The Strategy Unit.

Evaluation of the Dudley New Care Models Programme

Strategic Level Evaluation

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One-page summary of the report

In October 2014, the 'Five Year Forward View' set out the challenges facing the health and social care system. It also defined a series of new care models. To develop and implement these new models, NHS England established the 'New Care Models' programme, which was delivered through 50 local sites. Dudley was selected as one of these sites. It set out to test the 'Multispecialty community provider (MCP) model, which was designed to provide more services in local communities and primary care settings, reducing the need for hospital-based care.

This report is (one of several) from the evaluation of Dudley's efforts. It draws on interviews with 21 local strategic stakeholders, which were conducted between September and November 2017.

The report found that Dudley has pursued a twin-track approach, in that it has:

1: Established, primarily using national programme funding, specific services and innovations to bring about an MCP culture and new ways of working.

In very broad terms, this element of Dudley's work has gone well. Successful innovations – notably the increased role of the voluntary sector (in MDTs) and extended use of pharmacy – will provide a foundation for the MCP's model of care. The task now is to establish greater consistency of operation. Specific services and innovations were also backed with wider engagement work to build the partnerships, shared understanding and local culture seen as necessary to change ways of working. The main result here was a spread in understanding of what the new model of care might be, how it might operate and how this might feel different for those working in / using services.

2: Initiated a procurement process to commission an MCP. The end point for this would be a new organisation (the MCP) holding a new contract.

The scale of contract on offer meant that a large-scale procurement was seen as necessary. Nonetheless, the value of this exercise has not been clear. In some respects, it has tended away from integrated working: the disciplines required have limited interactions within the system; and efforts have been focused on contractual / legal matters, rather than organisational / system development. The outcome remains uncertain and the process has created short-term separations within a system which previously was working as one partnership.

The evaluation therefore has the following headline recommendations:

Local Commissioners

Take a 'hands-on' / developmental approach to the MCP partnership - and continue to support local cross-system working

MCP Partnership

Invests time in its own development – and gives more detailed attention to service improvement opportunities presented by the new contract

NHS England

Advocates large-scale procurement as a last resort, not a default approach - and learns from the NCM programme's experience and model of change

Executive summary

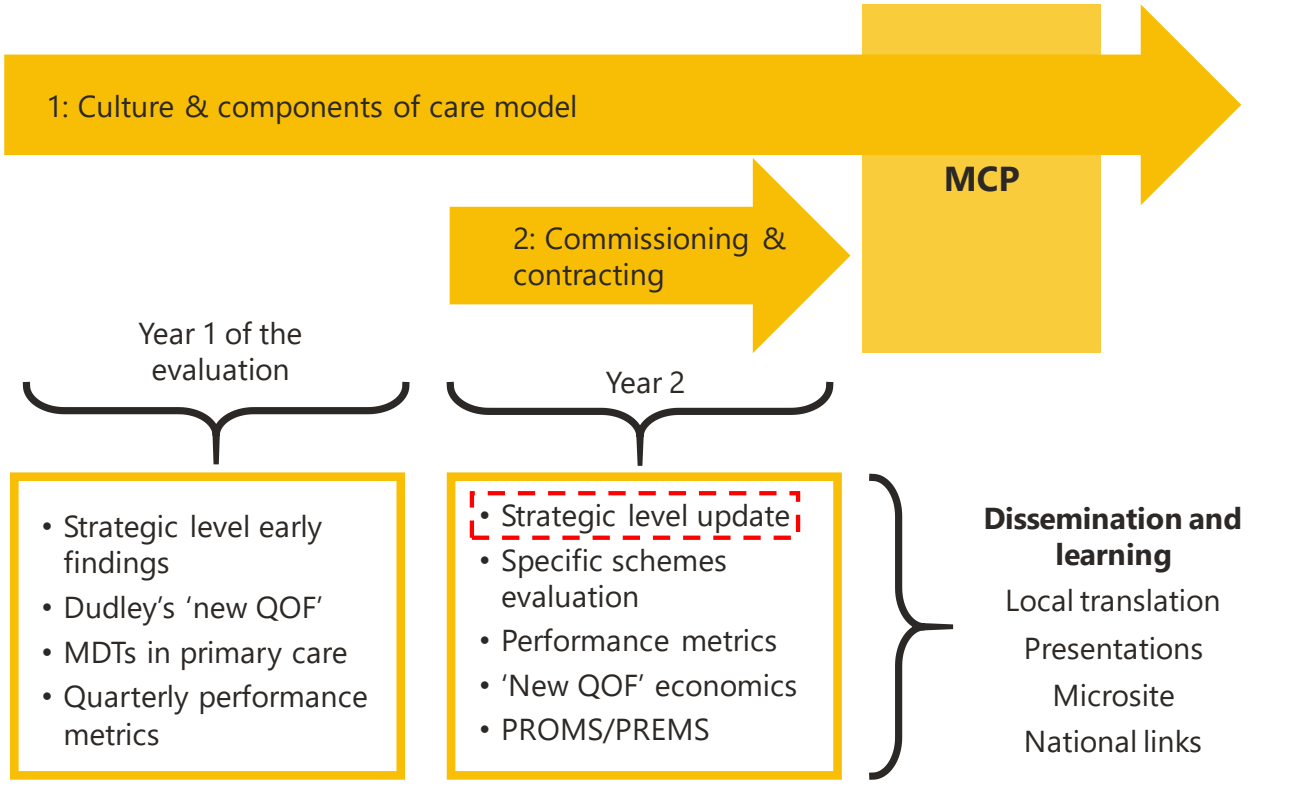
In October 2014, NHS England published the 'Five Year Forward View'. It set out challenges facing the health and social care system, making a case for change. It also set out a series of high-level responses, prime among was a series of new care models. The New Care Models (NCM) programme was then established in early 2015 to implement the models in practice. Delivery of the NCM programme was through 50 local 'Vanguard' sites

Dudley Clinical Commissioning Group (CCG), in collaboration with local partners, led a successful bid to become a Vanguard site. The model of care selected for Dudley's Vanguard was the Multi-speciality Community Provider (MCP). Fundamentally, the MCP model aims to strengthen primary and community-based care in order to shift the locus of support away from hospital and closer to people's homes.

In broad terms – and as the Figure below shows - Dudley has pursued a twin-track approach. It has:

1. Established, primarily using national programme funding, specific services and supporting infrastructure to bring about an MCP culture and 'ways of working'; and,
2. Initiated a procurement process to commission an MCP. The end point for this process would be a new organisation (the MCP) holding a new contract.

The Strategy Unit, working with partners ICF and the Health Services Management Centre, was appointed as the evaluation partner to Dudley Vanguard. As the Figure below also shows, the evaluation ran over two years and operated at multiple levels. Reports were housed on a microsite.



This is a summary of the 'Strategic level update' report shown in the dotted 'Year 2' box above. It was produced by the Strategy Unit and takes a broad perspective, focusing upon the overall system level and drawing on semi-structured interviews with 21 local strategic stakeholders conducted between September and November 2017.

The main **conclusions** in the report are that:

- Resources associated with Dudley's Vanguard programme have been used to augment, expand and accelerate the CCG's efforts to bring about a new model of care. Programme funding has been used to introduce innovations and services that exemplify this new model and pave the way for the MCP. These efforts have produced some positive results: notably around the increased role of the voluntary sector (in MDTs) and pharmacy. There have also been less successful efforts: work to develop interoperable IT systems has not progressed as planned and the telehealth scheme did not achieve desired results. Future developments mainly centre upon the need for greater operational consistency.
- Wider, less tangible, changes have also been brought about through broader engagement and mechanisms associated with the Vanguard programme. This work has helped broaden the local conception of care to further include 'social' interventions and a more general encompassing of mental health and wellbeing. There have also been engagement efforts with staff, patients and the public. There is no sense of this work being complete. But, in the main, these efforts have also helped prepare the ground for the MCP by establishing shared frames of reference.
- There has been a significant focus on primary care: especially in supporting primary care providers to enter the procurement process. In general, this has been a success. Work here also remains on-going: both to establish (contractual) relationships between GP practices and the nascent MCP; and in working through primary care representation in the MCP as an organisation.
- The scale and scope of contract on offer meant that a large-scale procurement was seen as the only viable option: and a necessity in order to comply with procurement regulations. Nonetheless, the value of this exercise is not yet clear. In some respects it has tended away from integration. The most immediate effect was felt in the CCG, which had to create a specific procurement team and divide this from its other functions. This raised significant practical and managerial challenges; and the disciplines of procurement led to a high opportunity (as well as direct) cost as the CCG was less able to lead system development (it had, to that point, led work to develop the MCP).
- The procurement was intended to achieve several long-term benefits, e.g.: establishing the MCP as an organisation rather than simply as a care model; the creation of long-term outcome improvement objectives; the alignment of incentives to support the objectives of the clinical model). Yet, at the time of writing, the realisation of those benefits is still to be proven, while

the procurement itself has proven a complex process which has necessarily created short-term separations within a system which previously was working as one partnership.

- There is a need for national bodies to focus on learning for replication. Dudley has acted as a rich source of insight which can be shared; many of the lessons are relevant to large-scale change *per se* – as well as the specific requirements of establishing models of accountable / integrated care.

The main **recommendations** that follow are:

For Dudley's commissioners to:

- *Consider a more co-productive approach to dialogue and MCP development*. The CCG has a significant stake in the MCP – not least in that many of its functions will transfer to it. As lead commissioner, the CCG has been the source of much of the thinking, expertise and resource behind the MCP. These factors suggest that it would be appropriate for the commissioner organisations to take a collaborative and co-productive approach to the dialogue process.
- *Maintain the Partnership Board in its role overseeing the system*. The local Partnership Board faces a change in remit from oversight (of the programme) to learning and system development. Its membership, terms of reference and operation should be reviewed accordingly.

For the MCP partnership to:

- *Invest time in partnership development*. The MCP partnership would benefit from specific developmental activities to surface and work through issues affecting its functioning. Outputs from this work might then guide organisational development.
- *Develop a detailed sense of demand and the opportunities provided by service integration*. This should include analysis of the population's current and likely future needs, mapping of current service use, followed by an evidence-based assessment of how – given that the MCP will integrate these services – current provision can be made more efficient to improve resource use, care and outcomes.
- *Put in place a further programme of service development around Dudley's Multi-Disciplinary Teams*. These teams have been established and operated for some time now; yet there is significant variation in their operation. They would therefore benefit from further, focused development work with the aim of codifying and optimising their structure and operation.
- *Make more of pharmacy*. Work with pharmacy colleagues to see whether there is further scope for extending the role of pharmacy within the MCP model.

- *Ensure that social care is not lost*. 'Better integration with social care' was one of the founding arguments for the MCP. The MCP needs to develop a clearer view on this, perhaps starting by using locality-based working as a framework.
- *Develop an operational model for multi-disciplinary locality-based working*. The MCP model has the multi-disciplinary management of populations of 30,000 – 50,000 people at its heart; yet these are not yet functional in Dudley. Developing these localities should include consideration of innovation and information needs to support service improvement.
- *Develop a framework for service innovation*. This should include: showing how vital innovation is; citing expected culture for and sources of it; delineating the disciplines of it; and setting rules around it (e.g. when to stop and when to scale pilots).

For NHSE / national bodies to:

- *Promote alternatives to procurement in establishing new models of care*. The evidence presented here points towards using procurement as a 'last resort' approach. Certainly the costs in time and resources, allied to the current highly constrained financial context of the NHS, mean that it should not be seen as a default or first response.
- *Learn from Dudley's approach on the role of primary care if procuring an MCP*. It may be that there is a means of combining significant input into the selection process, recognising that primary care will certainly feature as a provider in an MCP. Having primary care on 'the commissioner side' might be the most pragmatic solution.
- *Be very cautious in using the example of Dudley in considering replication*. Relative to many areas, Dudley is a non-stressed system; the CCG and other elements of the system are recognised as high-performing; and Dudley's efforts have been fuelled by additional resources – not all of which could be accounted for as 'R&D' that others would not need. What has been done in Dudley could not easily be 'lifted and shifted' elsewhere. Yet many elements could be replicated and Dudley has played an active role in sharing at national level and in other areas.
- *Learn from the model of change used in the NCM programme*. In effect, the NCM approach was: establish – codify – test - replicate / don't; this was backed by evaluation and learning at local and national levels. This is a modest and subtle approach relative to 'national definition: local delivery', which is a more usual model of change. With refinement – and noting the point about developing balanced approaches to measuring system change - it could usefully be adopted for other large-scale change programmes.

1. Introduction

This section sets the scene for the rest of the report. It briefly summarises the national context before introducing Dudley's programme, its evaluation and this report.

1.1 National context: the Five Year Forward View and the New Care Models programme

In October 2014, NHS England (NHSE) and partner agencies published the 'Five Year Forward View' (FYFV). This described challenges facing the health and social care system, making a case for change. It also set out responses to these challenges, defining a strategic direction for the system.

Prime among these responses was a series of new care models. The FYFV described these new models at a very high level of abstraction. The New Care Models (NCM) programme was then established in early 2015 to develop these descriptions and implement the models in practice.

Delivery of the NCM programme was primarily intended to be through 50 local 'Vanguard' sites, supported by national funding and national programme infrastructure. A central function of this infrastructure was to help further define each model (based on local experience) and to support their replication (e.g. through the development of new contractual forms and detailed 'blueprint' descriptions of each model).

Vanguards were therefore set up to elaborate, implement and test the new models of care sketched out in the FYFV; the rest of the NHS, aided by the NCM infrastructure, would then observe, learn from and adopt effective models or their component parts.

In the period since the FYFV was published, NHS performance has worsened. In March 2017, NHSE published 'Next Steps on the NHS Five Year Forward View'. It updated many of the challenges set out in the original FYFV; it also – albeit with significant caveats on the data used – noted tentative impacts from the NCM programme in terms of lower growth in emergency hospital admissions and emergency inpatient bed days in Vanguard sites (MCPs and their main alternative: 'Primary and Acute Care systems') the rest of England.

1.2 Local context: the Dudley Vanguard and its evaluation

Dudley Clinical Commissioning Group (CCG), in collaboration with local partners, led a successful bid to become a Vanguard site. The model of care selected for Dudley's Vanguard was the Multi-speciality Community Provider (MCP). Fundamentally, the MCP model aims to strengthen primary and community based care in order to shift the locus of support away from hospital and closer to people's homes.

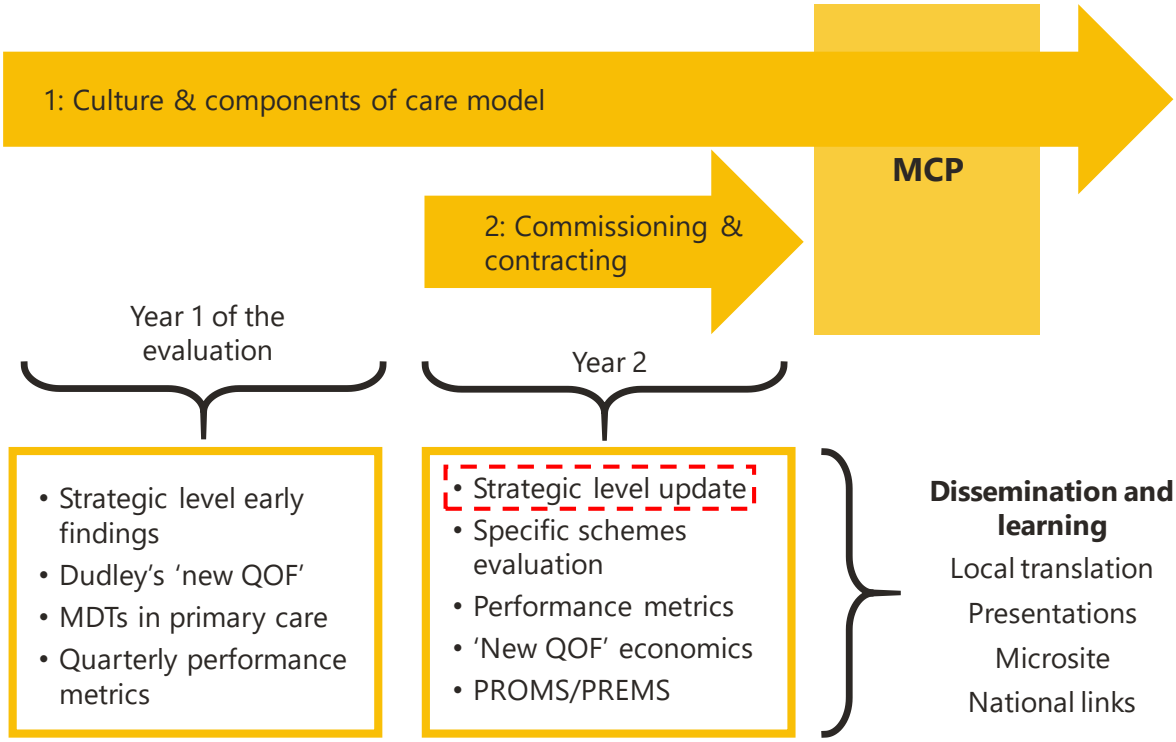
In broad terms, Dudley has pursued a twin-track approach in that it has:

1. Established, primarily using national programme funding, specific services and supporting infrastructure to bring about an MCP culture and 'ways of working'; and,
2. Initiated a procurement process to commission an MCP. The end point for this process would be a new organisation (the MCP) holding a new contract.

The Strategy Unit, working with ICF and the Health Services Management Centre, was appointed as the evaluation partner to Dudley Vanguard. The approach to the evaluation is detailed in the 'Strategic Level Early Findings' report (September 2016)[1]. But in summary – as the Figure below shows - the evaluation:

- Traces the development of Dudley's programme over time – covering both of the 'twin tracks' noted above (shown as the two arrows in the Figure);
- Operates at multiple levels of Dudley's programme – covering the overall system / strategic level and specific services and schemes within the programme; and,
- Is learning-oriented and formative – producing and disseminating multiple outputs to support local decision making and national learning.

Figure 1.1: Dudley's evaluation is designed to maximise insight and learning



[1] This, and all major outputs from the evaluation, can be found on a microsite: www.strategyunitwm.nhs.uk/dudley-mcp

In the interests of transparency, it should be noted that the Strategy Unit has also provided support to Dudley in addition to this evaluation: and that some of this support touches on areas covered here. Most notably, we supported the Primary Care Collaborative in selecting a partner to enter the procurement (see section 3). This role was limited to helping structure the process, providing background research and supplying specialist advisors.

1.2.1 This report

This report is the 'Strategic level update' shown in the dotted 'Year 2' box above. It takes a broad perspective, focusing upon the overall system level of Dudley's programme.

Note on timing

Research for this report was undertaken in Autumn 2017. The draft report was submitted in December, but the final version was not released until July 2018. This delayed release was because of the sensitive stage of the procurement process (see Section 3 for context) and the concern that information contained in the report might present a risk to that process. Agreement was therefore reached to delay publication until the procurement reached a less sensitive point.

The main implication of this, as far as the information contained in the report is concerned, is that views on the state of the procurement and local bidding parties are historic. The main messages and lessons – especially those for national policy - still hold.

The report draws on semi-structured interviews with 21 local strategic stakeholders (listed at Annex 1). Interviews were conducted between September and November 2017 by telephone (12) and face-to-face (9) using the topic guide contained in Annex 2 and on the basis that no views or direct quotations would be attributed to any individuals. Interviews were recorded, transcribed and analysed thematically using NVivo 11 and a coding framework derived from Strategy Unit work (funded by NIHR) to synthesise the evidence for the MCP model[2], modified to reflect local data.

The main strength of the data gathered is that it provides an account of the local leadership community's perspectives on a broad sweep of topics. The main weaknesses are a corollary of that: there is no sense as to how widely held (or indeed, factually correct) these views are.

[2] Turner A, Mulla A, Booth A, Aldridge S, Stevens S, Battye F, Spilsbury P. *An evidence synthesis of the international knowledge base for new care models to inform and mobilise knowledge for multispecialty community providers (MCPs)*. Systematic Reviews. 2016 Oct 1; 5(1):167.

Throughout, the report makes extensive use of verbatim quotes, allowing interviewees to 'speak for themselves' within the thematic framework used. The report is also structured using that framework and results are presented in the following sections:

- Section 2 presents interviewees' views on changes made to introduce the 'MCP care model' to Dudley. (In effect, this covers the 'culture and components of the care model' arrow in Figure 1.1);
- Section 3 considers the procurement process used to commission the MCP (covering the 'commissioning and contracting' arrow of the Figure);
- Section 4 outlines interviewees' lessons learnt; and,
- Section 5 provides a set of conclusions and recommendations arising.

1.3 The evolution of findings over time

In many ways – not least because many of the same stakeholders were interviewed - this report is an update to the Strategic Level Early Findings report referred to above. To provide further context for the material presented here the main findings are summarised briefly in the box below:

Headline findings from the 2016 Early Findings Report

On the case for change, the evaluation found that:

- There was a widely shared understanding of problems in the local system.
- Accepting some reservation and disagreement, the MCP model was 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.

On implementation:

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

Resulting recommendations were 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 its approach to overseeing the NCM programme.

The evolution of views presented in this report can therefore be traced against those in the box above. Yet it would be a mistake to consider what follows as definitive final account: Dudley's MCP is at a particular point in its development and work is still very much on-going.

Interviews were undertaken at a point in time where Dudley's system had:

- Established several new services as component parts of an MCP care model. These components had recently been subject to evaluation (see microsite) and were being considered for adoption / non-adoption within the MCP. This element of the work was therefore reasonably mature; and,
- Progressed a procurement process to the point where the prospective providers of the MCP had come together and commenced dialogue with the CCG commissioner. This element of the work was therefore early and on-going.

What follows should be read with this in mind.

2. Changes in the delivery of care

This section sets out interviewees' views on changes to the provision of care in Dudley. In the main, although not exclusively, these views relate to changes brought about using funding provided – through the 'value proposition' (VP) process – by NHSE as part of the NCM programme. Readers wanting further detail or specific evaluation of many of the schemes referred to will find it on the evaluation microsite here.

The section begins with interviewees' views on some of the particular services and innovations put in place as part of the Vanguard programme. It then moves on to describe broader – and slightly less tangible – outcomes. The section concludes with interviewees' views about the future of the changes made within the context of the forthcoming MCP.

Section summary:

- Changes have been made to exemplify the 'MCP model of care' and prepare the ground for the MCP itself.
- There have also been broader cultural and strategic changes helpful to the MCP.
- 'Greater consistency' is the next step for many of the changes made; the MCP is seen as a means of achieving this.

2.1 Changes have been made to exemplify the 'MCP model of care' and prepare the ground for the MCP itself

This sub-section considers implementation of the services and schemes initiated as part of Dudley's Vanguard programme. As noted above, most were funded using additional resources following the VP process; yet several were initiated prior to the Vanguard and/or resulted from changes in the CCG's 'mainstream' commissioning.

VP funding was used to establish new, or enhance existing, ways of working on the expectation that – if successful (and once the MCP as an organisation was established) – they would become component parts of the MCP's model of care.

2.1.1 The multi-disciplinary teams (MDTs) in primary care – and the 'Integrated Plus' component especially - were the most frequently cited change to care

When asked about the main changes to care in Dudley most interviewees cited the MDTs. This was partly because they are a very tangible and comparatively well-established service; it was also because MDTs were seen as exemplifying an 'MCP way of working' by bringing together staff from different backgrounds and currently separate organisations and services to tailor support to individual patients:

"If I were put on the spot and asked what we've done in Dudley, then clearly the MDTs would be the first thing…they are probably the most tangible new element of the new care model."

Interviewees also then frequently singled out the 'Integrated Plus' element of the MDTs (where MDT patients are linked into voluntary sector / community based opportunities) as being particularly positive:

"I totally recognise the value of Integrated Plus and looking at people holistically, linking in with the voluntary sector. It's not all clinical medical interventions that people need. People need different services so it's giving clinicians and professionals a different outlook on people that they may not have come across before."

"[Integrated Plus] looks at the needs of the individual and the reasons they're going round the system [e.g.]…not having enough money, not having food, having problems at home, having family problems, having problems with their children…The idea is to help their social connectedness - to engage them to be part of their communities."

"Increased use of the social and voluntary sector is actually improving outcomes for patients…it's improved their quality of life and means they're much more connected actually at home."

Finally, a small number of interviewees also noted that the MDTs were evolving to improve their operation and also to extend their remit:

"I've been particularly pleased really around things like the Care Coordinators, helping the evolution of the MDTs to include picking up on emergency admissions and tracking those… We're seeing some positive iterations of the care model."

"Sometimes a mental health condition can be made worse by other factors… the way that that whole MDT process is working now I think is making big inroads in that."

Several interviewees then noted a need for greater operational consistency; this is discussed at the end of this section.

2.1.2 Pharmacy has played an expanding and valuable role

VP funding was used to extend the role of pharmacy in the care model. Two specific schemes - Practice Based Pharmacists and the Prescription Ordering Direct (POD) Contact Centre – were established / enhanced using this money.

Expanding the role of pharmacy was widely noted by interviewees as having been successful in terms of increasing efficiency and therefore offering potentially wider system benefits:

"When a patient needs a repeat prescription, rather than going to the practice or to the community pharmacy, they ring the POD and the POD checks through their medicines and

ensures that it's still appropriate for them to have a repeat prescription. As a result of that, they've been able to reduce the number of items that have been prescribed."

"We've been testing out the POD in pharmacy and that's producing some remarkable results in terms of producing repeat prescriptions. So, again, the only issue really there now it seems to me is how do we scale it up, so we can make it systematic across the whole system."

These schemes were also cited as having more specific value in relation to making best use of the workforce and resources in primary care:

"One of the things that I've been particularly struck by has been the extent to which pharmacists can get involved with the management of a patient's long term conditions, who take up a large proportion of GP workload…it will release GPs to focus attention more on patients who need them the most, and take the pressure off primary care… we need to be doing everything we can to be releasing GPs from tasks that they don't really need to be doing [where] other people could be doing them just as safely."

"The practice based pharmacist is invaluable within our practice." [GP]

2.1.3 The 'Dudley Quality Outcomes for Health' framework is beginning to improve long-term conditions management in primary care

In commissioning primary care, the CCG has replaced the Quality Outcomes Framework (QOF), Local Incentive Schemes and Directed Enhanced Services with the Dudley Quality Outcomes for Health. This provides a rationalised set of performance indicators (with the aim of increasing efficiency) alongside an increased focus on care planning and shared decision making for people with long-term conditions (LTCs) (with the aim of increasing effectiveness).

This development was cited by several interviewees, albeit from differing perspectives and with differing – albeit generally positive – views. Two interviewees raised points about changes in approaches to care planning for people with LTCs:

"I've been really pleased to see the progress that's been made on the way the practices are managing long term conditions. They're doubling the number of patients that are co-producing their outcome objectives and recording their own personal goals…it's tens of thousands of patients who are sitting down and articulating what they want to achieve. And if you think about really what the whole culture of the MCP needs to be about, it needs to be about empowerment of the individual."

"Some patients like care planning. Other patients refuse to do it. Some patients like the fact they're going to spend 40 minutes with my nurse or my health care assistant going through their three long term conditions. And other patients think it's a waste of time." [GP]

While a third interviewee noted a degree of subtlety – highlighted in a further specific local evaluation (to be published) - in the extent to which the new outcomes framework was actually more efficient and effective at the level of the individual practice:

"The evidence [from evaluation] on the outcomes framework is genuinely very positive. But I'll caveat that: it's positive where practices have restructured the way in which they deliver those services and the way that they organise delivery. Where that's happening and they're genuinely engaging in honest conversations and structured interviews with patients and they're genuinely producing care plans and setting targets and actually co-producing with patients…[then] patients talk very positively about the experience because they're more involved in their healthcare…it follows through in terms of the clinical outcomes that we see."

As with the MDTs, several interviewees noted a need for greater operational consistency (see the end of this section).

2.1.4 The care homes telemedicine scheme did not work as intended

Throughout the Vanguard programme Dudley's emergency admissions rate has continued to increase (discussed further below and tracked in performance reports from the evaluation). One of the schemes put in place to address this was the 'Airedale model', which supported residential and nursing homes to help prevent admissions (particularly out of hours) by providing clinical support to nonclinical staff through telephone or video triage.

For several reasons (documented more fully in the evaluation of VP schemes), this model was not well implemented and did not have the desired effects. Several interviewees reflected upon this. Two drew wider points: one relating to the (on their account rushed and insufficiently considered) process by which the model was commissioned; the other on whether, notwithstanding its failure in this case, the model nonetheless exemplified a way of working that would be useful to the MCP:

"I think we've done the Airedale scheme almost out of desperation because we were conscious of the fact that we had a fairly significant number emergency admissions from nursing and residential care and…we've sort of leapt into it without necessarily kind of testing out the validity of it."

"We've had the trialling out of the Airedale model, which I think we got mixed feelings about in terms of its impact but, for me, it's not really so much been the pros and cons of that model itself…It's as much to do with the concept of having a single point of access…so it's a toe in the water really to that central coordination."

2.1.5 There are common IT systems in primary care, yet 'interoperability' remains a problem at the system level

A small number of interviewees reflected on changes in the use of digital technology and the exchange of information across different parts of the care system. Notwithstanding the subtlety of points made, the broad view seemed to be that significant progress had been made in getting all GP practices onto the same IT system (a change pre-dating the Vanguard), yet there had been a lack of progress in enabling broader information exchange of the type that would be needed under an MCP:

"On a technical level, bringing all of the practices onto EMIS Web - having a single electronic information system - is foundational. It's difficult to imagine how you could make an MCP work without having everybody on the same system."

"I would have hoped that we'd have at least fully mapped what the problems were, so that we could try and tackle those interoperability issues [getting different IT systems to 'talk' to each other]…It seems to me that system is crucial to the MCP model. And I don't think we're properly sighted on what the problems might be, fully yet."

2.1.6 There has been frustration with NHSE's focus on emergency admissions as the main measure of the changes made under the Vanguard programme

The schemes summarised above (and described more fully elsewhere) have given rise to multiple effects. These effects have been direct (e.g. on staff, on patient experience), as well as also generating lessons and insights of use to the development of an MCP.

Yet national performance management has focused largely on emergency admissions: a focus that has become more pronounced over time. In Dudley, largely because of a specific local coding policy, emergency admissions for the period of the Vanguard programme have been higher than comparable health economies. They have also continued to rise (when achieving improvements was part of Dudley's 'pitch' to become a Vanguard).

Interviewees reflected upon these issues. At heart was a view that Dudley's programme ought to be seen more broadly: incorporating the broader set of effects noted above and readying the ground for the MCP:

"Does it save money? A lot of the stuff that I get asked about the [primary care] outcomes framework is: it benefits the system, it benefits the patient, it improves the clinical outcome, it benefits staff experience…but actually is it reducing emergency admissions, is it saving money?"

"The things that we're counting are the things that we always have…there's a recognition of the importance of things that have always mattered to those people who are providing

services on the ground but…if we consider value as emergency admissions, we're still placing our value base weighted against that."

"A reduction or a slowing in the rate of emergency admissions is really a by-product of the purpose of the MCP. It's not the purpose of the MCP. The purpose of the MCP is about maximising the potential of the individual together with their own social networks to manage their own health and wellbeing."

"We've had a number of visits, actually from all over the country and further afield…whichever part of the system people come to Dudley to talk about, I think the interest is very much in…have we saved money. That's just how it feels."

2.2 There have also been broader cultural and strategic changes helpful to the MCP

The sub-section above concerned individual schemes and innovations. Interviewees also described changes resulting from the interaction and aggregation of these schemes – and from wider engagement and partnership work. These effects were, in general, broader and less tangible than those arising from specific schemes. They included:

2.2.1 A greater sense of 'system'

Interviewees referred to changes such as a greater sense of 'system readiness' for the MCP, or a stronger sense of a 'shared local agenda' across different organisations. In large part, this was explained as being the result of increased partnership working (through the Partnership Board established to oversee Dudley's Vanguard programme for example) and through more shared conversations within the Dudley system than had previously been the case:

"*There has been significant value in the Partnership Board around the partners that operate in Dudley working together, identifying issues, identifying a way forward.*"

"*The system does work together now. So you have commitment from organisations that actually they shouldn't be alone in this anymore - because they can't resolve their own problems unless they work together as a system.*"

"*The healthcare deliverers and social care deliverers have gelled and [are] orientated in the same direction. All understand what we're trying to do, moving towards a much more integrated model. So, I think there's a lot of positive benefit from working in a different way and understanding the issues that we all have in the system.*"

Again, as noted above, the MDTs in primary care were cited as being an exemplification of the broader requirement to 'think in systems', rather than focus on individual organisations or services:

"If we think of the development of the MDTs and the person being at the centre when services come round to discuss those individuals. Before everybody would have been totally in siloes…So, I suppose that integration of workforce and organisations taking away some of their boundaries being one of the biggest [changes]."

"If you think about what the [MCP] care model is all about, it's all about getting the right staff together so that they can collaborate together to jointly get better results for our patients…In many respects we've created some aspects of the MCP before the organisation. So, if you take the MDTs, the ones that work really effectively, we're getting to a place now where their dominant sense of purpose comes from their team working and therefore their sense of shared identity with that team. They still have an identity with their organisation…but it's less now because the identity they're presented with every day is their face-to-face contact with their patients and the conversations with colleagues in the [MDT] team they're working with."

Finally, one interviewee followed the logic of this greater sense of system by noting that there would be a need to consider investment decisions in the light of changes in pathways, activity and agencies involved:

"Integrated Plus is adding more demand onto voluntary organisations at a time when they have less funding and are not being kind of financially valued for the work they're doing on behalf of the system."

2.2.2 A wider agenda that encompasses mental health and wellbeing

A small number of interviewees noted that there had been a broadening of the agenda considered by health and social care providers. In the main, this was described in terms of addressing mental health and wellbeing. Again, in part this was seen as resulting from the MDTs (seen as showing how social problems could be addressed through a healthcare route); yet it was also seen as resulting from strategic level conversations and partnership working:

"If we go back five years in Dudley, nobody would have been talking about social isolation and the impact that health services have on people's lives just by being there…So for me I think what's changed is the recognition of what's important and giving people and our providers more fluidity to allow for that."

"[Before the Vanguard started] We had an event to say we will need to work differently and mental health was almost an afterthought. What I see now is conversations, be it at the

Partnership Board or in the MCP procurement process, not an afterthought but how do we make sure that we incorporate mental health…Mental health is a natural part of the conversation, before it was a bolt on."

2.2.3 A more engaged primary care sector, with a growing sense of the need for development

There has been a significant focus on primary care over the last year of the programme. This has largely been due to the procurement process (described later in this report), where engaging, updating and consulting with primary care has been vital given primary care's structure and role in the procurement process.

In practical terms, this engagement has been through the Primary Care Collaborative (which has represented primary care in the procurement), CCG membership events, locality meetings, an on-going / recurring programme of practice visits and other mechanisms. This work has been led by CCG staff, but also by individual GPs who have assumed a leadership role in relation to engaging and representing primary care.

The changes resulting from this work contrast with the situation documented in the Early Findings report from this evaluation, which highlighted a need to further engage primary care with the MCP. In general terms, interviewees described primary care as being more coherent and engaged – albeit far from uniformly and with no sense of the task having been completed:

"There are a lot of GPs out there who are very interested in the process, but not enough to want to participate in the development of the MCP themselves…There's another bunch of GPs who just want us to get on with it. And there's another bunch who are just watching and waiting to see what happens and then will make up their minds at the last minute."

"We've had a lot of engagement events and talking to the GPs and keeping them on track and building trust with them. That's the major thing we've been doing [over the last year]."

A further effect of this engagement work - allied to involvement in specific changes described above and the CCG's primary care development programme ('EPIC') – has been a growing sense of the need for changes in the operation of primary care:

"Primary care itself is going through a transformational agenda of its own. Without all of this I'm not really sure what would have happened to primary care - it would [probably have] just kept chugging along as it always has. You've got a recognition now that primary care actually does need to change and that primary care should be where it's at."

"We've got primary care listening and prepared to make a change. That's a big step forward actually. To get them interested in working in a different way and working

collaboratively…they're much more prepared to share information and share facilities and share patient workload to a certain extent. That's very different to how it's ever been."

2.2.4 Increased staff engagement, albeit with significant uncertainties remaining

In addition to the significant push on primary care engagement, there have also been more general efforts to engage staff working for different organisations across the system. These efforts, which have been led primarily within the organisations themselves, with some coordinating function provided by the Partnership Board and CCG, have aimed at informing staff about the intentions and developments of the MCP: both as an organisation and as a model of care.

Interviewees raising this topic reflected cautiously. They noted the difficulties in communicating something with necessarily high levels of uncertainty when the intention was to engage and reassure. They also noted the challenges of coordinating messages across different organisations to ensure consistency:

"Obviously our staff are our greatest asset. But we don't know how threatened they feel by this process, and whether they understand that we're still going to need the manpower. We need to be able to reassure them…that's been the most difficult part of it. At every turn, you're standing up there and saying 'this is going to be great, it's going to be fantastic for the patients of Dudley, it's fantastic for sustainability of the workforce'. And then when they say 'well how's respiratory going to work?' You say, 'well actually we don't know yet'."

"That's been a variable experience across the organisations. I think some organisations have been very positive about what they have communicated to staff about what is happening. Some of the quality has been variable from what I understand. Some of it didn't take place when we agreed it should…we've always wanted to get a similar message out to people, I'm not always sure that we've achieved that in practice."

"There's a lot of staff feeling very anxious…wondering what sort of organisation am I going to work for? Is it going to be an NHS organisation or non-NHS? Will my terms and conditions be the same? Will I be affected? Will my pension be affected? Will I have a job? Will there be redundancy?"

2.2.5 Structured involvement of patients and the public, with a clear on-going need for this to continue under the MCP

There has been a programme of public engagement in Dudley on the MCP. This has been a continuation of 'mainstream' CCG work in this area, augmented in response to the requirements of both the procurement process and also because of the foundational role that self-care, community resilience and wider networks of support have within the MCP model:

"The first year it was about involving people in the decision of the care model, so all that on-going involvement that shaped the [themes of the MCP] that then fed into the public consultation about whether people understood MCP and whether they thought it was a good idea. [Recently] we've been doing a lot with staff and with the public around…deciding who the final MCP provider is, so working with them in the dialogue."

In practical terms, this work has been developed both using specific and focused engagement activities – alongside a workstream under Dudley's Partnership Board charged with stimulating and coordinating this work:

"We also developed and run a number of sessions earlier last year where we developed an 'Activate' pack where we went round and met with a number of people from the community talking to them about what keeps them well, healthy, cared for, what hinders them, what opportunities are there for them to think about actually how we can I suppose change the emphasis about services being done to people, people having to take more responsibility themselves, what does that mean, how could that happen, how do we need to empower people and what are some of those opportunities."

"The development of the definition of 'People in the Lead' workstream [of the Partnership Board] is a good example of how you build on social capital to embed the model of care. I would look at that kind of thing as being where we've innovated and developed the model as a result."

Interviewees reflecting on the results of this activity described a mixed (and expected) picture:

"*I think some of the usual suspects will know about stuff. Other people…if I were to go and walk down Dudley High Street and talk to people about the integration of services and people working together better - I don't know that half of them would even know or half of them would even want to know, to be honest.*"

"It was very patchy. The patient engagement in [names area] where I work is shocking…Elsewhere, they've had really good patient participation. And in fact, the Patient Participation Group meeting that I went and spoke at was very well attended."

Finally on this topic, interviewees also reflected on the on-going importance of this type of engagement work, noting how central changes in patient, professional and public behaviour will be to the future of the MCP:

"Our biggest job is going to be to re-educate our patients on how to use the NHS. …Because they're used to having access to their GP first. And we need to reverse that…the fact that we're utilising a wider skill mix within primary care, I know that patients are benefitting from [that]."

"I would call it our bread and butter work within the CCG of the community development work, working with public health and CVS colleagues to get our communities as resilient as they can be for this new MCP and to give it what I describe as the foundation of community resilience that we've just continually been building on in Dudley and that would be happening regardless of this, but is clearly intrinsic to the success of any future MCP."

2.3 'Greater consistency' is the next step for many of the changes made; the MCP is seen as a means of achieving this

As the previous sub-sections show, interviewees could list and comment upon individual changes made to prepare the ground for the MCP; they could similarly elaborate upon broader strategic effects of improved partnership working and engagement within the local system. In the main – and notwithstanding the drawbacks and deficiencies noted – these changes were felt to represent progress towards a new model of care in Dudley.

Again notwithstanding multiple subtleties, in considering the future of these developments most interviewees cited a need for greater consistency in operation. The meta-narrative here was of having established and tested multiple innovations, of having an emerging sense of which innovations merited continuation, and now of needing to optimise, scale and be more deliberate about their operation:

"I think there's maybe an issue around consistency…I suspect we've probably got 46 different multidisciplinary teams."

"When I talk to general practice about how they're utilising their MDTs, how it benefits the practice, how it benefits the patients, how it's functionally operation…what I hear is that there's a tremendous amount of variation…the Outcomes for Health Framework…there's a standard set of business rules around that, there's a standard set of outcomes that we're commissioning, but the way in which that's kind of implemented on the ground varies to practice to practice…So, again, there's variation in delivery."

"There's a conversation about whether forty six [MDTs] is the right number. For some things it might be, but for many things it isn't. For mental health they struggle to get beyond ten practices. It's well received with the psychologists in the MDT but they're never going to have the workforce to do forty six."

"If you put these models in you need to have consistency and you need to have adoption and spread across the whole health economy not one part of Dudley wants 'x' and another part of Dudley wants 'y', because otherwise it just causes confusion around what you needed to do so I think we need to agree what is the model going forward."

A further and related point, made explicitly by a small number of interviewees and implicitly by others, was that it was not always clear how the innovations started under the Vanguard should sum to a coherent overall package:

"When we've commissioned all those individual schemes through the Value Proposition, we've done them all individually, but we haven't shown how they add together to create the big picture on the box."

"There's the Airedale [telemedicine in care homes] project. There are the community rapid response nursing teams. It gets a bit blurred as to who's organised what, because I know that the hospital have also started setting up different services since the new Chief Executive arrived…The IV teams in the community, the new CHC, and intermediate care pathways have improved. The frail and vulnerable pathways that are being developed are good. The diabetes consultants coming out to the community is a fantastic idea..."

Addressing variation and providing consistency was then linked by many interviewees to the establishment of the MCP. Since the MCP would, following the procurement exercise described in the next section of this report, hold a long-term contract with the ability to develop its own investment and development strategy, interviewees saw the MCP as being the means by which greater consistency would be realised.

Some interviewees saw this most immediately as being about providing certainty (and clarity, which some felt was lacking) over which of the VP-funded innovations would be invested in on-going:

"My understanding is there is some core CCG money that contributes towards it but an awful lot of it has been funded from the Vanguard money, which obviously comes to an end…So we will be in conversation with the MCP… but there's no guarantee I suppose at this stage."

"The question [for the MCP] is can we find significant and sufficient savings, cutting of waste, duplication of stuff out of the system to fund all the investment, fund all the growth? Whether they have to fund the VAT as well [depending on the MCP's organisational form] we'll have to wait and see."

Other interviewees saw the MCP as being helpful to ensuring operational consistency within a more clearly defined and fully developed model of care:

"We're seeing variation [in primary care] and my assessment of it is that that variation exists because not all practices have engaged in restructuring the way that they work [to manage LTCs]. So, for me, there's something really critical about the MCP and trying to standardise that operating model."

"You get people in certain areas getting a worse kind of service than you do in other places. And that is inappropriate. We need equity across the system. But because we're on that journey we've not seen all of the advantages that the MCP model can deliver…that's yet to come."

And finally, for one interviewee in particular, there was also a specific operational gap for the MCP to bridge in terms of place-based working, designed around local 'care hubs' serving specific local populations within Dudley:

"You've got to have a coalescence of teams at a hub level. We're not really doing the work on how we create that sense of team and identity at that level, but I think that's where the sense of team will be [in the MCP]…It's going to be a very different look and feel and a very different sense of purpose. And it will coalesce around those hubs."

3. Procurement of the MCP

This section outlines interviewees' views on the procurement process. This process, led by the CCG, began in late 2016 with a Prior Information Notice and a market engagement event in January 2017[3]. It was then launched formally in June, with the result of the Pre-Qualification Questionnaire (PQQ) stage being announced in August.

The sole bidder passing the PQQ comprised local GPs, Birmingham Community Healthcare NHS Foundation Trust (BCHC), The Dudley Group NHS Foundation Trust (Dudley Group), Dudley and Walsall Mental Health Partnership NHS Trust and Black Country Partnership NHS Foundation Trust.

Competitive dialogue between the CCG / Local Authority (LA), as the commissioners, and 'MCP partnership' (the above organisations) then began in September and was on-going at the time interviews for this report were undertaken. The expectation is that the MCP contract will be signed in 2018 with service delivery commencing in 2019.

The section begins with a discussion of the role of primary care in the procurement process. It then moves on to consider the performance of the commissioning function (CCG and LA) and the procurement timetable. The section concludes by outlining interviewees' views on procurement as a means of bringing about change.

Section summary:

- The role of primary care necessitated a 'non-traditional' approach to procurement.
- The commissioning function has had to navigate some difficult territory; it has performed this task well.
- The timetable for the procurement has been tight; this has affected the development of the MCP partnership, which has not got off to a good start.
- Interviewees were therefore generally sceptical of the value of procurement in affecting change.

3.1 The role of primary care necessitated a 'non-traditional' approach to procurement

In some respects the procurement process summarised above followed a typical structure. It was led by the CCG, supported by the LA as the other commissioning body in the local system, and made use of market engagement, supporting materials and a PQQ stage followed by competitive dialogue.

[3] More information and official documentation relating to the procurement can be found here.

Yet there were also novel features to the procurement. In the main, these features arose from the role of primary care in terms of the:

- Centrality of primary care to the MCP model: there would be no MCP without primary care;
- Stability of local primary care providers: GPs tend to live and work in local areas, with far less 'churn' than other health professionals / organisations; and,
- Consequent CCG requirement to show primary care support as part of the PQQ: any prospective provider of the MCP had to show commitment from local GPs.

These factors combined to mean that other prospective providers would – in effect – be selected by primary care before entering the commissioners' procurement process. The weight of this decision led to primary care running a structured exercise to assess and chose partners to enter the PQQ with.

3.1.1 The 'Primary Care Collaborative' was formed to represent primary care's interests entering the procurement; it was seen as an effective mechanism

In order to run a process whereby primary care could select partners, it was necessary to design a means for discovering primary care's interests, making them explicit and representing these interests in engagement with prospective partners. This was made more complex in Dudley since there are no GP federations or 'super practices': the primary care sector comprises 45 individual practices. As one interviewee noted:

"*There is a question mark to which GPs in the Borough will ever speak as one. I don't think that's a realistic expectation so the best you're hoping for is aggregate or consensus view.*"

To address this, the 'Primary Care Collaborative' was formed. Led by a small number of individual GP volunteers, this Collaborative was charged with making a decision on which partner organisation(s) to enter the procurement with. The process used included making criteria explicit and public; using interviews, documentary analysis and presentations to assess prospective partners' offers; 'checking back' with and involving the wider Collaborative to gauge and account for the body of GP opinion; and live documenting of the process.

Several interviewees reflected on the challenging nature of this task - especially given that one of the founding arguments for the MCP was the extant strains on the primary care workforce:

"*The reality is, that GPs want to be involved in this, but as you know, the GP workforce is under tremendous stress at the moment, and there just isn't the time in the day for a lot of GPs to be involved in these things very easily.*"

Despite the difficult nature of the task, most interviewees commenting on the group considered that it had performed well:

"It's a collection of people that were very disparate prior to the start of it. A lot of people actually hadn't worked together, a significant number of them were very new to doing this, so actually to come together as a group and to stay together - particularly with some of the personal opinion that constantly brought back into challenge what we had tried to do - I think that was quite good, that was quite strong. There were a number of significant problems en route."

"The people that have the hardest job in this are the GPs leading the Collaborative. I have a huge amount of admiration for their commitment to this because they're not professionals in all these kinds of big institutional negotiations which we're now embarked on with the procurement...They've got to negotiate with three lots of people. They've got to negotiate with the CCG…they've got negotiations with their other partners…they've also got to constantly check back and keep on-board with 200+ GPs in the system…it's costing them a lot personally to put the time in. Also the emotional effort that's required to do this is very significant."

3.1.2 The CCG made resources available to support the GPs; this support was necessary and welcomed

As the quote above shows (and as the Early Findings report from the evaluation documented) there was also recognition within the CCG that the GPs would require specific support and expertise in order to discharge their task effectively:

"We [the CCG] realised late in the day the work that needed to be done to support general practice through that process and we've had to play a bit of catch up on that and we appear to have recovered as far as that's concerned."

Support was provided using a combination of VP funding and the release of managerial expertise from the CCG (the implied split of the CCG into 'commissioning' and 'MCP development' functions is discussed below). Again, interviewees commenting on the effectiveness of this support were positive in their assessment:

"What's worked well is the fact that we've [GPs representing the Collaborative] been very, very well supported by people who understand how the process works. Because General Practitioners would have had no inkling of how any of this works… the whole reason that it's moved forward, is because we've had that support."

"That systematic structured way [of primary care selecting a partner] evidencing en route why and how decisions were made and constantly engaging back into the wider [Collaborative] membership to take them with us on that journey. I think that was good."

3.1.3 To the extent that procurement was seen as 'right', primary care merited a central role in selecting partners

The end of this section sets out interviewees' views on the merits and drawbacks of the use of procurement. Within this broad topic, the role of primary care was a prominent theme. To the extent that interviewees accepted procurement as a necessary route, several commented on the unusual structure of the process given primary care's role:

"We used the phrase 'a kind of unique process' to describe it, because of the parallel GP selection process that ran at the same time…The CCG…they're fulfilling all the legal requirements, they're very clear about what they're doing and they've got really good documentation about what they're after…[but] having a procurement as a provider who's mandated [GPs] is very weird and just skews the system."

A few interviewees then raised an alternative approach, whereby the CCG could have commissioned a partner for primary care to form an MCP with – or could have more actively managed the process of selection:

"What we could have done is basically say we're going to go through a full procurement process and decide who would be the best provider of the services are, and then have a preferred provider there. Because the GPs aren't actually in the MCP till they become fully integrated we could say that: 'well GPs, you need to work with who we've procured as the best partner for you'."

"I wonder in retrospect if we'd taken a meticulous look at the data, looked at the best performing Community Trusts [in the country], looked at the personalities involved, understood the story of how integration had actually come to pass, and then put a huge amount of effort into proactively reaching out and encouraging those organisations to come to Dudley and pitch their wears, whether we could have given those GPs and indeed the whole procurement process a lot more meat."

But ultimately no interviewees were convinced that this would lead to a successful MCP partnership – and that providing local GPs with a material say in the selection of partner was the right thing to have done:

"I don't see how we could have done it differently in Dudley in terms of engage GPs or don't engage them. I think if we hadn't, we would just be procuring something that our [GP] colleagues out there would have just said 'well actually this is not us'."

"I can guarantee you now that if this had just gone out as a tender without needing to have Primary Care at the centre…[BCHC] on their own would be responding to this tender in a very, very different way to how they are. Primary care at the heart of it is what holds it all together, but also what causes a lot of the friction."

Several interviewees went on to reflect on how the power given to primary care had not helped the early development of the MCP partnership. Those making this point saw a continuation of the sense that primary care was 'in the driving seat', which had been unhelpful to the development of a functioning and balanced bidding partnership.

3.2 The commissioning function has had to navigate some difficult territory; it has performed this task well

This sub-section presents interviewees' views on the commissioning function. Primarily it concentrates on the CCG, but it also considers the role played by the LA.

3.2.1 The CCG organised itself into 'commissioner' and 'MCP development' functions; this has been handled well

The implication of the decision to provide support to primary care in entering the procurement meant that the CCG was presented with a conflict of function. In responding to this, it arranged itself into commissioning and MCP development functions: assigning members of staff to one or the other and seeking to avoid information passing inappropriately between the two.

Several interviewees noted the difficulties of this situation, citing occasions when conversations between 'the different sides' in the CCG (and/or stakeholders to them) had to be handled very carefully:

"Who's allowed to, or should be talking to whom? And what information is or is not supposed to be transferred? There are plenty of cases that I can think of, where it would be nice to know in general terms where things are at, or whether a conversation has happened, or whether something's been considered. And not knowing whether it has or not, not knowing whether you're allowed to ask or who you should ask, whether it's been included, or finding out because somebody else has a chance conversation with you about something, and then thinking well am I supposed to know that or not? It has sometimes made things, shall we say, a little bit unnecessarily bureaucratic."

"The CCG have tried to handle it as well as they can, that everywhere possible, I know when dialogue's started to go into a procurement conversation it was like categorically we can't talk about this at Partnership Board, end of, no more discussion, stop conversation. Certain people don't come to Partnership Board now because they're part of the procurement process."

In general terms, interviewees commenting on the way that the CCG (supported by NHSE's NCM programme infrastructure) handled these challenges considered that it had been

done skilfully and with significant resilience given the requirements and multiple audiences for this element of the work:

"The [CCG] team has been remarkable. I don't know how they've done it...I just feel dead sorry for them because I just see them jumping through hoops to satisfy other purposes that have been detracting from the original purpose."

"The CCG's huge skill in this is that we [Dudley] are on a national stage that despite competing pressures on all sides at times where they have the providers kicking off, they have NHSE expressing disquiet or Monitor [sic] jumping up and down, they have everybody telling them that this cannot and will not work – that it's not possible and it's inherently dangerous and then plastering that all over the HSJ. I think that, I the CCG has been incredibly adroit in the way it's handled."

3.2.2 The commissioning function has a stake in the MCP provider's success: challenging and assessing or co-producing?

Later sections of the report consider the state of the MCP partnership as it enters the competitive dialogue stage of the procurement process. What follows focuses on the role of the commissioner.

Interviewees commenting on this topic noted two main factors influencing the process. Firstly, that – to date - the CCG (as led commissioner) had been the originator of much of the thinking behind the MCP model. It defined most of the arguments for the MCP; it delineated the model of care; and, through the procurement documentation, it decided on the characteristics that the MCP provider should exhibit. It also received additional resources to develop many of these features and to support a procurement process. The prospective provider, by contrast, has received these things – and has had to react without additional resources.

Under these circumstances, a small number of interviewees observed that this creates a dynamic whereby the CCG must take care to 'ask the right questions, while not supplying the answers':

"The role of the CCGs is really fascinating...the biggest success in this I believe has been the CCG because they have lead all of it and they've held it all together and now what they should do is take a step back and let the procurement happen - but they can't because they're such a strong player."

"We've almost created a situation where the providers are...not emasculated that would be going too far but, you know, they haven't taken up the mantle of leadership of the care model because the CCG has occupied that space. So now we're in procurement, we as a CCG are now procuring that from the providers, because they haven't developed that shared sense

of leadership of the care model for themselves before, they're now having to rapidly try and find it."

"It's both a strength and a weakness actually of the approach, that it's been CCG led. The CCG has pushed really hard to define the components of this model and to develop those components to such a point that they are capable of being transferred into a new entity. The flip side of that is that it still feels as though providers are waiting to be told what to do."

"We're [the CCG] having to hold the provider's hands quite a lot through the process in terms of guiding them as to what we expect. [But] we're not doing it for them…to keep the purity of the procurement."

The second factor noted by interviewees was that (in addition to the reputational stake implied by the above) the CCG has a direct stake in the MCP in that many functions currently performed in the CCG (and so many staff performing them) will eventually transfer into the MCP. This was seen as giving the CCG a further material interest in the outcome:

"The CCG will want to influence what this looks like. Partly that will be because certain people will see their roles in the MCP. And they will want to exist in an organisation that they think has certain values and a culture that they would want to exist in."

Finally, a small number of interviewees noted that having one (rather than two or several) providers in dialogue with commissioners necessarily limited competitive pressure. By contrast, others considered that having more than one provider in the process would be extremely difficult to manage practically given the likely exchange of information between the parties.

3.2.3 The procurement has been run within NHS rules and processes; the role of the LA has consequently diminished

The Early Findings report noted the strength of the CCG-LA relationship in defining the requirements for the MCP and in seeing the MCP as a means of integrating health and social care in Dudley.

While still noting a commitment to this end, interviewees commenting on the role of the LA considered that the CCG had played an increasingly dominant role. This was explained by the procurement operating under NHS rules – and social care being almost entirely absent from the prospective provider's response (discussed further in the next section):

"From a local authority prospective I'd guess the process has become, by virtue of the check point process and the tendering process, increasingly NHS focused."

"[The LA seem like] observers attending the process - looking in, with very little influence and control…that's just simply down to the fact that the NHS procurement methodology and the command and control approach."

One interviewee noted that the most likely effect of this would be a softening and further staging of integration between health and social care services within the MCP:

"We've got a mechanism in the contract that allows up to £90M of adult social care to be rolled in which I think is a good option for the system, for the council and potentially for the provider… We can start looking at where money is currently spent we can start jointly looking at opportunities to reduce cost and demand."

3.3 The timetable for the procurement has been tight; this has affected the development of the MCP partnership

The timetable for the procurement was a common theme in the interviews. All interviewees raising the topic did so to note that the timetable was very tight. This was both from the commissioner and provider perspectives:

"We [the commissioner] knew that was quite an aggressive timeframe, but we thought it was realistic and achievable, noting the amount of work that was needed on both sides to get to the point where we achieve that endpoint. We thought that with a fair wind that that could be achievable."

"It causes frustration because the timeline that procurement have set is hard and you know you've got providers at the moment who are saying it can't be achieved, so you've already got a three month gap in what the CCG is expecting and what the bidders say that they can produce at the moment."

Several interviewees then went on to outline the effects of this timetable:

Not addressing necessary detail given clinical engagement requirements and the length of contract

"It feels like we are starting from scratch in a lot of areas…it is [also] so rushed at the moment…We'll struggle to get the engagement when it comes to the change and delivery of that clinical model."

"My concern is that the timescales for the procurement now are so tight and at such a pace that I'm concerned that things will get missed or not thought out fully, bearing in mind what we in essence are committing to is a 15-year contract."

Affecting the development of the MCP partnership (positive and negative)

"Having some timelines in there forced some decisions in the partnership which is good, it's created a bit of leverage. So I think actually we've probably gained more momentum post PQQ than we had before."

"What I'm observing now is that they [MCP partnership] haven't been given the chance to be a team so they're responding together because they've been put together but they're not as one: they're responding as three [separate organisations]…not the MCP team."

Pressure on the commissioner side

"I think that we're in a position now where we're having to dialogue a lot more than we thought we would have to do. And it's working OK to be honest. We do have pressure on."

3.4 The MCP partnership has significant areas for development

At the time interviews were undertaken, the partnership bidding to form the MCP partnership (the local GP Collaborative, BCHC and Dudley Group) had passed the PQQ stage (August 2017) and had begun the 'competitive dialogue' process with the CCG and LA in September. In broad terms, and following from the above, interviewees reported that the MCP partnership had not developed at the pace required by the procurement process. The reasons provided for this were various. They included:

- the nature and speed of the procurement;
- some difficult local history between organisations and individuals;
- differing – and perhaps conflicting - organisational incentives for bidding;
- lack of specific development activity designed to help form a true partnership;
- lack of national policy / guidance on organisational form (which had dominated early conversations);
- the imbalance of power between partners following the procurement process (primary care having selected 'its' partners early in the process);
- the challenge of moving into the space hitherto defined and occupied by the CCG leadership in terms of defining what the MCP might be; and,
- the bid requirements crowding out a focus on strategy, population health and a clinical model given the opportunities presented by integration.

3.5 Overall, interviewees were highly sceptical about procurement

For many interviewees, the issues outlined above called the use of procurement into question more generally. Yet, of those raising this point, many were simply accepting that

(legally) procurement was a requirement given the resources at stake. Very few interviewees were enthusiastic about the use of procurement.

In broad terms then, interviewees were sceptical (or in some cases scathing) about procurement:

"*Procurement's a complete farce. It does not do what people want it to do…Procurement is a ridiculously complex, overly bureaucratic and legally dominated system to try and produce change. The change can be produced without employing armies of lawyers to do procurement…but we are stuck with procurement as the answer.*"

"*If I was to have my time again, I would probably have said that we should have looked at the alliance [contracting] model first rather than leaping straight into the procurement, but that's looking through the lens of today.*"

Several interviewees expressing scepticism then made the contrasting link between the changes on the ground described earlier in this report and the - on their account less fruitful - efforts around procuring the MCP:

"There's some very practical things that have happened in terms of the way that services have been reorganised outside of any contractual sort of stuff. So, I think about particularly [lists MDTs, Integrated Plus, primary care outcomes framework]… they're there, they're tangible. So I can see a lot of stuff where the MCP model of care is up and running outside of any kind of MCP contractual framework or outside of any procurement."

"*Procurement has got in the way of progress. Because if, twelve months ago, we started these conversations with the coalition of the willing to do something different and really trusted each other to do it in the way that we wanted to do it, we'd have made so much progress.*"

"My question is 'did the MCP procurement and model create that?' Well if I'm honest the MDT ways of working have been up and running for a while now, so it's happened regardless…I can see pockets of brilliance. The operational characteristics [of the MCP] was really first class, the engagement piece…but what is attributable to the MCP? I'm struggling with it…My conclusion is that the procurement process has just throttled the life out it."

4. Lessons learnt

In the final part of the interviews, stakeholders were asked to reflect back on their experience of the Vanguard as a whole and to pull out the main lessons they had drawn. The list of responses was long and varied; it also included many examples of personal lessons and personal development.

This section focuses on those lessons of a more general, and perhaps therefore widely applicable, nature. Accepting some overlap and necessary fuzziness of definition, lessons are presented in two categories:

- 'Technical', which refers to components of change defined in part by law or policy or guidance (e.g. procurement) or which draw upon some codified set of technical skills (e.g. modelling); and,
- 'Social', which refers to ways of acting, culture, how relationships are conducted (etc.).

These categories reflect the underpinning theory of change in Dudley, where efforts on procurement (for example) have run in parallel to increased engagement and partnership working within the system. Lastly, it is also interesting to note that much of what follows represents an elaboration and refinement of lessons drawn out in the Early Findings report.

Section summary:

Lessons on 'technical' components of change:

- Understand and engage deeply with primary care; consider the role of primary care in procurement if commissioning an MCP.
- Seek national action and guidance on organisational form.
- Be prepared for flexible, hands-on commissioning; carefully consider whether large-scale procurement is the best route.
- Think population, not (just) patient; attend to analysis and detail.
- Invest in project and programme management skills.

And on 'social' components:

- Keep describing the destination, why it's important to get there and the difference each step makes to the journey.
- Give freedom to experiment; distribute leadership and attend to culture and relationships.
- Create (bounded) freedom to innovate and evaluate.
- Gather resources and resilience; celebrate milestones along the way.

4.1 Lessons on the 'technical' components of change

4.1.1 Understand and engage deeply with primary care; consider the role of primary care in procurement if commissioning an MCP

Several interviewees drew lessons from Dudley's experience on the need to have a detailed understanding of, and on-going engagement with, primary care. This point was made in relation to the local context, where the CCG in particular was seen as being especially strong:

"Collaboration and good leadership going back a long time. If you were trying to do it in an area where there was less trust between GPs it would be a lot harder. So, it may be that what we're doing in Dudley can't be directly replicated in areas where GPs are not in entrusted in working together in this sort of way."

The point was also made – albeit while noting a deficit – in relation to national policy and the general background of leaders within the NHS:

"We have an NHS management training scheme that is a feeder for system leaders of the future. None of them do any sort of placement in primary care. It is all secondary care based. So we have generated a national health service that through our non-clinical leadership generally doesn't understand primary care and has had no exposure to it. So there is something about how to get a better understanding of primary care can be embedded."

Reflecting back on primary care's role in the procurement (described earlier in this report), one interviewee also saw the need to carefully consider how primary care acts within any procurement process:

"You could be forced into a position where you end up commissioning a service from an organisation because it's the organisation that general practice most gets along with, rather than the organisation that's going to deliver the most benefit to the system. And that's a fairly fundamental issue in terms of how the policy is at the moment."

4.1.2 Seek national action and guidance on organisational form

The NCM programme is built on a theory of change that encompasses both local action and national support. The decision about which level to act at will always require judgement. But one area noted by interviewees as being clearly right for national action was on organisational form for MCPs:

"Unless there's a change in VAT rules, and that doesn't look like it's going to happen, the viable organisational form for an MCP is some form of NHS provider. The problem with that

is that the two forms of NHS Trust…have both got strengths and weaknesses but neither of them really fit ideally the model that you'd have for significant GP involvement."

The lesson here was to seek decisions and guidance from national bodies as soon as possible, avoiding the possibility of multiple, duplicative (and expensive) local actions.

4.1.3 Be prepared for flexible, hands-on commissioning; carefully consider whether large-scale procurement really is the best route

One interviewee saw a need to learn from Dudley's experience in having a commissioner that supported (in this case, led) the development of an MCP:

"*Other [Vanguard] areas that say 'we wish we had your CCG' because they've got their model, they've done it the opposite way round, they developed their model as providers and then they need a commissioner that wants to commission it. [Lists other MCP Vanguards] are an example of that…they haven't got a CCG that wants to commission that model of care.*"

Others, in part building upon the point above about the role of primary care, drew lessons on the mode of commissioning needed, noting that Dudley's experience suggested that a more 'traditional and hands-off' approach (commissioner specifies, provider does) was not appropriate given the complexity of establishing an MCP:

"*We're trying to do it jointly [between commissioner and provider] because I think as much as anything else it's obviously a lot different from a traditional contract.*"

While others, again drawing on the scepticism detailed earlier in the report on the value of procurement, suggested that one lesson was to think carefully about whether a large-scale procurement was the right approach:

"*If you can develop the relationships and the partnerships without going through procurement, I think the outcome is probably going to be achieved sooner.*"

4.1.4 Think population, not (just) patient; attend to analysis and detail

Several interviewees, reflecting that insufficient attention had been paid to these areas to date, considered that it was important for discussions of both population need (present and likely future) and areas for potential efficiency (given the integration of currently separate) services to be informed by analytics.

In part, this was motivated by a desire to ensure a focus on population health (including mental health):

"*Focus on the population. And don't come into this with the idea that your role in the NHS is to treat local patients. Your role is to be part of a health and care system…We need to come in to the MCP thinking in terms of what's good for the health of the entire population of*

Dudley, not just what is good for the patients who happen to be in the system at the moment."

But in the main those raising the need for more detailed work did so in relation to assurance - and also starting the process of realising opportunities for efficiency provided by the integration of services:

"*The more we can detail the clinical model, then the more we've got something to hang all the finances and risk around. At the moment there's probably two much narrative and not enough who is going to be where, doing what to whom and for how long, how much.*"

"*We need to get agreed by our [provider] boards because actually it's right.*"

4.1.5 Invest in project and programme management skills

One of the lessons from the Early Findings report was that, mainly in relation to the projects funded under the VP, there had been an underinvestment in project and programme management skills, which had hampered delivery. This point was raised again (here as a lesson) by several interviewees:

"One thing that maybe the overall approach to the implementation of the various schemes that we've got in the value proposition has lacked is proper kind of programme and project management."

One interviewee also extended this lesson out to the broader transformation efforts being undertaken by the CCG. They felt that the CCG had been 'underpowered' in this respect and that many staff had been required to work 'above and beyond' for the duration of the Vanguard programme:

"*The need for a robust independent project team to actually manage the MCP…transformational project management to be built into the process from day one.*"

4.2 Lessons on 'social' components

4.2.1 Keep describing the destination, why it's important to get there and the difference each step makes to the journey

As noted in the introductory section, the model of change used in Dudley has drawn upon 'technical' elements such as procurement and contracting; but it has also (perhaps more so) drawn upon cultural and relational approaches to making change.

On this, one of the lessons cited by a small number of interviewees was the need for a consistent narrative that drew together the – to some eyes disparate – elements of the changes being enacted:

"People come at this [the MCP] from different perspectives but there are very few people in the system who articulate this as a whole model and articulate ultimately what it's designed to do. And I don't think we've got a consistent narrative across to everybody and that's reflected back in the way in which the system behaves."

This was linked to the need for broad engagement across the system (organisations, patients and the public) to help generate and maintain that shared understanding:

"Bringing together organisations with a vision that people [the public] steered in the first place, around access, continuity and coordination [themes for the MCP to address]."

4.2.2 Give freedom to experiment; distribute leadership and attend to culture and relationships

As in the Early Findings report, many interviewees considered that the NCM programme had provided freedom to act - alongside resources with which to do so. At that point, interviewees mainly described freedoms at the level of the system (freedom for Dudley – mainly from national control); this was also true during this round of interviews – albeit with some sense that these freedoms had been narrowed over time:

"Being part of the New Care Models programme has been fantastic because…we've had an incredible amount of freedom to do this how we want and we've also had an incredible amount of support [from NHSE] to do it properly."

"Freedoms that were given to Vanguard are very quickly [being] taken back through the performance monitoring of us. That's been incredibly frustrating and has stifled a lot of what we maybe could have achieved quicker without it…If I have to fill in another spreadsheet I'll kill someone!"

During this round of interviews, stakeholders further developed this lesson to also include creating licence for people within the local system – in part to generate a sense of distributed leadership:

"Enabling leadership and freedom is just so important."

"Sometimes you learn a hell of a lot more by getting one thing wrong than by getting everything right, because actually if you're getting everything right you're not taking risks are you?"

On a related point, several interviewees drew lessons on the importance of leading change through relationships (often contrasting this with the use of contractual mechanisms); people making this point often also noted the need to give this approach time to bear fruit:

"This is a massive, massive, culture shift and it needs to be given time. If you try and rush it won't happen, if you try and buy it, it won't happen, if you try and contract for it, it won't happen…we don't make cars, we don't make widgets, we make people that look after people and we provide the facilities to enable that. So, treat it as a people business."

"*My plea is that the system is given that time. You know, that the performance pressures from NHS England aren't piled on the system to such an extent that it's not given the opportunity to embed the changes.*"

Finally on this topic, one interviewee projected forward to think about the MCP as an organisation and the importance they saw in the deliberate creation of the right organisational culture:

"*The MCP leadership team that comes into place would do extremely well to take a step back on day one before they start taking on any services and say 'right, fundamentally what kind of culture do we want to create, what are the fundamentals about the style of working and decision making that we want in the system?*'*…And they really, really need to invest upfront in that kind of whole HR / OD [organisational development] process.*"

4.2.3 Create (bounded) freedom to innovate and evaluate

Reflecting on the process of establishing and testing new services and innovations under the VP, several interviewees drew lessons relating to the use of evaluation and rapid feedback. In their view, using evaluation would help to bound innovation - for example by having the disciplines of specifying desired outcomes, theories of change as to how they might be achieved, and rules around the stopping / scaling of innovations:

"*Some of the [VP] schemes that we've invested in have suffered from the lack of a clear design and when that's happened you get people saying 'that was never the intention*'."

"*Embedding this sort of evaluation is helpful, actually to be testing but then go back and testing again what is it that's making the difference.*"

Again, one interviewee thought forward to what this would mean for the MCP in creating a culture of freedom, innovation and learning:

"*The leadership of the system ought to be creating the right infrastructure and framework which allows our clinicians to innovate and try things out and audit them and report them back and then constantly iterate and progress that.*"

4.2.4 Gather resources and resilience; celebrate milestones along the way

Finally on lessons from this round of interviews, perhaps the most commonly cited lesson was about the need for resilience given the difficulty and complexity of such large scale change:

"*That when you think you get to the top of the hill, it's not the top of the hill. There's always going to be like another ascent to get to where you need to get to. You need significant stamina and you need a strong team to be able to do it because it's hard work.*"

"*You shouldn't go into this thinking that it isn't going to have an impact on your organisation and you individually but you always believe it's the right thing to do, resilience is so important.*"

The point about the need for resilience was frequently linked to the need for additional resources to make change on this scale:

"People shouldn't underestimate the amount of time and effort that needs to go into something like this. It's far bigger than you ever imagine so, you know, don't underestimate the amount of time that's involved. Don't underestimate the resource that's required to do it properly and the amount of dedicated resource that you need."

Lastly, one interviewee also reflected on the importance of celebrating milestones:

"*There has to be a celebration of what's been achieved. It's easy at the moment to feel like we haven't got there and, yet we have to look at how far we've come. We're nearly there and then the fun part really starts because then this is really about building an MCP. But to have got that far there needs to be a celebration.*"

5. Conclusions and recommendations

This final section draws conclusions from the evidence presented above. Reflecting back on the learning-oriented purpose of the evaluation, the report then ends with a series of recommendations for both local and national organisations.

5.1 Conclusions

On local changes made as part of the Vanguard programme

Resources associated with the Vanguard programme have been used to augment, expand and accelerate the CCG's efforts to bring about a new model of care. Programme funding has been used to introduce innovations and services that exemplify this new model and pave the way for the MCP (once the new organisation is established and the contract is awarded).

These efforts have produced some positive results: notably around the increased role of the voluntary sector (in MDTs) and pharmacy. There have also been less successful efforts: work to develop interoperable IT systems has not progressed as planned and the telehealth scheme did not achieve desired results. Where changes introduced as part of the Vanguard have been successful, such as the pharmacy-based schemes, they have become 'mainstream' (albeit assuming continued investment), altering the way care is commissioned and delivered in Dudley.

Future developments mainly centre upon the need for greater operational consistency – especially for the MDTs and Quality Outcomes for Health framework – to codify and optimise models that have evolved at the GP practice level. More general lessons include the need for a clearer strategy on innovation (e.g. decision rules on stopping or scaling) and the project management capabilities needed.

Wider, less tangible, changes have also been brought about through broader engagement and mechanisms associated with the Vanguard programme. The Partnership Board, for example, has helped to develop relationships and a shared agenda across the local system. This work has helped broaden the local conception of care to further include 'social' interventions and a more general encompassing of mental health and wellbeing. There have also been engagement efforts with staff, patients and the public. There is no sense of this work being complete and staff engagement remains an area of uncertainty; but, in the main, these efforts have also helped prepare the ground for the MCP by establishing shared frames of reference.

On the engagement of primary care and the procurement process

The last year has seen a significant focus on primary care: especially in supporting primary care providers to enter the procurement process. Measured by the Primary Care

Collaborative being able to select partners to enter that process (and, less tangibly, by increased GP engagement with the MCP), this has been a success.

Work here also remains on-going: both to establish (contractual) relationships between GP practices and the nascent MCP; and in working through primary care representation in governing and leading the MCP as an organisation.

The role and standing of primary care led to an untypical procurement process, with primary care making the decision as to which organisations would (in all likelihood) form the MCP. With additional management support, primary care came together through the Primary Care Collaboration and made this decision. The CCG was also seen to perform well in managing its consequent division into 'procurement' and 'MCP development' arms. Neither of these tasks was simple.

The scale and scope of contract on offer meant that a large-scale procurement was seen as the only viable option: and a necessity in order to comply with procurement regulations. Nationally – and reflecting the 'test-scale' logic of the NCM programme - it may also have been seen as a desirable test case. Nonetheless, the value of this exercise is not yet clear. In some respects it has tended away from integration. The most immediate effect was felt in the CCG, which had to create a specific procurement team and divide this from its other functions. This raised significant practical and managerial challenges; and the disciplines of procurement led to a high opportunity (as well as direct) cost as the CCG was less able to lead system development (it had, to that point, led work to develop the MCP).

The procurement was intended to achieve several long-term benefits, e.g.: establishing the MCP as an organisation rather than simply as a care model; the creation of long-term outcome improvement objectives; the alignment of incentives to support the objectives of the clinical model). Yet, at the time of writing, the realisation of those benefits is still to be proven, while the procurement itself has proven a complex process which has necessarily created short-term separations within a system which previously was working as one partnership.

On the role of NHSE and thinking behind the NCM programme

The local view of national performance management is that it has narrowed to an almost exclusive concern with emergency admissions. While there are clear reasons for this – and local programmes would have all made claims in this regard - if reducing emergency admissions were the only aim of the NCM programme it would have been constructed (and named) very differently.

There is a need to retain the focus on learning for replication. Dudley has acted as a rich source of insight which can be shared; many of the lessons are relevant to large-scale

change per se – as well as the specific requirements of establishing models of accountable / integrated care.

Finally, the above has played out within a local system that is – relative to other areas of the country – well-led, in reasonable financial health, and with many high-functioning relationships between organisations and key individuals. Even accepting that Dudley is bearing some of the R&D cost for other areas, this set of contextual factors ought to be enough to induce caution about the replication of efforts built around large-scale procurement.

5.2 Recommendations

5.2.1 For Dudley's commissioners to

1: Consider a more co-productive approach to dialogue and MCP development.
The MCP contract is large in value, scope and timescale. The current MCP partnership faces a significant challenge to develop and mature. Constituent organisations also – as all providers do – have to decide how much to invest in a necessarily uncertain future opportunity (securing the contract) weighed against certain and current service demands (doing the day job).

The CCG has a significant stake in the MCP: reputationally (to successfully commission an MCP) but also, more substantively, in that many of its functions will transfer to the MCP. Moreover, as the lead commissioner, the CCG has been the source of much of the thinking, expertise and resource behind the MCP. In combination (and not withstanding any legal considerations) these factors suggest that it would be appropriate for the commissioner organisations to take a collaborative and co-productive approach to the dialogue process. This might include joint work on many of the recommendations made below to the MCP partnership.

2: Maintain the Partnership Board in its role overseeing the system.
This recommendation has some immediate implication (given the Board's remit for the Vanguard programme that ends in March); but should also be considered in the medium-term (the role of the Board as the MCP comes into being) and perhaps also beyond (system development once the MCP is established). Whatever the timeframe, the Board faces a change in remit from oversight (of the VP programme) to learning and system development. Its membership, terms of reference and operation should be reviewed accordingly.

5.2.2 For the MCP partnership to

3: Invest time in partnership development.
The multiple factors set out above mean that the MCP partnership would benefit from specific developmental activities to surface and work through issues affecting its functioning. Outputs from this work might then help design an OD programme as the MCP begins to form as an organisation.

4: Develop a detailed sense of demand and the opportunities provided by service integration.
This should include analysis of the population's current and likely future needs, mapping of current service use, followed by an evidence-based assessment of how – given that the MCP will integrate these services under a single contractual / organisational framework – current provision can be made more efficient to improve resource use, care and outcomes. In addition to analytical inputs, this might also usefully include external (to Dudley) clinical challenge. The thinking behind the MCP rests upon realising these opportunities; this exercise should therefore then be used as the basis for a service improvement strategy.

5: Put in place a further programme of service development around the MDTs.
These teams have been established and operated for some time now. The evaluation of them described their value and quantified their effects; it also noted – as did this report – significant variation in their operation. They would therefore benefit from further, focused development work with the aim of codifying and optimising their structure and operation. (To a lesser extent, the same applies to the Quality Outcomes for Health framework). This could be done as part of the MCP's early operations.

6: Make more of pharmacy.
Work with pharmacy colleagues to see whether there is further scope for extending the role of pharmacy within the MCP model, building on the value realised from the schemes funded under the VP.

7: Ensure that social care is not lost.
'Better integration with social care' was one of the founding arguments for the MCP; yet uncertainty remains as to how / whether / when this might happen. The MCP needs to develop a clearer view on this, perhaps starting by using locality based working (see below) as a further means of showing what joint working looks like operationally and the benefits that follow.

8: Develop an operational model for multi-disciplinary locality based working.
As it stands, this is an underdeveloped aspect of the care model in Dudley. The MCP model (in abstract) has this level of operation – multi-disciplinary management of populations of

30,000 – 50,000 people - at its heart and it stands to be a functionally important way of integrating teams from currently different organisations and services. Developing these localities should include consideration of innovation (see below) and also the information needs of managers and teams in order to support on-going service improvement.

9: Develop a framework for service innovation.
This should include: showing how vital innovation is; citing expected culture for and sources of it (notably frontline teams); delineating the disciplines of it (e.g. clear theories of change, tight monitoring and evaluation); and setting rules around it (e.g. when to stop and when to scale).

5.2.3 For NHSE / national bodies to

10: Promote alternatives to procurement in establishing new models of care.
The evidence presented here points towards using procurement as a 'last resort' approach. More detailed work on the costs, risks and expected benefits involved – of procurement and of alternative approaches - would help to refine decisions about the circumstances under which procurement is likely to be needed. Certainly the costs in time and resources, allied to the current highly constrained financial context of the NHS, mean that it should not be seen as a default or first response.

11: Learn from Dudley's approach on the role of primary care if procuring an MCP.
It may be that there is a means of combining significant input into the selection process, recognising that primary care will certainly feature as a provider in an MCP, while not running (in effect) a parallel process. Having primary care on 'the commissioner side' for the early stages of the process might be the most pragmatic solution.

12: Be very cautious in using the example of Dudley in considering replication.
NHSE's NCM programme should consider what the experience of Dudley says about the likely ability of other areas of the country to replicate accountable / integrated care models. There are reasons for caution. Relative to many areas, Dudley is a non-stressed system; the CCG and other elements of the system are recognised as high-performing (and have felt the strain during the programme); and Dudley's efforts have been fuelled by additional resources – not all of which could be accounted for as 'R&D' that others would not need. What has been done in Dudley could not easily be ‘lifted and shifted’ elsewhere.

13: Learn from the model of change used in the NCM programme.
In effect, the NCM approach was: local development (and evaluation) of broadly described models, backed by national support (and evaluation) to aid learning and guide replication. This is a modest and subtle approach relative to 'national definition: local delivery', which is a more usual model of change. With refinement – and noting the point about developing

balanced approaches to measuring system change - it could usefully be adopted for other large-scale change programmes.

Annex 1: People interviewed

Name	Title	Organisation
Andy Gray	Chief Officer	Dudley Council for Voluntary Service
Chris Handy	Lay member for Quality Chair of Partnership Board	NHS Dudley Clinical Commissioning Group Partnership Board
Dan King	Director of Membership Development & Primary Care	NHS Dudley Clinical Commissioning Group
David Hegarty	Chair	NHS Dudley Clinical Commissioning Group
David Pitches	Public Health Consultant	Dudley Metropolitan Borough Council
Diane Wake	Chief Executive	The Dudley Group NHS Foundation Trust
Gillian Love	General Practitioner	Primary care
Jayne Emery	Chief Officer	Healthwatch
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
Micky Griffiths	Commercial Director Programme Director	Birmingham Community Healthcare NHS Foundation Trust (Dudley MCP Development)
Neill Bucktin	Head of Commissioning	NHS Dudley Clinical Commissioning Group
Paul Harrison	Deputy Chief Executive and Medical Director	The Dudley Group NHS Foundation Trust
Paul Johnston	Dudley NCM Programme Manager	NHS Dudley Clinical Commissioning Group
Paul Maubach	Chief Executive Officer	NHS Dudley Clinical Commissioning Group

Stephanie Cartwright	Director of Organisational Development & Human Resources	NHS Dudley Clinical Commissioning Group
Steve Mann	Clinical Executive for MCP Development	NHS Dudley Clinical Commissioning Group
Timothy Horsburgh	Clinical Lead for Primary Care	NHS Dudley Clinical Commissioning Group
Tony Oakman	Strategic Director People Services	Local Authority
Tracy Taylor	Chief Executive	Birmingham Community Healthcare NHS Foundation Trust

Annex 2: Summary of topic guide used

Interviewee background

Please explain the main areas of your involvement in the work to establish the MCP over the last year

Main developments in implementing the MCP

From your perspective, what have been the most significant developments in efforts to establish the MCP?

What areas or work need further / specific attention? What is missing and needs to be developed for the MCP to be a success?

Outcomes to date

Thinking about all the work undertaken to bring the MCP about – and the developments we have just discussed - what do you see as the main results / outcomes from this work? What has changed in Dudley?

Reflections, lessons learnt and recommendations

Given all the topics and issues we've discussed, what are the main lessons you have drawn from the work to date?

What recommendations would you make:

- To local partners / organisations currently working to bring Dudley's MCP about? and
- To other areas considering similar work – or to policy makers?

Finally, do you have any further points you would like to raise / comments you would like to make?

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