NHS Long Term Plan – "New Service Model for the 21st Century" – MCP Position

Long Term Plan	Dudley Multispecialty Community Provider (MCP)
• Improved responsiveness of community health crisis response services • Reablement care within two days of referral	• More community-based response to emergencies, particularly in relation to the frail elderly and those in care homes • Urgent Treatment Centre • Continuity of care with integrated practices
• Expanded community MDTs aligned with new PCNs based on neighbouring GP practices	• Population-based and founded upon list-based general practice • Primary care-led model incorporating GPs as significant component of the leadership model • Wide range of integrated services brought together around general practice • Community Integrated Teams = timely input to keep people in their own homes and avoid emergency admission or facilitate timely discharge • Clear community identity and presence consistent with 5 localities • Services delivered from accessible community-based locations
• Significant changes to the GP Quality and Outcomes Framework (QOF)	• GPOF is incorporated within MCP Outcomes and MCP IPS • All GPOF items are allocated an incentive within the MCP IPS to incentivize integrated working between General Practice/rest of the system
• Upgraded NHS support to all care home residents who would benefit • EHCH model rolled out across the whole country	• Whole Population Budget will include budgets associated with emergency admissions due to falls, ambulatory care sensitive conditions and from care homes, incentivizing the MCP to take appropriate preventative measures • Local GP practices/community teams will work together to provide more proactive care that helps patients to remain at home • GP 'ward rounds' for care homes • 'Red Bag' scheme to support residents admitted or discharged from hospital • Community Response and Care Home Support Teams (including out of hours) • Single Point of Access number for support and clinical triage across 7 days • Educational and training support programme for care homes
• PCNs will assess local populations by risk of unwarranted outcomes and work with local community services to make support available where it is most needed	• Integrated Care Teams will work holistically with GPs using formal risk to coordinate evidence-based case management for these patients • Working in partnership with the Council and other stakeholders to tackle the wider determinants of health/health inequalities and build community capacity and resilience
• Greater recognition and support for carers	• MCP will ensure that carers are identified, supported and involved • Carers Strategy seeks to identify/support/involve carers by raising their profile

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	• Carer Support scheme has focused on the development and implementation of a new Carer Strategy • Carers Personal Budgets are offered to carers with eligible needs
• Improving care to people with dementia/delirium in hospital or at home	• Increased emphasis on prevention, self-management, early diagnosis and proactive engagement with people who are at high-risk of developing Long-Term Conditions including Dementia • Voluntary sector support for people diagnosed with dementia • Dementia assessment service, including psychiatric input
• Single multidisciplinary CAS within integrated NHS 111, ambulance dispatch and GP out of hours services	• Integrated online and phone-based referral and information service for all MCP services • At least one local access centre/hub in all 5 localities for extended access 7 days per week.
• Fully implemented UTC model by autumn 2020 with option of appointments booked through a call to NHS 111	• Whole Population Budget will include urgent care centres and primary care out-of-hours services • More community-based response to emergencies that avoids unnecessary ambulance conveyance and admission to hospital
• Improving performance at getting people home without unnecessary delay when they are ready to leave hospital	• Community Integrated Teams will provide intensive support from advanced nurse practitioners working with rehabilitation/social care staff to facilitate timely discharge
• Social prescribing for a more wide/diverse/accessible range of support • Link workers in PCNs will work with people to develop tailored plans and connect them to local groups and support services	• "Integrated Plus" within ICTs work particularly with the most vulnerable people who are often socially isolated and have an unnecessary dependence on health and social care • Link workers are free of professional boundaries and can enable teams to look holistically at individual needs • Supporting community/carer/social networks to help maintain the resilience and quality of life for individuals
• Accelerated roll out of Personal Health Budgets	• Integrated Personal Commissioning and Personal Health Budgets for people with ongoing health needs
• NHS will personalize care, to improve end-of-life care	• Shared care plans will be developed, with a range of personalized services wrapped around the patient to meet their needs, supported by a named case manager and proactive monitoring of progress against the agreed plan • 7-day palliative care team, increased number of advanced care plans, and additional support for end-of-life patients in residential care
• Redesigned services so that over the next 5 years patients will be able to avoid up to 1/3 of face-to-face outpatient visits	• Services will be delivered from accessible community-based locations consistent with the CCG's estates strategy. These will support the movement of services traditionally delivered in hospital to community settings, whilst recognizing the need to deliver some forms of care in settings that do not create stigmatization • Some outpatient services, traditionally provided by secondary care, will be delivered by the MCP • More effective, integrated working between GPs and consultants will reduce unnecessary outpatient attendances

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• Supporting local approaches to blending health and social care budgets where councils and CCGs agree this makes sense	• Whole Population Budget will include services currently commissioned and/or provided by Dudley Borough Council in relation to adult social care • Single legal entity commissioned by the CCG and Council with a single contract • Appropriate joint commissioning arrangements when services are the responsibility of Dudley Council are within the scope of commissioned services or Council staff are seconded to the MCP
• Implementation and delivery of five-year action plan on Antimicrobial Resistance	• Anti-Microbial Stewardship work programme in primary care and collaboration with acute providers • Continuing participation in regional forums
• Local providers will be able to take control of budgets to reduce avoidable admissions, enable shorter lengths of stay and end out of area placements	• Whole Population Budget will include all CCG commissioning budgets for admissions and placements, giving the MCP responsibility to avoid unnecessary admissions and out of area placements
• Appropriate preventative treatments for individuals with high risk conditions, offered in a timely way with support for pharmacists and nurses in PCNs to case find and treat	• Partnership with the Council and other stakeholders to tackle wider determinants of health and health inequalities and build community capacity/resilience • Increased incentives to invest in preventative measures to improve population outcomes • ICTs will work holistically with GPs using risk stratification to coordinate evidence-based case management • Practice-Based Pharmacists will support effective case finding
• Better support from MDTs in PCNs for people with heart failure/valve disease	• Community heart failure team commissioned • Practice-Based Pharmacists have improved mortality rate for hypertensive-related disease
• More to support those with respiratory disease to receive and use the right medication. 90% of NHS spend on asthma • Medicine reviews by pharmacists in PCNs, including educating patients on the correct use of inhalers and contributing to multidisciplinary working	• Whole Population Budget will include some existing out-patient services for adults and children including respiratory medicine • The initial areas where the MCP will align services to achieve continuity of care, working to a set of shared outcome objectives, are with the Long Term Conditions that are most significant to the Dudley population (i.e. diabetology, respiratory medicine, and mental health) • Practice-Based Pharmacists carry out medicine reviews • ICTs will include specialist nursing teams, including for respiratory medicine
• Expand access to IAPT services with a focus on those with long-term conditions	• Majority of services will continue to be provided by DWMHT and subcontracted to them by the MCP • Primary community mental health services and IAPT services priority for inclusion in the MCP ICTs • Integrated service for people with mental and physical health needs • Workforce trained to deliver talking therapies for CYP
• Integrated primary and community mental health care supporting adults with severe mental illnesses	• Physical and mental health services will be integrated • Whole Population Budget will include all CCG-commissioned mental health services
• Direct access to MSK First Contact Practitioners (FCP)	• First Contact Practitioners are operating in 5 practices in 2018/19, will be extended across Dudley in 2019/20

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