target that 50% of the population will be covered by a new care model by 2020/21.

[4] This report does not rehearse the aims or main features of the MCP model (nationally or locally) on the assumption that most readers will have sufficient familiarity with it. Should readers require this detail, they are kindly referred to the 5YFV, the General Practice Forward View (April 2016), the hyperlink above and NHSE's national MCP framework (forthcoming, but imminent, at the time of writing). The aims and workings of Dudley's model is described, *inter alia*, in the public consultation documents (http://www.dudleyccg.nhs.uk/wp-content/uploads/2016/07/MCP-Consultation-Document-Final.pdf [accessed 25th July]), the CCG's Commissioning Intentions 2016/17-17/18 and CCG's July Board Papers.

[5] This report was produced solely by the Strategy Unit.

The overall approach to this work is detailed in Dudley's evaluation strategy; in summary, it:

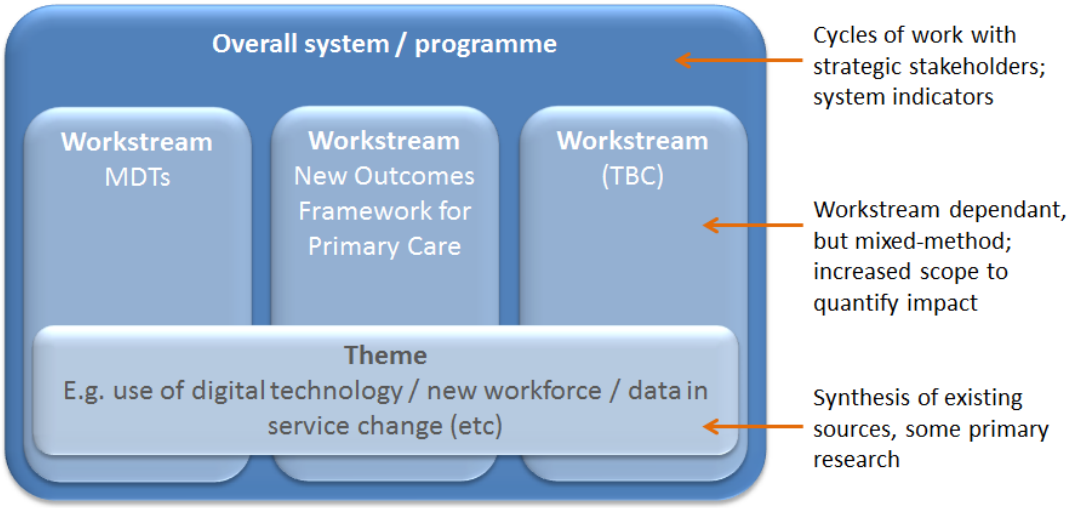
- Sets out a highly formative and learning-oriented approach to the work. Evidence will be gathered and fed back into the programme and its component parts as the work progresses. The aim is to help the programme as it is implemented, rather than pronouncing on it retrospectively, and the evaluation will be judged by its utility as well as its quality. Fundamentally, the evaluation is part of Dudley's ambition to create a self-improving system that demands and acts upon evidence;
- Translates the framework for local evaluation produced by NHSE into a set of questions (see below) and methods for Dudley; and,
- Operates on three broad 'levels' (shown in the Figure below):

1. **System / programme** – taking a broad perspective across the local care economy on the move to implementing the NCM;
2. **Workstream** – examining specific initiatives that are central to the NCM. Two such studies are in progress (reporting later this year), looking at Dudley's:

    a) Multi-Disciplinary Teams (MDTs) in primary care; and,
    b) New outcomes framework for primary care.

3. **Thematic** – this is currently the least-defined aspect, and candidate topics will emerge as the programme progresses, but the intention here is to examine specific themes through a synthesis of existing sources augmented by primary research. These themes will be cross-cutting within the programme – e.g. better use of digital technology.

Figure 1.1 The evaluation operates at system, workstream and thematic levels



Throughout, the evaluation is guided by eight main questions (which draw on the NHSE framework noted above):

1. *What is the context for the programme?*
2. *What was the perceived need for change and why was an MCP model seen as an appropriate response?*
3. *What were the major changes initiated by the programme and how well were they implemented?*
4. *How was the programme experienced across the system, e.g. by: the public, patients, staff and stakeholders?*

5. *What outcomes were achieved by the programme? How were these outcomes achieved? Were there any negative or unintended consequences of the programme?*
6. *In what ways and to what extent has the programme changed / improved the pattern of resource use within the local health economy?*
7. *To what extent has the programme addressed its founding rationale?*
8. *What lessons - for practice and policy - can be derived from Dudley's experience? What would need to be considered in order to replicate component parts? Conversely, what can Dudley learn from analogous practice elsewhere?*

1.1.2 This report presents the early views of strategic stakeholders

This Early Findings report is the first evaluative output; it has been produced by the Strategy Unit.

The report concentrates exclusively at the system / programme wide level and primarily addresses questions 1-4 and 8 above. Evidence comes from in-depth, semi-structured interviews with 16 strategic stakeholders (predominantly Chief Executives and Directors), drawn primarily from the Partnership Board and sampled purposively for their involvement in the programme.

The aim was to provide early feedback and to start the process of providing rapid feedback to the programme. The method was designed in support of this. Interviewees are listed in Annex A; topics explored are in Annex B. Interviews were conducted face-to-face (n=9) and by phone (n=7) between 14th June and 12th July 2016 (evidence gathered was then analysed for this report between the 13th and 25th July). Interviews were undertaken on the basis that no quotes / views would be attributed to individuals; interviews were recorded, written up and analysed thematically.

Important limitations follow from this method, in that:

- Stakeholders interviewed have varying levels of engagement and differing perspectives from their position in different parts of the local system;
- Only very senior stakeholders were interviewed and nothing can be said about how deeply or widely views expressed here are shared within respective institutions; and,
- Findings are from a point in time. The pace of change within the programme means that some of the issues raised - and recommendations made – will have been acted upon.

What follows is therefore an early set of strategic level findings from a live and necessarily complex programme of large scale change.

The intention of this report is to provide as much clarity and insight as possible given these limitations: to summarise developments to date and to highlight areas where more attention is needed in order to bring about a new model of care in Dudley. Interpretation is therefore kept to a minimum in presenting findings: direct quotes are used as far as possible, allowing interviewees to 'speak' for themselves.

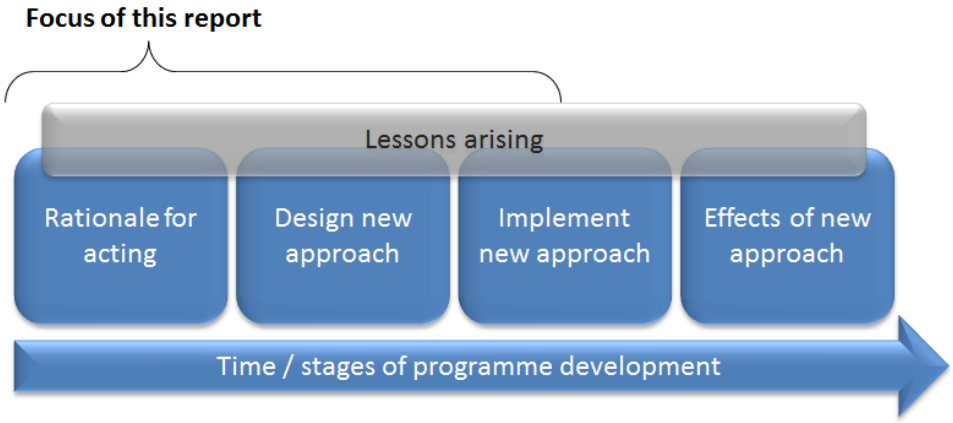
The report examines the following main topics in the following sections:

- Section 2 presents interviewees' understandings of the problem(s) that the MCP is being established to address – and views on the likely workings of the model;
- Section 3 sets out views on implementation of the model to date;
- Section 4 summarises interviewees' reflections on lessons learnt; and

- Section 5 provides reflections and recommendations from the evaluation.

The report therefore focuses on the early stages of programme development (illustrated in the Figure below). Later reports will revisit the same topics and questions, but will also extend to examine effects as they arise. Other elements of evaluative activity will make more specific and detailed assessments of particular services – notably the MDTs and the new outcomes framework in primary care.

Figure 1.2 This report concentrates on the early stages of the programme



Finally, this report can usefully be read alongside a companion document produced by the Strategy Unit, which sets out a quantitative baseline for Dudley on selected programme-level indicators (supplied in draft under a separate cover).

2 Rationale for intervention; views on the MCP model

This section sets out interviewees' views on the above topics. It begins by outlining their understanding of challenges in the local system, before developing this into a series of reflections on the MCP model's ability to address them.

The main points made in the section are summarised in the box below, before being elaborated in turn:

- There is a shared understanding of problems in the local system, in that:
  - Services in Dudley are too fragmented;
  - The care system is unbalanced, with insufficient focus on services provided in the community; this does not meet the needs of Dudley's population;
  - Primary care is under increasing strain;
  - Care is too reactive, with too little emphasis on prevention and self-care;
  - There are perverse incentives in the system; and,
  - Dudley's current system is not financially sustainable.
- Accepting some reservation and disagreement, the MCP model is seen as an important means of addressing these problems, by:
  - Integrating the right services;
  - Creating the right incentives through: a single, long-term contract, held by a single organisation; focused on outcomes and with a capitated budget; leading to
  - More proactive and enabling care, provided in the community; supported by
  - More strategic commissioning.

2.1 There is a shared understanding of problems in the local system

At the start of the interview, stakeholders were asked to outline their understanding of the problems in the care economy that led to a view that something needed to change. The detail of responses is set out below, but it is also noteworthy that:

- *The challenges identified are not peculiar to Dudley*. The problems summarised below are well documented in national analysis; moreover, many interviewees reflected that there are analogous problems in other local health economies (with a greater severity in some cases); and
- *A common set of challenges was identified*. There was a high degree of homogeneity in the responses - even accepting differences of emphasis and perspective. The component parts of the case for change appear to be widely shared and well understood between those interviewed.

2.1.1 Services in Dudley are too fragmented

The most fundamental, and most commonly cited, problem identified by interviewees was the mismatch between changing population needs and current patterns of service provision. (Many of the other challenges outlined below are causes of / explanations for this point).

The strongest theme within the responses was the fragmentation of services. For example:

"Historically, people have worked in silos and haven't joined up – haven't connected. For example, getting hospital services to talk to people in voluntary services who could support people in the community".

"The division between primary and secondary care has become more entrenched in the last 15-20 years and we need to join them back up and have integrated pathways".

"I didn't realise how far apart the system players are…I thought they worked a lot more closely than they do".

One interviewee explained this situation as following from 'an absence of design' in the system, such that the result was:

"A hotchpotch of services that weren't designed around the needs of the patients…The poor patient is left in the middle, having to repeat themselves fifty times over and not knowing how to navigate the system - and frontline staff find themselves in a very similar position".

2.1.2 The care system is unbalanced, with insufficient focus on services provided in the community; this does not meet the needs of Dudley's population

Many interviewees elaborated the point above by arguing that Dudley's care economy was unbalanced in favour of hospital based services at the expense of services based in the community. For example:

"We have a very hospital centric system. So the hospital sucks in most of the funding that we have locally, when what we could do is provide more services in the community, wrapped around the individual, rather than causing the individual to go to an institutional hospital setting".

"The resources in the NHS have gone far too much to secondary care…an ageing population needs more TLC and chronic management".

No interviewees considered that the current balance of provision was optimal (given population needs) and several considered that there was a need for 'significant' and 'radical' change. A small number of interviewees further reflected that there was a need for stronger system oversight, arguing that the current situation resulted from a series of uncoordinated institutional decisions (discussed below in relation to incentives), rather than a deliberate process of design:

"If we're honest about it, then these are all decisions we've taken individually [as institutions] that have had an impact on one another".

"There aren't really any effective mechanisms to look at managing increasing demand…[there are] no effective cross-system approaches to try and manage that".

Another interviewee extended this point to reflect upon the role and standing of the CCG, given its remit to take a view across the local system:

"Part of this has been about asserting the CCG's authority in the system".

2.1.2.1 Primary care in Dudley is under increasing strain

A small number of interviewees within the CCG reflected that they had good relationships with member practices – and that there is a local history of providing support and development to primary care. The change from being a Primary Care Trust to becoming a CCG was cited as giving local commissioners a clearer understanding of primary care – and that this provided a 'new lens' on problems in the system:

"What you very quickly got [in becoming a CCG] was the perspective of primary care. It became apparent that primary care was on its knees".

"It was a question of sustainability, rather than access, at that point".

"[Primary care] isn't really sustainable – you can't recruit GPs and the model of being partners in business is changing".

In addition to factors specific to primary care (such as GP recruitment), a small number of interviewees elaborated upon related issues in community services. The essential point made was that GPs felt their connection to (and control of) these services had been lost.

"GPs constantly talk about the fact that they don't know who their district nurse is, that they have no control over community services".

Those making this point typically connected it back to the Transforming Community Services (TCS) initiative. In their view, opportunities under this programme had been missed:

"There didn't appear to have been any transformation [under TCS]. If anything, opportunities for integration were lost".

2.1.2.2 Care is too reactive, with too little emphasis on prevention and self-care

Following the points outlined above, several interviewees considered that there was too little focus on preventive and proactive approaches (with consequent effects on patients and services). For example:

"The more resources we take out of 'prevention' - of services that help people to remain independent and help themselves - then what we see week on week is people coming through with more acute need".

On this account, there would be a need for more community and voluntary services, more proactive care and greater use of approaches such as care planning. A small number of interviewees extended this point, noting that local people were also not encouraged or supported to play an active role in improving and maintaining their own health:

"People are part of the solution…we need to create opportunities for them to identify things that can improve their health and wellbeing".

2.1.3 There are perverse incentives in the system

Several interviewees explained the above problems with reference to the incentives facing individual organisations and so individual staff members within them. For example:

"The system is full of perverse incentives. As professionals right now we spend far too much time arguing about where liability [to fund / provide services] sits".

The most commonly made point on perverse incentives related to payment systems. The essential point was that current approaches have not been designed so as to incentivise integration or promote the de-escalation of care to the least resource intensive setting. Within this, interviewees typically cited having predominantly activity-based payments (PbR) to fund hospital care and (again, predominantly) block contracts in primary care. One interviewee noted that:

"It struck us that there were multiple disincentives in the system and that these were hampering effective joint working…we were even incentivising some organisations to be less helpful in achieving wider gains".

While another gave a specific example:

"It's like care homes…they are quite happy for people to go to hospital, because what that means for the staff in the home is one less [resident]…they still get the money coming in".

On a still more detailed note, a small number of interviewees noted the (from their perspective unhelpful) influence of the PFI payments relating to hospital facilities, given that this reduced flexibility in the use of resources at a system level.

2.1.4 Dudley's current system is not financially sustainable

Nearly all interviewees reflected on the financial sustainability of the system. Most considered that the system was (just about) affordable now, but that it would not remain so. For example:

"From indicative work, it looked like we wouldn't be able to sustain what we had in five years' time...looking at pay, demand growth, things such as that. For me, that's what kick started it [the programme] – a financial understanding that something needed to change across Dudley".

"[The programme was] born out of economic necessity… more and more of the CCG budget was going into acute care – and there were pressures in primary care, social care and community services…and the more these services are cut, the greater the flows into acute care".

"The fixed point in the system is the commissioner budget - ours [CCG] and social care. Our budgets are under strain, social care is under even more strain, and the resources we've got are not going to keep pace with the demand that's going through the system".

Interviewees making these points noted that 'do nothing' was therefore not an option.

2.2 Accepting some reservation and disagreement, the MCP model is seen as an important means of addressing problems in the local system

Having outlined their views on the case for change, interviewees were then asked for their reflections on the MCP model. These were reflections 'in theory' given that the MCP has yet to be brought about in practice (views on efforts in this direction are outlined in the next section).

Before outlining specific points, it is worth noting that most interviewees described a situation whereby a direction had been set, and an outline approach arrived at, before the publication of the 5YFV and the 'invention' of the MCP model. A small number of interviewees noted that Dudley had applied (unsuccessfully) to become an Integration Pioneer; others noted that work under the Vanguard programme would have taken place anyway (albeit slower and/or to a lesser extent); and others pointed to the development of MDTs in primary care as both exemplifying and preceding this programme.

On this account, the NCM programme offered an opportunity to use resources and support to clarify, catalyse and enhance a set of pre-existing intentions. The MCP model was seen as the most appropriate response to the problems identified in the local system. For example:

"It became obvious that if we were concerned with primary care resilience and how services were organised around practices, then this would be the way to go".

"We [CCG] did a lot to get MDTs up and running. In one sense, an MCP is an aggregation of a set of MDTs - albeit putting some of the more specialised services into the mix...so it [the MCP model] was along a natural direction of travel".

"We [CCG] decided that we would do this anyway - that we were going to integrate teams [around GP practices]. We didn't contract for it, but took a very OD approach to get people working together…as a CCG, we're made up of our member practices, we've always been very patient and practice oriented and we've wanted to wrap services around the practice".

A small number of interviewees also reflected on the selection of the MCP model, rather than the Primary and Acute Care Systems (PACS) model. While this was not a focus of detailed exploration in the interviews, the main reason cited for this was that a PACS risked reinforcing some of the problems outlined above: that it was 'based in secondary care', and so may miss opportunities to re-balance the system; and, on a related point that the MCP's emphasis on primary care was right for the local system:

"[PACS are most appropriate] where primary care is broken. Now we're not in that situation. We have some problems, but we're not in the situation of primary care falling apart".

"When you look at the content of the different models [PACS and MCPs], they're all doing similar things, but the MCP gave an opportunity to structure community services around the leadership of general practice".

"It [a PACS] would have been easier to do - but we see the MCP as the right thing for this system…that's not a shared view".

As this final quote suggests, there were challenges to the general consensus that an MCP model was right given local challenges. Points made here included the suggestion of a different model (e.g. an Accountable Care Organisation (ACO) for the whole system), alongside related concerns that integration between the services included in the MCP might mean a sharper divide between MCP and non-MCP (predominantly hospital based) services. For example:

"My worry is about disintegration between acute and community care. At the moment you can see that Dudley Group could shift their resources to help get people back into the community…You could have a commissioner and two providers [MCP and non-MCP] who are actively working to different incentives".

"We've got models that perhaps hit the spot more than the MCP model, which addresses some problems but raises other questions".

General reflections were made more specific as interviewees were asked to reflect on particular features of the MCP and on *how* (by what mechanisms) the MCP was expected to bring about positive change. Four main points emerged relating to:

- Integrating the right services; and
- Creating the right incentives (a single contract, focused on outcomes with a capitated budget); leading to
- A more proactive and enabling model of care; supported by
- More strategic commissioning.

Each is elaborated below.

2.2.1 Integrating the right services

The main mechanism cited was the integration of services. This was most typically described in terms of bringing currently separate services, teams and professionals together within a single (institutional) framework.

Integrating services was thereby understood as a response to the problem of fragmentation described in the previous sub-section; it is seen as a fundamental design principle of the MCP:

"Who makes day to day decisions? Who really makes commissioning decisions? It's frontline staff – it's clinicians. So you want them to be able to make the right decisions and to be operating as efficiently and effectively as possible...but if services are provided by different organisations in different ways, then you're immediately creating barriers to this".

"What we have now is a set of decisions being made by a set of separate organisations. By integrating health and social care you can make a single decision, with the service user, about what is best for them".

"Integration of services across physical health, mental health, social care and voluntary sector services...by being able to integrate at practice level...there is alignment with the way that need is presented".

"Where should services sit? Logically you'd think they should be within the same organisation if the interdependencies [between services] are great enough. And why should services sit within a hospital setting if the vast majority of activity in that speciality doesn't need in-patient hospital facilities or technology that is advanced to the degree that it has to be centralised?"

As suggested in the last of the quotes above, if the integration of services is seen as the most important route to better outcomes / use of resources, there is then a question as to the boundaries drawn around the MCP. Interviewees reflecting on this point saw the position of social care services as being fundamentally important:

"It would be so much better if social care was in. But it's not at the moment. It's such an important part of the overall system, so that's a shame at the moment".

More generally (and as discussed in Section 3 in relation to implementation), the detailed question of exactly which contracts and service lines would come together under the MCP was also raised:

"We've got a concept. There's a lot of logic to it. But in terms of articulating it – almost on a service by service line…we are not at that point right now".

2.2.2 Creating the right incentives

In addition to bringing services together, the MCP model also seeks to change the incentives facing service providers (and, thereby, their staff). Stakeholders expanded upon this theme, considering how the MCP model might do this, and how this might lead to improved care, outcomes and resource use. One interviewee, reflecting back on the apparent lack of / perverse incentives in the current system, asked how this might be improved:

"What components of social care can you put together with health – within the same organisation – so that it's absolutely in the interests of those components to enable the other's effectiveness because they are enabling the organisation's [overall] effectiveness?"

Interviewees described three main features of the MCP model that they saw as having an effect on provider incentives: a single contract (1), focused on outcomes (2), with a capitated budget (3). Each is discussed below. In what follows it is important to note that these are individual views / ex-ante beliefs about the operation of a model – not statements of fact about the content of a contract.

2.2.2.1 A single, long-term contract, held by a single organisation

Bringing currently separate contracts and services together into a single MCP contract was seen as having a series of in-principle advantages. Primarily, interviewees related these advantages to removing some of the current incentives to move demand (i.e. patients / service users) and so cost around the system, since – in large part – this would stay within the MCP.

On a related point, the commonality – of (for example) objectives, leadership and policies – brought about by having a single organisation holding the MCP contract was also typically cited as a positive. For example:

"[The MCP would have] A common leadership structure, a common set of objectives and a common financial bottom line".

"You've got more chance of that [integration of services] working if the staff are in one set up, than if there are a disparate set of organisations negotiating with each other and the centre".

"One performance system, one electronic record…"

"One overarching organisation with a set of characteristics and an ethos".

Finally on this point, a small number of interviewees also reflected – again positively – on the length of the contract currently being designed. The main advantages cited here related to the ability to plan and invest over a longer period than is currently the case. For example, one interviewee noted that:

"A 15 year contract sounds appealing to me…not having to worry about balancing the books each year and being able to take a punt on a three or four year project".

2.2.2.2 A focus on outcomes

The MCP contract will be more outcomes-based than most current contracts in the system. Several interviewees described the ways in which this might lead to better outcomes for the population, in that:

- Commissioners would go through a process of setting outcomes and measures 'that matter' to the population, meaning that the provider would be better tasked; and that,
- The MCP provider(s) would then take these outcomes and 'work backwards' to define the best means of achieving them, meaning that the provider would be more focused on results; and,
- Commissioners would then hold the provider to account (and would pay) on achieving these results.

One interviewee from within the CCG summarised this as having:

"A whole population based budget linked to an aggregated set of outcomes - giving us a way of holding providers to account in a way that we don't currently… away from buying singular events to buying a set of outcomes".

Another interviewee developed this, describing the use of outcome-based commissioning as an approach to the knowledge problem of where expertise is held and so service design work best done. They also touched upon a likely change in function for commissioners (elaborated further below):

"Put all those services together, put a framework around it, and then leave it for the service to decide how it will operate...why try and design a service top down? Why not create an environment where the service can be live?...The reason an MCP has

a chance of working is that we will put the right groups of staff together and get them to decide how they will work together to meet high level objectives".

Yet there were also points of disagreement among interviewees as to how far this mechanism could / should operate in practice, in that:

- Some thought that there was a need to specify – in detail – the services that ought to be provided; while
- Others considered that this was more / less a matter for the provider(s): that setting and monitoring desired outcomes was the primary responsibility of the commissioner, not the detailed specification of how these results might be achieved.

2.2.2.3 *A capitated budget*

The MCP contract will have a capitated budget with some proportion of the payment linked to the achievement of outcomes. While a less commonly raised feature of the contract, several interviewees reflected on the changes in incentive and behaviour that they believe this form of budget / payment ought to result in.

Points made related largely to technical efficiency (the conversion of inputs to outputs within a given service); for example:

"We've had capitated payment systems in primary care for a long time. And if you look at the analysis of resource against activity across the system, it's the only part of the health architecture that has delivered increased activity against a flat-lined resource".

"It will make the providers think differently. At the moment, what is the incentive to stop people coming back for [hospital] appointments?"

Yet there was also some debate as to whether a capitated budget would also lead to gains in allocative efficiency (more optimal investment between areas / types of service):

"There is certainly an opportunity to think about the system and the totality of resource – capitation is one neat means [of doing so]".

Yet, on the whole, interviewees did not think this was a settled question – that it was not clear that the MCP provider would have the freedoms (in theory or practice) to define a new set of investments. For example:

"Yes it will give the MCP the ability to invest in different services, but that will still be defined by the commissioner…if we [CCG] haven't specified that we want a service provided, then some cut-throat provider might not do it… I don't think that there will be that flexibility for the MCP to invest without the disinvestment that goes with it…so [changes in investment] will be a longer term job".

"Are they [the MCP provider] a commissioning body? Can they sub-contract? That needs to be resolved".

While one interviewee linked the question of MCP 'savings' to changes in investment needed in non-MCP (in this case hospital based) services:

"The model, in theory, is absolutely right…what concerns me is that it's assumed that multi-disciplinary working is cheaper. It may – or it will – keep some people out of hospital. But unless you reduce the capacity in hospitals to pay for it then it is not cheaper [to the system overall]".

2.2.3 More proactive and enabling care, provided in the community

As a corollary of the above (and so occurring 'further down' the causal chain and therefore later in time), interviewees generally considered that the MCP ought to provide care in a different way. The essential features of this change in care were outlined by several interviewees:

"It's about the public, the patient, being more in control of their care. It's about GPs being the best person to signpost to services that people need. It's about the MDT, but wider than that – other services that contribute. There are also other advantages of shared care records – on quality and safety".

"I'm convinced that it will lead to better care planning, because we will be monitoring this kind of thing in the contract, and that this will lead to people having more control and understanding of the way the system works around them".

"To get people much more involved in their care management. And get the voice of the patient much more into the commissioning of services".

2.2.4 More strategic commissioning

The final main topic raised on the theory underpinning the MCP model related to the commissioning function in the system. The small number of interviewees raising this point worked through the logic of many of the issues described above and concluded that (with much of the commissioning budget committed; with outcomes set; with some detailed contract management functions 'going to the MCP' (etc)) the CCG would look very different once the MCP was in place. For example:

"What's the commissioning function that's left behind? The [MCP] supplier will be getting into commissioning, as well as presumably determining requirements".

"At the moment you have a whole financial management team [in the CCG] who spend their time in dispute with providers…that's not how the new contract will be managed".

Two interviewees extended this to outline a more strategic focus for the 'residual' CCG:

"CCG residual commissioning and the local authority should be much more focused on needs and JSNA [Joint Strategic Needs Assessment] type work".

"It [the commissioning function] will need to be citizen focused. To understand their needs and reflect these in the services that it providers – and to do this from a system perspective, not a single organisational perspective".

Finally on likely changes to the CCG, two interviewees wondered whether having a larger / longer MCP contract, alongside a slimmer commissioning function (with less detailed contract-by-contract oversight) might then reduce accountability in the system:

"If it all goes belly up...who's accountable?"

"You've got an MCP that's got real power about what to do…part of the accountability of a CCG could be lost".

3 Implementation of the model

Having discussed the problem the MCP sets out to address, and having outlined their views on the MCP model in theory, interviewees were then asked for their views on realising this model in practice. Their responses are presented in this section.

The topic of implementation is broad. Multiple strands of activity are in train, each of which is significant in its own right. They include:

- A supporting programme - focused largely on enabling measures, system and provider development - funded by NHSE through the NCM programme (hereafter called the 'Value Proposition' programme[6]);
- The MCP procurement (specifying a contract, commissioning a provider) and mainstream work of the CCG in support of this; and,
- The Partnership Board and consequent activities of partner organisations.

This list is not exhaustive; these activities are not mutually exclusive; they are also evolving. In sum, they add up to a highly complex and large scale programme of change. Moreover, stakeholders have differing standpoints in the system and different levels of involvement in implementing the model: very few (maybe even no) individuals have complete oversight and understanding of every element of implementation. The material that follows should be read with these provisos in mind.

There is a further corollary of the above: findings are wide-ranging, overlapping and difficult to summarise coherently. To help the reader navigate, the main points arising are therefore summarised in the box below, before being elaborated in the remainder of the section.

- Work to establish the MCP has raised inevitable organisational conflicts and potential system risks;
- The Partnership Board that oversees the work is not realising its full value;
- The CCG has largely driven the work to date;
- The CCG - Local Authority relationship is generally strong; further work is needed to clarify elements of the MCP model;
- More needs to be done to prepare primary care for the MCP;
- Significant change is likely to follow only after the MCP provider is appointed and established;
- There are some early signs of outcomes resulting from work to date.

3.1 Work to establish the MCP has raised inevitable organisational conflicts and potential system risks

As described in the previous section, the MCP is being established in part to 'rebalance' the local care economy: to shift some investment from hospital based services to primary and community based services. As also noted, this is being done

[6] The 'Value Proposition' was the bid that vanguard sites put to NHSE in order to access Transformation Funding. Dudley received just over £3 million for 2016/17.

at a time of general financial stress with the imperative of having an unaffordable system.

One of the major themes in the interviews was therefore the difficulties and tensions raised within the system as work to establish the MCP progresses. Several interviewees reflected that these tensions were perhaps inevitable given the way that the system is set up; within this, some considered that partners had held together while working through some very difficult issues:

"I thought it would be a rocky road because there are organisation interests at stake and people fight tooth and nail to protect those…but the willingness to exchange information, the willingness to work together in partnership has been stronger than I thought it would be".

The clearest theme within this related to the sense that – on the provider side of the system – there would be 'winners and losers'. And within this most stakeholders considered that the local hospitals trust (Dudley Group) faced the greatest risk: standing to lose revenue income should it not form part of the MCP provider; retaining costs associated with its Private Finance Initiative (PFI) funded estate; and having to manage interdependencies between any services 'lost' to the MCP and those remaining within the Trust.

Interviewees then described a series of approaches being used, and improvements necessary, to address the issues raised by this.

3.1.1 Surfacing and planning to mitigate risk

The most immediate response described by stakeholders was the work (underway at the time interviews were undertaken) to understand the implications and risks of establishing the MCP. These risks were primarily cited as institutional (and so service) risks, but individual level risks were also noted; for example:

"Understanding what people see as the risks – to organisations, but also to them personally – putting those on the table and getting system wide agreement to mitigate this…that's been a major halting point up until this point".

Yet, and as hinted at in the quote above, it was notable that interviewees most commonly spoke in terms of 'system' risks and system health. While some risks were described as being for specific organisations, many – especially on the scale implied by the changes being developed – were considered the preserve of the system, with the CCG (and, albeit to a lesser extent) the Local Authority having a central role in identifying and managing these risks:

"We [CCG] haven't done enough analysis to tell us whether the system is ready for this change…I don't doubt that it's the right concept, but have we done enough to check that it won't destabilise our providers?"

"Bits of the system need other bits of the system, and I don't think there's enough understanding of those relationships…I'm comforted that the CCG is interviewing everyone [providers] to see what those risks are".

"People are signed up to the concept of the MCP…there are concerns around the system as to the resilience of providers – both in the short and long term – and these are big issues…the CCG and Local Authority are working on that".

Finally on this point, a small number of interviewees raised the question of where 'the system' ended in relation to mitigating risks. One interviewee noted that national policy needed to be clarified in relation to where PFI debts could move to / be held. Others raised the question about the broader context provided by the wider Black Country Sustainability and Transformation Plan (STP), seeing this as providing a framework for discussions about changes to the 'provider landscape':

"If we see the activity shift follow through [planned under MCP] then you could see how hospital provision across the Black Country would not align with that clinical model. So there's a real need for a provider connection across the hospital landscape".

3.1.2 Providing clarity and reducing uncertainty

A small number of interviewees highlighted the role of uncertainty in creating risk. Those making this point generally considered that the MCP – and the approach to establishing it – had become clearer and more widely understood over time (having been previously understood as large in scale but unclear in detail and implication). The effect of uncertainty has been seen in some difficult relationships:

"There is palpable tension between Dudley Group and the CCG because of a lot of this uncertainty".

But, in broad terms, this uncertainty was seen as having reduced over time: largely because of recent work by the CCG to more fully articulate the model and its procurement (albeit that significant work remains to be done on this – discussed later):

"Relationships have changed over time. Over the last few weeks, where we've been clear with partners - and I don't think we've all been on the same page previously...that's starting to flush some of the previous angst out of the system…Now that we're delivering consistent messages, I think the misapprehensions are disappearing gradually".

"On implementation it's really key that we keep all of the partners engaged, so that they can clearly see what their role is going to be going forward...a high level of engagement is needed".

3.1.3 Focusing on 'what's ultimately right for the people of Dudley'

The final point raised by several interviewees on the topic of risks and conflicts was the need to 'rise above' individual and institutional interests. While noting the difficulty in doing so (and that some incentives run contrary to it), they saw that focusing on the population and taking a longer-term view would be a helpful perspective as tensions arose. For example:

"Organisations come and go…but the staff and the people of Dudley will be left with this".

"It doesn't matter if it's [lists leaders in the system] as individuals, because this is much bigger than that and we've got to take that collective ownership…this is a system that we've got to change".

3.1.4 The Partnership Board is not realising its full value

The Partnership Board oversees the move to establish the MCP – primarily by overseeing the NHSE funded programme of enabling measures. It brings together senior representatives from across the care economy and is serviced by the CCG and programme office.

While not exclusively the case, in the main interviewees considered that it was not realising the value it could – especially given the level of senior / strategic input provided. For example:

"Instead of being a place to spot and unblock problems, it became about governing the [Value Proposition] programme...we aren't solving problems through it - I can't think of any new innovations that have come from it… I think Partnership Board has

been revealing - it has shown some problems in the system - but it hasn't helped to make progress".

"I think the MCP model is essential. It's a real opportunity to do good things. I just fear that there are so many issues within it that we might not achieve what we want to…I sit at the Partnership Board and I'm not seeing the drive and inspiration to get this job done".

For some, this was explained primarily in terms of the tensions described above:

"The Partnership Board is a battle ground where organisational boundaries, protectionism, cultural differences, resource constraints, etc are played out".

But most considered that problems arose from a lack of clear function, following from the decision to procure the MCP (described below) and consequent need to limit the Partnership Board's coverage (to not cover topics relating to procurement and avoid giving preferential treatment to current providers). One interviewee noted that:

"We've got ourselves caught in a kind of limbo position. We've been given money by NHS England, we've got the procurement going on, and we're caught in the middle. We're not helping with programme management – we get a very quick update but we don't go through it in any detail. Equally we don't talk about the procurement process because we can't".

Yet there was not clear agreement as to how the focus of the Board should be revised. Some interviewees thought the focus ought to be on broad strategy and system-level issues as the MCP is brought about:

"The Board has changed too much. It worked better – at the right level – three or five months ago…we need to be focused on strategy – if it's going to be an operational group, then get operational people in to do it".

While others thought that a more detailed focus on governing the Value Proposition programme would be appropriate.

3.2 The CCG has largely driven the work to date

Nearly all interviewees raised the role of the CCG in designing and implementing the MCP. The CCG was cited as having driven the model of care and the programme to implement it; a point which several interviewees related to reflections on the strength of leadership within the CCG:

"They [CCG] have punched above their weight – and put Dudley on the map nationally, in the right way. There is no lack of vision and they have set the pace".

"My experience is that things [in the NHS] get watered down and watered down…without that drive and absolute vision [at the CCG], it wouldn't be going anywhere".

"Everyone [in the CCG] has done a fantastic job in putting in the effort to get us where we are".

"We've [the CCG] got passion and have kept the pace up...genuinely people believe that this is the right thing to do....it's also because it [the Vanguard] has become our strategy – it's not just the job of one or two people, every person in this organisation has something to do with this".

Nonetheless, interviewees – from within and outside the CCG – offered a series of reflections on areas where they felt attention was needed in order to establish the MCP.

The most commonly raised theme related to organisational capacity. Several interviewees, and especially those within the CCG, noted that the organisation was undertaking a complex, large-scale and high-profile programme of change, within very tight timescales and with very little additional capacity:

"The last 12 months feel like we've been on a high speed train…this is the track we're on and we're trying to keep on. And the people here [in the system] have also got day jobs…and we've got everything else – STPs, Dudley and Walsall [Mental Health Trust] have got their own Vanguard, [lists more initiatives]…we're trying to do so much in a relatively short space of time".

"The staff survey [CCG] shows that we're working silly hours".

"What worries me is that the implementation still all sits with the CCG. We are an active part of it, but I don't feel it as much as I probably should…all the ownership sits with the CCG".

A small number of interviewees then made further points around the need for additional programme management capacity (seen as badly lacking at the beginning of the programme and still 'underpowered' now); and / or for the 'backfill' of CCG staff to free them to perform MCP related tasks (although one interviewee noted that NHSE rules on management resources would prohibit this):

"If you want this MCP project to go forward, you need a dedicated MCP team to deliver it. You can't say to people at the CCG 'drop your day job and run the MCP project'…how do you do that? The day job doesn't go away – much of it is statutory obligation…Much of that £4 million [NCM funding from NHSE] should have been spent on a sophisticated additional management team to focus on the MCP…the resourcing we've put in is nowhere near adequate".

On a related point, a small number of interviewees reflected on the likely 'CCG of the future' (outlined in Section 2). One interviewee considered that more work was needed on this:

"We haven't given enough thought to what the CCG will look like. Now in future, we won't need so much clinical leadership in that part of the system [commissioning]...everyone is viewing this through the current lens, rather than thinking about the future".

3.2.1 The move to procurement has changed organisational roles in implementing the MCP

The CCG will be commissioning the MCP through a competitive procurement process. Accepting that details of the approach to be used are subject to discussion, interviewees were clear that this represented 'a change of direction' in implementing the MCP.

Two interviewees reflected upon this, noting that they saw the early days of the programme as being more collegial and partnership based (convening partner organisations to define the new model of care), which had changed following the decision to move to procurement:

"We've been confused as to whether things are a partnership or not…the CCG has probably been too participatory, wanting to get everybody round the table…but ultimately it couldn't be the case if we go to procurement".

"If we'd been clearer at the beginning that the CCG was going to procure it [the MCP] then we wouldn't have started with the partnership".

While most interviewees noted that the decision to use a procurement based approach was driven by EU legislation, a small number of interviewees also noted

that – quite apart from this – they saw arguments in favour of using the process to speed implementation and enable more far-reaching change. Two of them argued that:

"If it works properly, it will be a big disruption. Without that the MCP would take years and years to make that change. The contract gives us a way of doing that".

"When we start the procurement, I think we'll see a different attitude and set of behaviours, depending on the approach we [the CCG] take…whether we use a formal [competitive] procurement process or an inclusion process".

Providers interviewed also reflected upon this in terms of relationships between them:

"The relationships between us are good…now whether that's because you've got a procurement process coming up and that tends to galvanise people…but the relationships around the table are as strong as they have been".

Their main request was for as much clarity as possible on the process that would be used:

"It's evolving slowly and it feels like a drip feed. I find out things about the procurement from different places".

"There doesn't seem to be one version of what we're going to go through…on what this will look like and what the timescales are".

Finally on this, and as noted elsewhere in this section, the timescales associated with the procurement were almost universally considered to be too short. For example one stakeholder saw the procurement timetable as being:

"Totally unrealistic…is this to satisfy NHS England Vanguard people?"

3.2.2 There is a substantive question as to how far the MCP model is defined by the CCG and how far it is left for providers to develop

As noted in section 2 of this report, the question of how far the CCG should specify the MCP – or how far it should leave it open - was raised by several interviewees.

While no one raising this topic considered that it would be sufficient to 'simply' specify outcomes and leave the question of how results would be achieved over to the provider(s) of the MCP, a small number of interviewees did see that leaving sufficient flexibility for providers to suggest different ways of doing things was fundamental to the thinking behind the contract.

Yet most saw the need for further significant design work; for some, this was the main issue facing implementation. For example:

"I've got concerns about the way it's moving…there are problems with implementation because it's not clear what 'it' actually is. We've all got the vision, but beyond that it doesn't seem to have moved on".

"What are we trying to procure? If we can't express this clearly and accurately, then how can you procure it?...if you don't get the contract saying that you want things done in a specific way, then you won't get leverage over the provider. And if you think providers have the imagination to say how they're going to do it then you're deluded".

Others saw a need to establish clear principles rather than detailed service specifications – in some cases reflecting that the length of the contract being discussed (10-15 years) meant that changes in technology, expectations (etc) made a detailed and durable description very difficult. Two interviewees making these points considered that:

"I think we all understand 'the why', I don't think we've fully answered 'the what' and we've certainly not got into 'the how'".

"We've dived into process before we've got a clear sense of what it all means…there's an assumption that we're all in it together – but do we really all know what the building blocks are?"

3.3 The CCG - Local Authority relationship is generally strong; further work is needed to clarify elements of the model

There are parallels between the role of primary care and the role of social care in the MCP model. Both have been diagnosed locally as facing significant challenges (albeit that social care pressures are far more immediate and severe); both are described as fundamental to the MCP model; and both were cited by interviewees as being in need of attention in order to realise the potential benefits of the model. (Primary care is discussed later in this section).

These issues were raised by interviewees either in relation to the scope of the MCP and / or the relationship between the CCG and Local Authority (given their roles as commissioners and 'system stewards'). One interviewee encapsulated the views of many by summarising these issues as being at:

"Both a positive and a frustrating place".

The positive elements of the issues raised related largely to the relationship between the CCG and Local Authority, which was seen as being especially strong at senior levels. Moreover, interviewees considered that the Authority is committed to the MCP model. As one interviewee noted:

"The senior leadership in the Local Authority in social care think this is the right model. This is driven by a number of factors – one of which is the devastating fiscal position they find themselves in. For them to do nothing really isn't an option".

Interviewees also cited broad, cross-party, political support for the MCP model.

It was therefore in the detail of the respective roles of the Authority and the CCG that interviewees described some frustration (and several interviewees provided explanations relating to the substantive fiscal challenges the Authority faces and consequent squeezes on its capacity to engage). Issues raised here included:

The Local Authority as a commissioner and provider of social care

Interviewees raising this topic considered that social care, while aligned to the MCP, was not sufficiently central to the model as it currently stood:

"We've been talking about an integrated health and social care organisation - how can the Local Authority be able to now say that social care isn't going to be in there [the MCP contract]?"

"They [the Authority] need to be clear about their role as a commissioner [of the MCP]. I don't think that their view on being a joint commissioner has changed, but they aren't fronting it in the same way as they have before…In terms of their provision, not having social care in fundamentally undermines what we're trying to do".

"It's got to be about co-commissioning [with the Local Authority]".

"I'm not sure they [the Authority] are up to speed...they have engaged with the process, but haven't fully understood it until now...and haven't fully worked out what their relationship with it [the MCP] will be".

And one interviewee summarised the implications of this in terms of the proposed phased approach to the development of the MCP:

"We're still working through how to procure the MCP, what the role of providers will be…the Local Authority's role in all that – it's had issues with children's services and seems to want to delay coming in. So there are issues and tensions that mean you might not get a full MCP model straight away…it's not going to be a big bang approach".

The point in relation to timing and MCP development is returned to later in this section.

Political control and governance

Reflecting on points made at the Partnership Board, a small number of interviewees noted the significant difficulties of balancing political accountability and oversight with the aim of having a single budget committed through a single long-term contract. These interviewees saw a need to address this through governance arrangements for the MCP:

"They would be contributing £65 million [in budget] that they might not control…But they are crucial partners and the prize here is the integration of health and social care".

"Ceding control over a set of services that they are accountable for is anathema to them [the Authority]. This needs reflecting in the governance for the MCP".

Related topics raised by interviewees included: the need for more detailed design work on the scope of the MCP; and development work to promote integration between what would become 'MCP services', but that are currently provided separately. These topics are also returned to later in this section.

The role of public health

It was not a significant theme in the interviews, but a small number of interviewees raised the prospect of the MCP – because of having a long contract period – being able to 'invest for the future' in a way that current contracts don't incentivise. On this, one interviewee raised the involvement of public health (services and colleagues):

"I worry about the lack of involvement of public health…a lot of the MCP is predicated on better self-help, better understanding of doing the right thing for your own health. And public health has a huge role to play in that…children's obesity in Dudley is the highest in the West Midlands…the best thing you could do to stop health inequalities is to tackle this. You won't get any rewards for ten years, but there's not enough tracking of the longer term in all this".

3.4 More needs to be done to prepare primary care for the MCP

Addressing the sustainability of primary care was part of the founding rationale for the MCP. Moreover, primary care (alongside social care – discussed above) is foundational to the MCP model as conceived nationally and locally. Yet many stakeholders raised the current position of primary care as a fundamental challenge in establishing an MCP in Dudley. As one interviewee noted:

"Primary care is not well developed to take this [MCP] forward. As a cornerstone [of the MCP model], it's one of the biggest problems we've got".

In essence, the issues raised on this topic were two-fold:

- That primary care as a collection of providers might not be ready for the demands of an MCP model; and, on a related point,

- That, to date, there has not been an obvious or formal means of engaging with primary care as a sector.

Interviewees outlined a series of explanations and concerns, covering leadership within the sector, the role of the CCG (seen as related in that many GP leaders were within the commissioning body), and the associated timescales. For example:

"I'm concerned that there's no GP vehicle. There are some GPs that have signed a collaboration letter, but – unlike Modality [another, local MCP] and some of the other MCP models – this is commissioner led".

"Primary care development is vital - without that we won't have an MCP in the truest sense...there's an apparent unwillingness of general practitioners outside the current CCG leadership to take up the mantle".

"There has not been a collective avenue for providers and GPs to sit down and thrash these things through. The CCG has done the work with the GPs and the providers – and it's kept us [other local providers] pretty separate".

A small number of interviewees reflected on recent developments. Here, the CCG has worked to get its member practices to sign-up to a memorandum of understanding on collective working (the 'collaboration letter' referred to above). It has also convened a primary care steering group to define and oversee a development programme – and to offer a route to engage with the sector. It was seen as 'early days' for this work:

"It's a real challenge. Future Proof[7] could have brought primary care together. That hasn't happened. We've now got a collaboration of over 30 practices who will work together…but I can't see how it can achieve the maturity required within the timescale we've got".

"Primary care in Dudley has got a long, long way to go before it's ready to play a leading role…we tried Future Proof, that didn't work…now we've got the primary care development steering group, which is in its fledgling stages".

Finally on the role of primary care, one interviewee floated – but did not develop - the idea that the CCG might play a more substantive role:

"There is an organisation in Dudley that has its finger on every primary care list, that has a certain maturity and a skill mix, and that's the CCG…now if there was some negotiation that accepted there wouldn't be a procurement related challenge…you could see how it could be a more effective and timely progression".

3.5 Significant change is likely to follow only after the MCP provider is appointed and established

Nationally, the NCM programme has been initiated, resources and support have been allocated to local sites and local work to implement the new models is underway. Given the prominence and intention of the NCM programme, there is then an expectation of significant changes following. This has implications for the way that the programme is overseen (see the box below); it also has implications for expectations of impact in local sites.

Several interviewees cautioned against expecting rapid change resulting from the procurement of the MCP. In their view, it would be around two to three years before significant service changes would be made:

[7] A local GP organisation formed for the purposes of large-scale contracting. Future Proof did not meet a series of tests of institutional fitness set by the CCG for taking responsibility / contracts for sector development; it has, for all practical purposes, lost its position as a collective vehicle for local GPs to collaborate.

"To talk about a year of implementing this is just nonsense. This is going to take years…it will need a lot of leadership, a lot of training…we already know that we don't have the workforce".

"However this [MCP contract] is awarded, then they [the provider] shouldn't change things straight away – to keep things safe…so initially it should be a steady state".

"If you consider the ambition of us having a provider ready by April 17 – initially I thought there was no chance. Now, having a provider in place, but not necessarily delivering new services straight away, is much more reasonable. It will then take a year to mobilise".

"Part of our response might be to have a development programme that lasts three to four years. So the first year would be bedding the model down…then we might look at which services would transfer out to GPs after that".

The added value of the NCM programme; problems with its oversight

NHSE established the NCM programme; it has funded and supported local sites, and has – primarily through an account management function – overseen progress. Several interviewees described a change in emphasis in this relationship: from a supportive / enabling approach to a more 'traditional' performance management approach. In the main, interviewees raising this point considered this to be a change for the worse:

"We've lost a bit of that [emphasis on experimentation] as the programme has gone on...it's now 'where are your savings?', so it's ended up where most NHS programmes start".

"It's turned into an inordinate requirement that is consuming what little capacity the CCG has! …I don't see the space that was promised…They're [NHSE] micro managing to within an inch of their life the one bit of the system that's coming up with innovations".

"NHS England are expecting us to demonstrate that each project [under the Value Proposition programme] is performing …to connect project activity to effects. It's really difficult to agree metrics, but then to isolate effects?"

Yet there were also interviewees who, while describing similar frustrations to those above, considered that there was significant added value from being part of the NCM programme:

"What the Vanguard has done is provide pace. It has become one of the main focuses of work for this organisation [CCG]...sometimes that might have brought tension - when we've gone more quickly than the system would want - but equally we've got this badge as a Vanguard and an expectation of delivering… We wouldn't be where we are now if we weren't part of the Vanguard programme".

3.5.1 Organisational and system development work is needed to ensure that – once established - the MCP realises its potential value

Several interviewees argued that a change in contracts and incentives by itself would be insufficient to achieve the potential of the MCP. Two interviewees noted that:

"You can't contract for change - you have to win hearts and minds".

"I don't have a problem with the [MCP] model. What I have a problem with is people's assumptions…it [the model] requires huge investment [in time] in getting people to work a different way and I think that is underestimated".

Interviewees making these points typically referred to different sectors' diverging cultures, ways of working, staff roles, regulatory frameworks, mechanisms for rationing, business and accounting models (etc). These distinctions were made between: primary care, secondary care, community services, social care and mental health. For example:

"How do you reconcile a model that is about ability to pay versus a universal model?"

"My experience of newer social workers is that…one assumes they have the same values as the NHS, but they don't. When the money goes, the money goes and they just stop…we [NHS] use waiting lists, the Local Authority turns off the tap".

"There's a fundamentally different culture between hospitals and community [services]…hospitals are quite hierarchical and it's about immediacy…[community services] are more interested in a longer-term relationship with people".

A small number of interviewees therefore explicitly cautioned against thinking that bringing different services / contracts / staff together 'under an MCP umbrella' would lead, automatically, to better and more integrated care. Instead, these interviewees considered that a deliberate programme of development was required.

On a related point, one interviewee also argued that they had not seen sufficient analysis of the likely workforce needs of the MCP. They thought that more needed to be done, especially on understanding the roles that might be played (for example) by volunteers and 'experts by experience'; they also saw opportunities to design new roles to eliminate duplication between (currently) different services.

And two final points were made in relation to this broader development work:

- That current work – funded under a CQUIN – to provide for consultant inputs to primary care services would make useful links between clinicians, as well as illustrating ways of working that would be important under the MCP; and
- That specific engagement work would also need to be done with the public to examine the implications of the new model of care in terms of routes of access and the increased emphasis on self-care. One interviewee noted that: *"We need to reflect on expectations and what the systems are doing to encourage the right behaviour…so there's a need to have that conversation [with the public] and to educate people – to promote mutualism and for them to see that this is going to be different".*

3.6 There are some early signs of outcomes resulting from work to date

Despite the early stage of development – and also despite the fact that interviews did not directly seek evidence on outcomes – interviewees were able to point to some early changes resulting from the Value Proposition programme to enable the shift to the MCP (rather than resulting from it).

These changes were cited as exemplifying the types of improvement that would be extended and amplified by the MCP:

"Across the piece, it's at an early stage. We need to build this [Value Proposition programme] to make that [MCP] happen. It's very much about enabling…rather than building enduring features of the MCP".

"We are seeing evidence of good thing happening. So some of the GPs didn't know what was on their front door – they would see problems and give drugs…now there's IP [Integrated Plus, the voluntary sector 'part' of the MDTs] they ask about what's causing problems…they can offer that social support".

As noted in the introductory section, specific evaluation of the MDTs is underway; these results will be examined as part of that. More broadly, the system-wide evaluation will also examine effects as the move towards the MCP progresses.

4 Lessons learnt from the process to date

As noted in the introductory section, Vanguard sites are an experiment. They are testing new models of care on the expectation that these new models will have a wider application. They are therefore a potential source of lessons which ought to have value: within the local site; within analogous (in this case, commissioner led MCP) sites; and perhaps also the NCM programme more generally.

In this context, interviewees were asked to reflect, in broad terms, on the main lessons that they have derived from their involvement in Dudley's NCM programme. The main lessons raised by interviewees were:

4.1 To continually communicate to engage people in the new model

Several interviewees reflected upon the reduction in ambiguity that has come about as the CCG (in particular) has become clearer and more concerted in its efforts to explain the MCP model. This point was made in the context of the idea for the MCP having been designed by (a small number of senior people within) the CCG:

"I think there's more clarity now - and perhaps we [CCG] expected people to get it [the MCP model] too quickly, because we've been living and breathing it - but not everyone has".

"You can't underestimate the work involved in trying to gain consensus - and how it is dependent upon personal relationships, and how they can flip".

4.1.1 To ensure that primary care is engaged and ready

On a related topic, and building upon points outlined in the previous section, several interviewees also drew lessons on the need to make sure that primary care is engaged and capable:

"The amount of time we've spent talking – and the amount of time we've spent at Partnership Board…at the end of the day this [the MCP] is about primary and community care and I don't think we've put enough time and effort into these providers. That's a building block that we need to base everything else on".

"GPs are all running small businesses – have they got a sense of what it takes to run a £270 million revenue business, with all that entails?"

"It's been a slow process in developing the primary care resource in terms of having a credible agency to bid for the MCP itself…but there are some promising signs now…they have to be on board or it rather undermines the model".

And one interviewee reflected upon the challenges of the CCG doing this in the context of having multiple programmes of work to bring about the MCP:

"The procurement exercise is fine - there are rules to follow there. The challenge is still the provider development work - we have a million [pounds] to support primary care and are working our way through it to get something going. But this is hard work...we need to run the procurement and the development plan at the same time - but you couldn't procure an MCP without developing the infrastructure".

4.2 To focus on getting the contract and procurement right

Many interviewees reflected upon the importance of the procurement process and lessons learnt in relation to this. For example:

"Be very clear early on as to whether we are in collaboration or competition…we originally came together because we wanted to solve problems collaboratively, but now we've moved into the NCM and it's very much CCG driven".

"The risk analysis should have been done earlier. We need to know what the consequences and ripple effects are…you can't mitigate a risk that you haven't identified".

There were also more specific reflections on the nature of the procurement task in terms of specifying and performance monitoring outcomes:

"We've got to get the right provider in and we've got to get the right things to monitor and measure them against".

"We're learning this on the job. It's an arena that we've not been in before...Vanguards were almost set up to do that - so we're doing what was expected in that sense".

Two interviewees in particular noted the very different (more open ended and collaborative) nature of the procurement process, relative to the more standard 'draw up a detailed service description and tender for it' approach. They wondered how the supply side of the market would react:

"The big issue for us now is knowing how we - commissioners and providers - behave as we go through the competitive dialogue process. The centre [NHSE] describes this as an inclusive conversation, with the CCG acting as an honest broker, which is different from the usual adversarial tendering process".

"This will be so new that I don't know how the providers will respond".

4.2.1 To consider conflicts of interest when a CCG commissions an MCP

A small number of interviewees raised lessons / points about conflicts of interest. They did so within the context of a commissioning body composed of GPs seeking to commission a service model based on primary care. In effect, the task of commissioning an MCP was seen as amplifying the more everyday conflicts of interest inherent in a CCG's work. Here, while not elaborating detailed proposals, they saw a need to step back and consider a new approach:

"We've been too hung up on conflicts of interest…we have to find a way of managing conflicts, but also enabling people to get in and take things on. Other areas of the country have taken a very different view".

"We're all conflicted and you need the skills of the people who are conflicted…if you want to get things going, you've got to break some people's rules – that's innovation".

4.2.2 To work closely with the provider post-procurement

As noted in section 2, many interviewees described the need to establish a programme of post-procurement development support. One interviewee described this as a way of mitigating a common risk of procurement (that provider incentives are to talk up likely success on the way in, before managing them down once appointed). Others reflected upon the fundamental importance of integrating teams and services:

"There's the complexity of bringing together different teams from different organisations…what you've got here is not just multi-disciplinary teams, but multi-organisational teams that you're trying to get into a single organisation. It will take years to get that aligned".

"Where you've got an organisation set up, it has its culture and people will assimilate to that. But what you're talking about in Dudley is an organisation that doesn't exist and has no culture…this is hugely complex".

And one interviewee in particular considered that leadership style was important to this task. They considered that leadership styles rewarded within the current NHS system would not be right within the context of the MCP:

"Our system is so used to doing what it is told - but we need a way of working that responds to population need, that doesn't 'look up' [to the centre]...most leaders in the system won't be used to that".

4.3 To use the NCM programme to add value to local efforts

While not exclusively the case, and notwithstanding previously noted points of tension arising from information requests and changing approaches to performance management, interviewees (and particularly those within the CCG) considered that the NCM programme had added value to local efforts to change the model of care in Dudley:

"Being part of the Vanguard programme - and working with NHS England...yes there have been tensions, but it's the best programme I've been in in terms of support and freedom...partly because they are writing the policy as we are delivering it".

"The fact that it came about from something we'd already started has been a big advantage…with the Vanguard programme, that just hugely accelerated the pace. Sometimes I think it's fantastic, other times I think 'do we really want to go first'?"

"We would be further ahead, but in a different way, if we weren't in the national process. We'd be further ahead on the model of care...but the national programme has helped because it's given licence to do something radically different".

Another extended this point to note that the experiences in Dudley would have value elsewhere:

"It's got to work for the people of Dudley, and also act as a beacon [nationally] to share that learning…so we're [the NHS] not into reinventing wheels".

While another interviewee considered that there remained scope for a greater alignment of nationally led regulation given Dudley's Vanguard:

"What is the assurance that we need to give and how aligned are the regulators that we are supposed to be giving that to? There really needs to be some form of coordination here…we're expected to be pushing the boundaries…there really doesn't seem to be acceptance of the primacy of the Vanguard".

4.3.1 To understand the level of programme and project management capacity required for implementation and assurance

While a small number of interviewees made this point in the context of a strength of the programme being 'that this isn't a programme' (but mainstream CCG business), many interviewees reflected that Dudley had underestimated the programme management capacity required to deliver the Vanguard:

"It's got better, but the initial programme management was underpowered and they could have done with more support".

One interviewee noted that this was also true at the project level:

"Very few people have come forward for additional resources for delivery at a project level…for us as an economy sending money back to NHS England [last financial year] is criminal".

While another interviewee placed this into a context of rules about CCG expenditure:

"To give us resource, but then hamper us within a management cost envelope that is the same for us as for other CCGs that aren't even taking on primary care commissioning. It's not sensible".

4.4 To see the MCP in the broader context of the Black Country STP

Finally, a small number of interviewees reflected upon the STP process and the framework provided for planning beyond the immediate local area. This might provide a route for assessing, learning from and adopting work led in Dudley. As one interviewee noted:

"Where does this fit in the STP? I can well see that ending up in a wider health authority model in a few years, so how does that fit together? …we might get stronger strategic thinking if that does happen, which would be helpful".

5 Reflections and recommendations

To the best of our knowledge, this is the first substantive evaluative output from the NCM programme. Two points follow:

- Dudley ought to be commended for its approach. Programmes as high profile and 'political' as the NCM programme are not often characterised by a desire to create and share learning, by taking an open and plain view of progress, and by doing so as events unfold. Yet Dudley has commissioned a transparent assessment of its work; it has done so in support of the NCM programme's intention to test, experiment and learn; it has further done so in an environment where the easier (and more usual) option would be the production of 'good news case studies'; and
- The timing of this report means that there is an opportunity for the evaluation to provide a broader than would be usual set of considerations and recommendations, since this early / high level feedback might also be of use to the efforts of the NCM programme and MCPs more generally.

Given these factors, this final section is slightly more discursive than a classic 'conclusions and recommendations' section. It builds upon the evidence presented in previous sections and reflects upon implications arising; it also draws on insights from the Strategy Unit's wider work.

The recommendations at this early stage are to:

1: Focus on primary care

This is a recommendation to the CCG.

In the animating set of arguments for establishing an MCP in Dudley 'the sustainability of primary care' features highly. Put more positively, the MCP offers an opportunity for an enhanced and improved set of services in the community, with the GP-patient relationship at the heart of it.

Yet locally primary care does not appear to have kept pace with developments. The reasons for this will be many and will reflect varying levels of engagement and understanding, alongside differing institutional and individual incentives (etc). But whatever the explanations, the fundamental point is that the MCP needs strong primary care involvement.

This phase of the evaluation is limited by knowledge of the detailed considerations involved (having focused solely on strategic perspectives); notwithstanding this, the recommendation is that work needs to be done to address:

- *Leadership*. Local GP leadership has, to date, been primarily concentrated within the CCG. With an MCP in place, the requirement for clinical insights in commissioning will reduce, while the demand for clinical leadership within the MCP will increase. The CCG should encourage its clinical leaders to consider how they can add the most value during this transitionary period: it may be that moving outside the CCG is the best means of doing so; and,
- *The demand for support in practices*. There are resources in place to support primary care development. These resources have been committed to a multi-component programme, backed by a primary care steering group and General Practice champions: the supply of support to primary care is largely in place or is being developed. The missing component is well articulated demand for support. Accepting that this is far from easy (given the multiple actors involved), the CCG should continue to engage with its members to emphasise the benefits of

engaging in a development programme specifically and the MCP more generally. It is not clear how widely understood these benefits are at present.

2: Define, and plan to mitigate, system risks

This is a recommendation to the CCG.

As would be expected in a programme of large scale system change, the move to establish an MCP has created tensions and raised potential risks for different providers / parts of the local system. Some of these risks look significant. They must therefore be clearly defined (nature, likelihood, implications, etc) and ordered by the CCG. Some risks will properly remain the preserve of individual providers; yet others would properly be understood as risks to the system, given interdependencies and so potential ripple effects.

Such system risks should be mitigated on a system-wide basis. They will require dispassionate assessment in an environment where such assessment will be difficult and dispassion in short supply. Advice from regulators and the support of independent agencies (with clinical knowledge where risks have clinical content) may therefore be required to support the CCG with this assessment.

Finally in considering system risks, one additional factor is the boundaries of the 'system' under consideration. Here, links into the wider Black Country STP process may be helpful in providing a framework for discussing the likely future shape of provision and providers. System risks identified by the CCG should therefore be taken to the STP for potential sources of mitigation.

3: Design a post-procurement development programme based on 'MCP theory'

This is a recommendation to the CCG and Local Authority, supported by the Partnership Board.

Procurement exercises and related structural debates can be complicated and time consuming. They can also distract from more fundamental questions.

The procurement exercise underway in Dudley is large-scale, high-profile and challenging; the result will be a new institutional form holding a new contract; constituent providers may / may not be 'new to the patch' (etc). Each of these factors – and the many others that follow or that could be listed – tends towards a focus on the practicalities of *doing* the MCP.

On one level, this is surely right, but this focus on doing needs to be guided by clear thinking on *why* the MCP was seen as needed and, more particularly, *how* it is expected to bring positive change about.

Moreover, it is clear that – however well designed the procurement process - a change in contractual form will not bring about the promises of the MCP model. Nor will aggregating services within a single institutional framework. Nor is there a weight of good evidence supporting the core propositions of MCP theory.

What follows the procurement exercise is therefore of fundamental importance. The points above can be combined to inform the design of a programme of post-procurement system and provider development by:

- Delineating and supporting a set of arguments (or mechanisms) as to *how* the MCP contract ought to lead to desired outcomes. Many of these mechanisms are set out in this report (section 2.2) and the Strategy Unit is undertaking broader work (funded through NIHR) on MCPs that may also help. Mechanisms may relate to (for example) reduced duplication of services, integration of

frontline teams and better clinical communication, more proactive care, improved resource allocation, better use of performance data by frontline teams, (etc); then,

- Using these factors to design a programme of support, so that this work is clearly informed and focused by the thinking underpinning the MCP model. So, for example, if 'improved resource allocation' is seen as a core mechanism, then the MCP needs to be able to use economic frameworks to inform decision making, to have data showing resource use between different services (etc). This would then form part of the development programme; and
- (Again accepting that the evaluation lacks detailed knowledge on the rules involved) ensuring that positive engagement with such a development programme is 'required' as part of the procurement process.

The above asks questions of the programme's core theory of change: to what extent is change expected to result primarily from the contracting and procurement exercise - or from allied efforts in relation to organisational and system development?

Finally on this point, the reason for recommending this as joint work between the CCG and Local Authority is two-fold in that it would:

- Support joint work between the two commissioning bodies in the system, furthering the oversight of the MCP provider (see Recommendation 6 below); and
- Provide an opportunity to do further detailed design work on how health and social care services might come together post-procurement (a vital part of the MCP model / theory).

4: Re-confirm the function of the Partnership Board

This is a recommendation to the Partnership Board.

The Partnership Board is not currently adding the value that it could, given the seniority of representation on it. Notwithstanding some of the tensions that follow from different organisational perspectives on the MCP, the main explanation seems to be ambiguity the Board's function following the decision to procure the MCP.

Within this, the main point of distinction seems to be whether the Board is:

- Strategic, with a primary remit around the move to the new care model, with all the cross-institutional requirements and need for breadth of perspective inherent in that; or
- Operational, with a focus upon governance, oversight and steering of the Value Proposition programme to support the bringing about of the MCP.

The suggestion from the evaluation would be to focus on strategic issues. The CCG is in any case the accountable body for the Value Proposition programme and updates could be taken to the Board for information / as problems require unblocking. But it should be for the Partnership Board to collectively discuss and re-confirm its function.

5: Stress-test the MCP contract

This is a recommendation to the CCG, the Local Authority, NHSE and NHS Improvement (NHSI).

There is debate within Dudley as to how far the detail of the MCP contract ought to be defined by the commissioner and how far it ought to be 'left open' for the provider

to do things differently (given a set of outcomes). There are legitimate arguments both ways (e.g. the space created for a provider could equally be used to innovate or exploit) and the final result will be a point of judgement.

The proposed MCP contract could usefully therefore be stress-tested. The value of this would be to raise risks and opportunities such that the contract itself can be improved – and that ongoing management oversight of it can be designed in the light of insights generated.

At local level, this work is underway. The contract will be reviewed as part of the competitive dialogue / procurement process; it will also be scrutinised through a joint (NHSE and NHSI) assurance process. Areas for improvement will be raised; Dudley's MCP contract can be iterated and improved; and the judgement noted above can be informed.

But, given that the MCP contract is simultaneously being developed in Dudley and nationally, it would also make sense for some stress-testing to take place nationally (in partnership with local MCP sites).

Different angles could be taken, e.g. to expose opportunities for gaming; to highlight the major trade-offs between outcomes specified in the contract; to test core assumptions about the flexibility for providers to invest / disinvest between services and between years. A range of methods could also therefore be used (e.g. scenario planning, 'gaming' workshops with participants 'playing' providers and commissioners, reviews of empirical evidence on analogous contracts, etc).

One related element which could be explored here is the question of local political accountability: of how governance / rules can be constructed to retain this link back to local politicians and local citizens.

6: Describe the planned changes in commissioning function

This is a recommendation to the CCG and Local Authority.

Once the MCP is established, the CCG will have a substantive change in function. Fundamentally, it will have less day-to-day involvement in contract monitoring and will have a broader and more strategic role. The resulting CCG will also partly have oversight of social care services aligned to (eventually joining) the MCP, currently commissioned and, in part, provided by the Local Authority.

Accepting that substantive uncertainties remain, it should nonetheless be possible to trace the logic of these developments forward such that a joint commissioning function can be described with reasonable precision.

Doing so would help to clarify likely relationships in the system between the main commissioners and providers. It would identify areas of potential saving in commissioning functions and may also give staff a greater measure of certainty as to what the future might look like. In practical terms, this work could be developed as a sub-set of Recommendation 3 above.

7: Refine the approach to overseeing the NCM programme

This is a recommendation to NHSE.

NHSE may, in some respects, be frustrated by the contents of this report. The NCM programme has high expectations and commensurately high-level support. These factors, allied to a programme design which has an in-built expectation of (and so requirement, and now target, for) success and widespread roll-out, creates demand for 'good news stories' and 'quick wins'.

This report will not satisfy this demand. Instead it documents the hard technical and social work that has gone into Dudley's programme, estimating that substantive 'MCP effects' will be seen in around three to five years. (NB: this is not to say that no improvements would be expected in the interim – notably, there will be effects from the Value Proposition programme - but it is to say that no empirically-based assessment can be made of the MCP model itself).

While accepting that Dudley is obviously not representative of the NCM programme as a whole - nor even of MCPs as a whole - it clearly says something of relevance for commissioners wanting to institute an MCP.

On this count, the experience is salutary: getting .where they have got to has required extraordinary efforts from a CCG recently rated as 'outstanding' by NHSE (and which had already begun the development of its new model of care).

This experience should be enough to prevent the view that an MCP can be established solely (or even primarily) via the contractual levers of description and procurement. It should further, as a corollary of this, make others reflect on the likely skills, abilities and timescales needed to commission an MCP.

With this in mind, NHSE should reflect upon:

- *The expectations it creates for the NCM programme and any 'endorsements' that follow for specific care models*. Accepting that some Vanguards are not taking a commissioning-led approach, there is a need for a mature assessment – by care model type - as to when substantive effects might be expected from local sites; and
- *Its approach to performance managing local sites*. Plainly, performance management is needed; the question is not whether, but what. In considering this question, it is useful to start from the original logic to the NCM programme, which, in broad terms, set out to achieve two main types of benefit:
  - Those arising directly from the new models being tested; and
  - Knowledge generated on these models to help analogous efforts elsewhere.

This admittedly rough typology is nonetheless useful since it adds the question 'what have you learnt?' to the traditional performance management questions of 'what have you done?' / 'what has resulted?' Answers to this question – which could be synthesised and publicised by NHSE - would further help to refine thinking on MCPs, which can then be used to guide their adoption elsewhere.

ANNEXES

Annex 1 Stakeholders consulted

The Strategy Unit would like to extend thanks to the following people for giving their time to participate in interviews:

- Andy Gray, Chief Officer, Dudley Council for Voluntary Service
- Chris Handy, Lay Member for Quality, NHS Dudley Clinical Commissioning Group and Chair of the Partnership Board
- David Hegarty, Chair, NHS Dudley Clinical Commissioning Group
- Jayne Emery, Chief Officer, Healthwatch Dudley
- Karen Downman, Chief Executive Officer, Black Country Partnership NHS Foundation Trust
- Laura Broster, Head of Communications, NHS Dudley Clinical Commissioning Group
- Mark Axcell, Chief Executive, Dudley and Walsall Mental Health Partnership NHS Trust
- Matt Bowsher, Assistant Director of Adult Social Services, Dudley Metropolitan Borough Council
- Matt Hartland, Chief Finance Officer, NHS Dudley Clinical Commissioning Group
- Neill Bucktin, Head of Commissioning, NHS Dudley Clinical Commissioning Group
- Paul Johnston, Dudley NCM Programme Manager, Head of Programme office
- Paul Maubach, Chief Executive Officer, NHS Dudley Clinical Commissioning Group
- Paula Clark, Chief Executive, Dudley Group NHS Foundation Trust
- Stephanie Cartwright, Director of Organisational Development and Human Resources, NHS Dudley Clinical Commissioning Group
- Timothy Horsburgh, Clinical Lead for Primary Care, NHS Dudley Clinical Commissioning Group
- Tony Oakman, Strategic Director People Services, Dudley Metropolitan Borough Council

Annex 2 Topic guide used in interviews

A: Interviewee background

1. Please describe your role and your involvement with the programme

B: Problem definition / rationale for intervention

2. Please describe the problem(s) that the programme has been established to address. What do you think would happen to this problem(s) in the absence of the programme?

C: Programme design / expected results

3. Why was an MCP model selected as a response to the problem(s) we've just discussed?
4. What are your views on the main activities within the programme to bring the MCP about?
5. To what extent, and in what ways, do you think the programme is well set up for delivery?
6. At the end of the programme period, what outcomes do you expect to have been achieved?

D: Implementation

7. What are your views on implementation to date? Are any programme components going especially well / badly and *why*?
8. What are your views on relationships within the system?
9. Are there any factors external to the programme (e.g. in the policy / funding / regulatory environment) that are especially helping or hindering the process of implementation?

E: Lessons learnt and recommendations

10. What lessons do you draw from the programme so far?
11. What changes, if any, would you like to see made in order to improve the programme?

Annex 3 Bibliography

Economist/Ipsos MORI Issues Index (June 2016). https://www.ipsos-mori.com/researchpublications/researcharchive/3748/Concern-about-immigration-rises-as-EU-vote-approaches.aspx [accessed July 7th]

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