Good Governance Institute

Developing an MCP: learning from the experience of Dudley CCG

NHS Dudley Clinical Commissioning Group

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Introduction

The NHS is in a period of transition. Responding to a range of financial, organisational, population and workforce pressures, Sustainability and Transformation Partnerships, as well as the development of a range of new models of care, are reshaping how care is delivered in England, with emphasis placed on joining up services, improving individual health and wellbeing, and keeping people out of hospital by offering a wider range of services within the community.

The development of multi-specialty community providers, whether through the Vanguard programme or subsequently, is a key part of this process. In June 2017 Dudley CCG became the first NHS organisation to launch a contract for the procurement of an MCP. This paper reflects on the lessons for the wider NHS from the experience of Dudley, and also explores some of the demographic and policy changes that has led to the introduction of new models of care.

Why does the NHS need to change?

Although the NHS is often recognised as one of the most equitable and high performing health systems in the world, it is now 60 years old and serves a markedly different population with markedly different needs to the one it did when it was established in 1948.

The most recent Office for National Statistics projections suggest that by mid-2026, the population of England will have increased from 55.3 million people (in mid-2016) to 58.5 million, an increase of 5.8%[1] This growth is marginally faster than the UK average of 5.5%, and significantly faster than the estimated population growth across Europe of less than 1%.[2] For reference, when the NHS was established the population of England was around 38 million.[3]

At the same time, the population is living for longer and with an increasing number of often complex long-term conditions. In 2012, the Department of Health estimated that around 15.4 million people in England were living with a long-term condition, and that by 2018 2.9 million people would have three or more conditions.[4] When you consider that those with long-term conditions are the most frequent users of health care in England, and that the average cost to the NHS of treating those living with three or more long-term conditions is more than twice that of those living with one, and almost eight times that of those living with none, it is clear this is contributing considerably to the strain the NHS finds itself under.[5] Indeed, Dr Sarah Wollaston, Chair of the Health Select Committee, has called long-term conditions "one of the greatest challenges facing the NHS", arguing that

In 2012 we had over 15 million people who were living with at least one long-term condition but by 2025 there will be 18 million. Already 70% of the entire health and social care budget goes towards looking after the 30% of the population suffering from these conditions.[6]

Changes to the population profile in England have been accompanied by a transformation, particularly influenced by technological advancements and the gradual transition from a manufacturing to service economy, in the way in which people are working and living. Although it is arguable that collectively we are more prosperous than ever before, society is also increasingly unequal.[7] The impact of this has inevitably trickled down to the health sector, where the likelihood of an individual suffering mental ill health, becoming obese, or living with a long-term condition is closely aligned to deprivation.[8] As we, and others, have previously argued, steps taken by the UK Government to improve health and wellbeing and focus on ill-health prevention have not been as effective as they might have been, and there is a recognised need for the public to take greater ownership of their health if the NHS is to be sustainable.[9]

1. Office for National Statistics, National Population Projections: 2016-based statistical bulletin, 2017
2. United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects: The 2017 Revision, 2017
3. Office for National Statistics, Social Trends: Population (ST41) - data tables
4. The King's Fund, Long-term conditions and multi-morbidity
5. The Guardian, NHS could be 'overwhelmed' by people with long-term medical conditions, 2014
6. Nursing Times, Cost of treating long-term conditions set 'to soar' for NHS, 2014
7. Oxfam, How to close Great Britain's great divide: the business of tackling inequality, 2016
8. Public Health England, Health Profile for England, 2017
9. Good Governance Institute, How population health management will deliver a sustainable NHS, 2018

Increasing demand has had obvious and significant implications for the finances and workforces of NHS and social care organisations. CCG and specialist commissioning funding for the NHS are due to increase by 2.6% against an annual increase in demand for NHS services of 3.1% and of 2.1% to NHS costs.[10] What this means is that, even taking into consideration non-recurrent and temporary funding, NHS providers are collectively forecasting a record full-year deficit of £931 million for 2017-18.[12] To realise even this figure, NHS organisations have already achieved significant cost savings (3.7% in 2016/17 and 3.6% in 2015/16) and serious questions persist about the impact of this on the quality of services.

In 2018, The Office for National Statistics revealed that the health and social care sector contributed 125,000 (15.4%) of the 810,000 job vacancies in the period October to December 2017.[13] Whilst data published by NHS Digital reveals that almost 33,500 nurses left the service in 2016-17, some 3,000 more than entered[14], and that in the same period the number of GPs in post in England decreased by just over 1,000 despite government pledges to increase the GP workforce by 5,000 and provide a seven-day service by 2020.[15] The lack of any comprehensive national long-term workforce planning, compounded by the UK's decision to leave the European Union, static or declining wages (in real terms), and increasing workloads, has long been apparent, with a recent report from the Select Committee on the Long-term Sustainability of the NHS arguing that this represented "the biggest internal threat to the sustainability of the NHS."[16] Whilst caps on spending on agency staff have reduced spending in this area by over £1 billion since their introduction in October 2015, more will need to be done.[17] Worryingly, over the past three years, UCAS have reported a 23 per cent decline in the number of students applying to nursing and midwifery courses, closely linked to the removal of the student bursary.[18]

These pressures are heightened by the fractured nature of the current health and care system which makes coordinating care challenging. For example, NHS and social care are funded differently with the NHS free at the point of access, and social care typically funded for adults identified as having significant needs and limited means. Social care funding has declined by up to 30% in some areas since 2010 resulting in an estimated funding gap of £2.5 billion by 2019, and leaving the sector in crisis as it struggles to cope with rising demand.[19] The challenges experienced by the care sector have implication for the NHS, and have contributed to 168,000 delayed discharges in the second quarter of 2017/18.[20]

Considered collectively, these issues represent a perfect storm which the NHS must rapidly prepare itself to meet. Its approach to doing so has been outlined in policy documents such as the NHS Five Year Forward View and The Next Steps on the NHS Five Year Forward View.

What has happened?

The NHS Five Year Forward View, published by NHS England in 2014 and refreshed in 2017, made the case for substantial system change, arguing that:

Quality of care [in the NHS] *can be variable, preventable illness is widespread, health inequalities deep-rooted…[patient] needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patient. Service pressures are building.*[21]

Envisaging a "radical upgrade in prevention and public health", it promotes a health system in which people are supported to take greater ownership of their own care and in which decisive steps are taken to break down longstanding barriers to the delivery of care ensuring services are patient centred and better integrated.[22]

10. NHS Providers, Mission impossible, 2017
11. The King's Fund, The NHS in a nutshell, 2018
12. The Nuffield Trust, The NHS deficit is here to stay, 2017
13. Office for National Statistics, UK labour market: January 2018, 2018
14. BBC, NHS 'haemorrhaging' nurses as 33,000 leave each year, 2018
15. The Guardian, Jeremy Hunt accused of 'astonishing failure' after GP numbers fall by 1,190
16. Select Committee on the Long-term Sustainability of the NHS, The Long-term Sustainability of the NHS and Adult Social Care, 2017
17. NHS Improvement, Agency controls: expenditure reduced by £1 billion and new measures
18. The Guardian, Nursing degree applications slump after NHS bursaries abolished
19. The Guardian, The Observer view on the social care crisis, 2017
20. NHS Improvement, Quarterly performance of the NHS provider sector: quarter 2 2017/18, 2017
21. NHS England, Five Year Forward View, 2014
22. Ibid.

The development of new models of care is a key component of achieving this vision. In 2015, 50 vanguard sites were chosen (of which Dudley was one), following a rigorous selection process, to develop new models of care, pioneering new approaches to the improvement and integration of services that will serve as the blueprints for NHS in the future. In particular, the Vanguards have looked to develop:

- Primary and acute care systems - integrating GP, hospital, community and mental health services
- Enhanced health in care homes - developing better, joined up health, care and rehabilitation services
- Multispecialty community providers - focusing on moving specialist care out of hospitals and into the community
- Urgent and emergency care - improving the coordination of services and reducing pressure on A&E departments
- Acute care collaborations - linking hospitals together to improve their clinical and financial viability, and to reduce variation in standards of care and efficiency

Evaluation of these initiatives is ongoing but emerging findings suggest that the new models of care are having a positive impact in terms of patient experience and quality.[23]

Alongside these sit Sustainability and Transformation Plans (STPs), now Sustainability and Transformation Partnerships. Announced in NHS planning guidance in December 2015, these bring together NHS organisations and local authorities across 44 geographical footprints in England to develop five-year plans that set out how health and social care services within their areas will be designed and delivered in the future.[24] It is likely that each STP will incorporate a number of different new models of care.

What are multi-specialty community providers?

"A MCP is what it says it is - a multispecialty, community-based, provider."[25]

MCPs, built upon the GP registered list, combine the delivery of primary and community-based health and care services, and serve the whole population of a given area. This includes some services currently delivered in hospitals. They differ from other models of care such as Primary and Acute Care Systems in that they don't deliver hospital services, providing care in the community through a series of integrated 'care hubs'.

NHS England's MCP contract framework suggests that there will be three types of contractual solution for an MCP:

- The first is the 'virtual' MCP, under which individual providers and commissioning contracts are bound together by an 'alliance' agreement.
- The second is the 'partially integrated' MCP contract, the scope of which excludes primary medical services, supported by contractual arrangements between the MCP and the GPs to achieve operational integration
- The third is the 'fully integrated' MCP contract model with a single whole-population budget across all primary medical and community-based services.[26]

The level of integration pursued by the MCP will be dictated by local context and, in particular, the willingness of GPs to relinquish their current contracts and become salaried members of the MCP. Within the 'virtual' and 'partially integrated' models, GPs are able to continue to hold their GMS/PMS contracts. However, in a 'fully integrated' MCP, GPs would suspend their GMS/PMS contracts for an agreed period of time (likely the duration of the MCP contract) after which they are able to reactivate their GMS/PMS contracts. Provision has also been made within contracts for GPs to reactivate their GMS/PMS contracts at two-year intervals.[27]

23. NHS Clinical Commissioners, Sharing learning from new care models, 2017
24. NHS England, Delivering the Forward View: Planning guidance 2016/17 - 2020/21, 2015
25. NHS England, The multispecialty community provider (MCP) emerging care model and contract framework, 2016
26. Ibid.
27. BMA, Salaried GPs working under new models of care, 2017

What are MCPs intended to achieve?

MCPs are about the integration of health and social care services and seek to address many of the problems this paper has outlined previously. As described in NHS England's The multispecialty community provider (MCP) emerging care model and contract framework:

"The transformation of care involves major shifts in the boundary between formal and informal care, in the use of technology, and in the workforce. The opportunity for an MCP is across all three. An effective MCP engages and activates patients, their carers, families and communities in helping to take control of their own care – rather than assuming that the main source of value is clinicians doing things to people. It harnesses digital technology, not only to provide fully interoperable electronic records and real time data, but also to redesign the process of care delivery, for example through phone and Skype consultations, diagnostics, the use of apps and early adoption of innovative drugs and devices. And it empowers and engages staff to work in different ways by creating new multi-disciplinary teams; by redesigning jobs so that they are more rewarding, sustainable and efficient; and by implementing newer professional roles."[28]

Accordingly, this framework identifies the following as key features of successful MCPs:

- A population health and care model focused on proactive and preventative care tailored around the needs of the individual
- Empowering patients and local people to support each other and themselves in their health and care
- Multi-disciplinary health care professionals working within an organisation that has accountability for the delivery of health and care services for their population
- Contracting and payment systems that incentivise and enable the delivery of services for population health[29]

What are the lessons for the wider NHS from the development of Dudley MCP?

Dudley is a large metropolitan borough in the West Midlands region. It is predominantly urban and has a population of roughly 315,000 people.[30] It has an aging population, as well as higher than average levels of disability and deprivation.[31]

Mirroring the situation in many parts of the NHS, it is recognised that:

- Services in Dudley are too fragmented,
- The care system is unbalanced, with far greater emphasis placed on acute cate than care in the community; not reflecting the needs of Dudley's community,
- Primary care is under increasing strain,
- Care is reactive, with a lack of emphasis placed on prevention and self-care,
- There are perverse incentives in the system, and
- The system is not financially sustainable[32]

However, there is also a strong and rich history of collaboration between the health and care organisations in the region and Dudley was an MCP Vanguard site. The MCP is understood as a vehicle through which the collaboration and integration can be further developed.

Dudley's MCP will receive a single, whole population budget for those patients registered with practices who are part of the MCP and non-registered patient's resident in Dudley. This means that the MCP will serve a population of circa 315,000 people. The contract will run for 15 years and the MCP will be commissioned to deliver a set of specific health outcomes. Importantly, engagement with members of the public in Dudley has helped frame and develop the following broad-based outcomes:

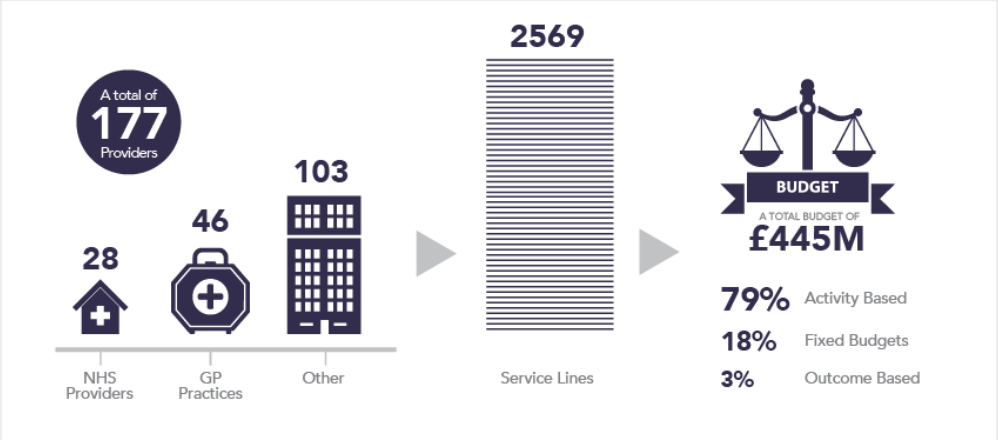
28. NHS England, The multispecialty community provider (MCP) emerging care model and contract framework, 2016
29. Ibid.
30. Dudley CCG, Prospectus for the Procurement and Commissioning of a Multi-Specialty Community Provider (MCP)
31. Ibid.
32. Midlands and Lancashire Commissioning Support Unit, Evaluation of the Dudley New Care Model Programme: Early Findings Report, 2016

- improved access to care - which would result in improved patient experience and ultimately healthier lifestyles;
- continuity of care provision – which would support stable management of long term conditions, reducing variation in care and ultimately reducing inequalities;
- coordination of care - which would enable people needing care or support to remain in their own homes, reducing social isolation and ultimately remaining connected to their community.[33]

In procuring the MCP, the ambition has been:

"To improve health and wellbeing for local people through more closely linked health and care services, based around GP practices, which allow easier access to care that is consistent and better co-ordinated."[34]

By introducing multi-disciplinary teams and orientating a significantly larger range of services within general practice, it is hoped that Dudley's will simplify the provision of care. Moving from this:



To this:

In June 2017 Dudley CCG became the first NHS organisation to launch a contract for the procurement of an MCP and, in August 2017 announced its preferred bidder for this service: a consortium of four NHS trusts and 38 GP practices. We reflect here on the experiences and learning from Dudley CCG.

33. Dudley CCG, Prospectus for the Procurement and Commissioning of a Multi-Specialty Community Provider (MCP)
34. NHS England, Dudley Multispecialty Community Provider

Resourcing

The formal procurement of an MCP is a technically complex and resource intensive task. Key programmes of work within this include:

- Issuing the Prior Information Notice (PIN) - this process enables commissioners to give advanced notice of their intention to launch an NHS procurement
- Issuing the Contract Notice - this process enables commissioners to give notice that the procurement has been launched and provide information to potential bidders about the contract
- Market engagement events
- Issuing of Pre-qualification Questionnaire (PQQ) - this process enables the CCG and partners to identify suitable bidders
- Invitation to Participate in Dialogue (ITPD) process - this process enables the CCG and partners to engage with suitable bidders in order to develop credible options for the MCP. The bidders are then invited to tender
- Integrated Support and Assurance Process (ISAP) - this process is designed to support commissioners and providers considering a complex contract mitigate potential risks by engaging at key points in the development of a proposal. It begins when a commissioning organisation starts to develop a strategy which includes the procurement of a complex contract. There are four checkpoints that need to be prepared for:
    - An early engagement (EE) meeting takes place while a commissioner is developing a strategy that involves commissioning a complex contract and typically before a formal market engagement exercise, if relevant, begins;
    - Checkpoint 1 (CP1) takes place just before formal competitive procurement or other selection process begins;
    - Checkpoint 2 (CP2) takes place when a preferred bidder has been identified, but before the contract is signed. (NHS Improvement will be responsible for performing the transaction review on NHS trusts and foundation trusts where the thresholds for transaction reviews are met; NHS England will be responsible for assuring CP2's procurement aspect); and
    - Checkpoint 3 (CP3) takes place just before the service begins[35]

Dudley CCG's staff have effectively had to procure the MCP alongside their existing day jobs. To inform this paper, we were told that "this work can't be considered an 'add-on task.'" Whilst CCG staff speaking to the review team for the *Evaluation of the Dudley New Care Model Programme* revealed that "it has become our strategy - it's not just the job of one or two people, every person in this organisation has something to do with this."[36] Organisations beginning the commissioning of an MCP or alternative new model of care must recognise the time and resource challenges in realising this, and staff must be both committed and resilient.

Although there is significant learning from the experience of Dudley CCG and others, it is not the case that all of the processes and approaches employed by the Vanguards and other exemplars can be adopted and rapidly applied in other parts of the country. Organisations must reflect on their own local context and adapt in order for the procurement and development of an MCP to be effective.

Dudley CCG and others have also received financial and technical support from the regulators and external agencies in developing and delivering the MCP. This includes legal, governance, and commercial advice. The CCG have reflected that external support aided and sped up the process, helping to plug resource and experience gaps within the organisation. In particular, the early engagement of regulators was deemed crucial. This reflects some of the learning from the experience of Uniting Care Partnership and Cambridge and Peterborough CCG (which we reflect on later) and should be factored into any planning.

35. NHS England, The Integrated Support and Assurance Process (ISAP): guidance on assuring novel and complex contracts
36. Midlands and Lancashire Commissioning Support Unit, Evaluation of the Dudley New Care Model Programme: Early Findings Report, 2016

Strength of relationships

There is a strong history of collaboration in Dudley including:

- The Building Health Partnerships programme which aims to improve health outcomes through supporting the development of effective and productive partnerships between Clinical Commissioning Groups (CCGs), local authorities and voluntary, community and social enterprise (VCSE) organisations
- The co-development of an Emergency Treatment Centre at Russells Hall Hospitals between Dudley CCG and The Dudley Group NHS Foundation Trust providing an improved point of access and one stop shop for urgent and emergency treatment

Early engagement with stakeholders in the area also demonstrated that there was a shared understanding of the challenges that Dudley faced and that the MCP model was seen as the most appropriate mechanism to address these. This provided a firm foundation to develop and procure an MCP.

However, as the CCG has taken a leading role in designing and implementing the MCP there have been challenges in ensuring that everyone is kept up to date and singing from the same hymn sheet. We were told that "the CCG is living and breathing this stuff, the others less so," and that "partners can often alight on certain features, for example, multi-disciplinary teams or specific outcomes, rather than putting together the whole picture." Strong leadership and clear communication has therefore been necessary throughout to ensure that all are aligned behind the vision for the MCP.

Furthermore, whilst the leaders of local healthcare organisations may support in principle the integration of services and provision of services closer to home, the current NHS is built on a system which favours competition and isolation over collaboration and partnership. In the early stages of the procurement this was manifest in the behaviours and dynamics at the Partnership Board. *The Evaluation of the Dudley New Care Model Programme revealed that:*

"The Partnership Board is a battle ground where organisational boundaries, protectionism, cultural differences, resource constraints, etc. are played out."[37]

Relationships between the CCG and any bidders, other parts of the system, and the Council therefore have had to be tightly managed. A history of collaboration in the area, strong leadership across stakeholders, and a clear and well understood vision have helped in this regard.

The role of general practice

The NHS General Practice Forward View recognised that "British GPs are under far greater pressure than their counterparts, with rising workload matched by growing patient concerns about convenient access."[38]

The situation in Dudley mirrors this with research undertaken by Dudley CCG in advance of beginning the procurement process revealing that:

- A significant portion (37%) of their GPs were planning to retire within five years[39]
- GP recruitment is challenging (nationally, in the last decade, the number of hospital consultants has increased by 48% whilst GP numbers have increased by just 14%, and in 2017 18% of training places in England were unfilled)[40]
- GP workload is increasing in line with the declining number of GPs[41]
- Patient demand is rising[42]
- Many GP premises are in need of development (a recent survey conducted by the British Medical Association reveals that 52% of GP premises have seen no investment or refurbishment in the last 10 years[43], whilst a review of estate by the British Property Federation found as many as 4,000 of the 7,692 GP practices in England and Wales to not be fit for purpose[44])

37. Midlands and Lancashire Commissioning Support Unit, Evaluation of the Dudley New Care Model Programme: Early Findings Report, 2016
38. NHS England, General Practice Forward View, 2016
39. Dudley CCG, Implementing the General Practice Forward View in Dudley
40. Pulse, 18% of GP training places unfilled after two recruitment rounds, 2017
41. Dudley CCG, Implementing the General Practice Forward View in Dudley
42. Ibid.
43. PHP, Investing in the future of integrated healthcare Helping to deliver a 24/7 NHS, 2015
44. British Property Federation, Unlocking investment in primary care infrastructure, 2015

- GPs would welcome more collaborative working between practices and the sharing of back office functions[45]
- GPs felt that they would benefit from the wider integration of community and other services being organised around GP practices to provide a more coordinated and holistic response to patient needs[46]

Pursuing an MCP was therefore a logical decision for the CCG and other partners. As NHS England's Multispecialty community provider (MCP) emerging care model and contract framework makes clear *"A big reason to develop an MCP is to provide practical help to sustain general practice right now."*[47]

The MCP model by giving access to multi-disciplinary teams and improving coordination of care between services will improve GP work life balance and, depending on the extent to which the MCP is integrated, provide increased career flexibility, arguably making the GP profession a more attractive proposition.

The multispecialty community provider (MCP) emerging care model and contract framework also states that

"Before deciding to procure an ACO Contract commissioners will need to engage with providers to develop the clinical model and consider the contractual models that GPs and others could be interested in. During procurement GPs will negotiate how they will work with the MCP to deliver services and whether (and how) they might choose to share in financial incentives."[48]

And

"The intention is to make MCPs as attractive to GPs as possible, and offer them more control and influence over their local health system – GPs will (understandably) only sign up to arrangements that offer them terms and conditions that are right for them."[49]

This effectively gives the GPs final say in the choice of provider to deliver the MCP as they must be willing to work with them. Dudley CCG has therefore had to invest significant time and resource to take primary care through the procurement process. Rather than simply identifying a preferred bidder and presenting this to local GPs, which would both put the programme at risk and alienating GPs, the CCG adopted an inclusive approach involving the GP federation in the procurement as appropriate and through market engagement events.

Furthermore, as the MCP model necessitates significant transformation of primary care, involving local GPs in the development of the vision and process is important. The development process of the MCP can also serve to develop local GPs.

Conflict of interest

In procuring an MCP it is likely that those GPs sitting on CCG Governing Bodies and taking commissioning decisions will also ultimately end up working for the MCP, as such, and in much the same way as with co-commissioning, the inherent conflicts of interest within this will have to be managed appropriately.

Research by the National Audit Office published in September 2015 suggests that whilst "almost all CCGs had put in place most key elements of the legislative requirements which help them to prevent and manage conflicts," there was only a limited understanding at NHS England as to how effectively conflicts of interest were being managed by CCGs.[50]

It has been important for Dudley CCG, in procuring the MCP, to have clearly defined roles and to be as transparent as possible.

45. Dudley CCG, Implementing the General Practice Forward View in Dudley
46. Ibid
47. Ibid.
48. NHS England, The multispecialty community provider (MCP) emerging care model and contract framework, 2016
49. Ibid.
50. National Audit Office, Managing conflicts of interest in NHS clinical commissioning groups, 2015

The future of commissioning

The introduction of STPs and new models of care has begun to blur the line between what constitutes a commissioner and provider in the NHS. The MCP contract is a long-term, capitated contract with some elements of the payment linked to the delivery of certain outcomes. Members of Dudley CCG communicated to us that the CCG would have benefited from a greater consideration of what this meant for the organisation as it began the procurement of the MCP. In particular this included:

- What roles and responsibilities moves from the CCG to the MCP?
- What does this mean for the contractual framework?
- What does the future commissioning organisation look like?
- What is the transition plan for this change?

This theme has been explored by organisations such as The Health Foundation and The King's Fund and it seems clear that in future commissioning organisations wil need to be leaner and with a different emphasis and skill-set, perhaps focusing more on provider accountability and the delivery of outcomes. However, as stated to us by one interviewee:

"We are less likely to get this right if we try and codify all this into one approach. The whole philosophy of the Vanguard approach was to create a number of models for others to build on."

At this stage there is no right answer as to what commissioning will look like in the future and health systems will need to reflect the context and needs of the populations they serve. That said considering these questions early can help better frame the development of the MCP, ensure a smoother transition of services, and assuage uncertainty amongst staff.

Engagement

Dudley CCG and its partners have from the outset of the procurement placed emphasis on the importance of engagement with patients, the public, and stakeholders to inform the development of the MCP. Significant time and energy has been placed on ensuring that this is an open, transparent and thorough process. As Paul Maubach, Chief Officer at Dudley CCG, has said

"If we believe that our NHS is all about our people: both the public we serve and our staff who deliver care to them; then we do a dis-service to them by not constantly engaging publicly about what we are doing. And it turns out that working in this way has helped us to learn how to work with those tensions, rather than allow them to prevent progress; and it has fostered positive public engagement in helping us to continuously refine our care model."[51]

This began in January 2016, when a public consultation sought to help the CCG better understand the needs and priorities of the local population. This continued between July and September 2016 when the CCG formally consulted on:

- A prospectus
- The scope of the services to be provided by the MCP
- The outcomes which the MCP should be expected to deliver

The consultation was heavily promoted through the local press, social media and the CCG's website and newsletter. It reached 8,910 people on Facebook and 233,084 accounts on Twitter with a total of 861,597 impressions, clearly demonstrating the interest that the public had in this work.[52]

In total, 347 people attended a range of events including:

- 11 public meetings at which the CCG gave a general presentation on the MCP and took questions

51. Dudley CCG, Paul Maubach on the experience of being public about the work on the Dudley MCP and the importance of sharing know-how in the NHS, 2016
52. ICF International, Dudley Multi-Speciality Community Provider - Public Consultation and Equalities Impact Assessment Report, 2016

- Five focused meetings, three of which explored what the MCP may mean for patients with diabetes, primary mental health and respiratory conditions, and two that looked at the outcomes, characteristics and scope of the MCP
- Five workshops, conducted by the Centre for Equality and Diversity, which worked to ensure that the voices from potentially vulnerable groups within the community were heard[53]

The public consultations were independently reviewed by ICF International.[54] Whilst Healthwatch Dudley have been heavily involved in the procurement exercise attending the Partnership Board and consulting independently, where it has been deemed appropriate, on the development of the MCP.

This activity helped moderate any public concerns or opposition to the MCP and ensured that the tender best reflected the health and wellbeing needs of the local population. Importantly, it also helped to build legitimacy for the MCP.

In addition to this, events were held for staff and for potential bidders. These included events with Dudley and Walsall Mental Health Partnership NHS Trust, governors from Dudley Group NHS Foundation Trust, and local GPs to ensure their views were captured, as well as a significant market engagement event to ensure that potential bidders were familiarised with the objectives of the MCP and the process.

As before, the time and resource implications of delivering a large-scale consultation should not be underestimated and support from partner organisations such as local Healthwatch can be pivotal in ensuring their success.

Learning the lessons from the Vanguards and United Care

To support the development of an MCP or other new model of care, it is important that organisations learn from good practice as well as past mistakes from elsewhere in the system.

The evaluation of Vanguards is ongoing but, as touched on earlier, is beginning to build a body of evidence which supports the wider adoption of new models of care. NHS organisations will need to be cognisant of any learning from these and organisations such as The Health Foundation and NHS Improvement are disseminating good practice.[55]

Specifically, when procuring a complex contract, the lessons from the experience of Uniting Care Partnership and Cambridge and Peterborough CCG should be reflected on.

In November 2014, Cambridgeshire and Peterborough CCG entered into a contract with Uniting Care Partnership to provide community care for over 18-year olds, acute emergency care for those over the age of 65 and older peoples' mental health services. This was a novel contract worth £725m across an initial five years with an option to extend for an additional two years and which required integrating services for the elderly with a significant proportion of the contract payment based on outcomes.

However, the contract was terminated by Uniting Care Partnership in December 2015 for financial reasons and there are significant lessons for the wider NHS from the experience of these organisations including:

- The need to ensure adequate specialist procurement advice
- The need to understand the VAT implications of certain organisational forms e.g. a limited liability partnership
- The need to be ensure robust risk management processes
- The need to ensure there is adequate information about the services to be provided to ensure that bidders can price their bids realistically
- The need to ensure that the evaluation of bids does not take place in silos
- The need to ensure appropriate governance around the Programme Board[56]

These findings informed the development of the ISAP process described previously and should be reflected on by other organisations looking to procure complex contracts.

53. ICF International, Dudley Multi-Speciality Community Provider - Public Consultation and Equalities Impact Assessment Report, 2016
54. Ibid.
55. Starling, Anna, Some assembly required: implementing new models of care, 2017
56. NHS England, NHS England review of Uniting Care Contract, 2016

Conclusion

The experience of Dudley CCG in developing their MCP presents some clear learning for the wider NHS. In particular organisations wishing to procure an MCP or alternative model of care should reflect on:

- The time and resource necessary to realise the delivery of an MCP
- The importance in taking time to develop relationships and align organisations behind a shared vision
- The need to engage and develop GPs so they can take an active role in the procurement process
- The need to ensure robust management of conflict of interest
- The importance of undertaking a thorough engagement exercise to build legitimacy for the work and ensure that it properly reflects the needs of the local population
- The need to create space to adequately reflect on the experiences of others in the procurement of complex contracts

GGI is the governance partner of Dudley CCG and is committed to working with the CCG to develop further resources and learning as the MCP develops. We will be hosting a number of events and releasing several publications in the course of 2018 that will present some of the emerging findings and begin to grow the body of knowledge in this field.

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