Thinking Differently

NHS
Dudley
Clinical Commissioning Group

Prospectus for the Procurement and Commissioning of a Multi-Specialty Community Provider (MCP)

Document 11

Dudley Clinical Commissioning Group

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A. Background

1. Dudley CCG was selected to join NHS England's Vanguard Programme in early 2015 with the intention to develop a new care model – the Multi-Specialty Community Provider (MCP). Since that time the CCG has been working with local partners and stakeholders on the development of the MCP.

2. The CCG now wishes to take this to the next stage of development by entering into a procurement process leading to the award of a contract and the commissioning of a MCP. This will be consistent with "The Multi-Specialty Community Provider (MCP) Emerging Care Model and Contract" Framework https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf. Relevant page references are shown below.

3. This represents a significant and unique opportunity for potential partners. The MCP will bring together services in an integrated service model and in a manner that has never occurred before in the history of the NHS. Through a series of multi-disciplinary teams, the MCP will support people in their homes and communities, working with all partners to enhance individual independence, prevent unnecessary admissions and facilitate speedy discharges (page 4).

4. It will be unique because:-

   - physical and mental health services will be integrated;
   - some out-patient services, traditionally provided by secondary care, will be delivered by the MCP;
   - primary care, delivered by general practice, will be at the heart of the delivery model building on our new contractual framework for primary medical services;
   - these services will operate within the MCP alongside voluntary sector services;
   - the contract will be based upon a single, whole population budget with a duration of 15 years;
   - the MCP will have the right to determine how that budget is utilised to meet a set of outcomes;
   - the contract will be designed to deliver those outcomes and will include a performance related payment mechanism.

5. The CCG wishes to work with partners who share the vision for our new care model and consider that they have the right qualities to respond to the

challenges ahead.

6. This will redefine the relationship between commissioner and provider with the ultimate aim of delivering better, more integrated care and reducing health inequalities.

7. This prospectus describes the CCG's intention to procure and commission a MCP. It should be read in conjunction with a number of other supporting documents including:-

- The multi-specialty community provider (MCP) emerging care model and contract framework
- Service Scope
- Service Outcomes
- Practice Scope
- Population Scope
- MCP Contract
- Financial Modelling
- Procurement Timetable

8. The service scope, outcomes and characteristics were the subject of a consultation process from July to September 2016.

9. The complexity of this development will require a lengthy mobilisation process following agreement of a contract with a successful bidder. It is anticipated that a contract will be awarded and signed by 1 April 2018. Mobilisation will take place thereafter with full mobilisation expected by 1 April 2019.

B. Services to be provided

10. The Service Scope sets out the full range of services to be provided by the MCP. The MCP will be expected to demonstrate the highest level of commitment to community based service delivery and implementation of the MDT based service model (see below).

11. Essentially, the MCP will manage a whole population budget for the following: -

- community based physical health services for adults and children;
- some existing out-patient services for adults and children including ophthalmology; urology; respiratory medicine; gynaecology; diabetic medicine; dermatology; rheumatology; general medicine; and geriatric medicine amongst others;
- primary medical services provided by general practice;

- local improvement schemes currently provided by general practice;
- urgent care centre and primary care out of hours service;
- the budgets associated with emergency admissions due to falls, ambulatory care sensitive conditions and from care homes;
- all CCG commissioned mental health services;
- all CCG commissioned learning disability services;
- intermediate care services and services provided for people assessed as having NHS Continuing Healthcare needs;
- end of life care;
- voluntary and community sector services;
- services commissioned by Dudley MBC's Office of Public Health including health visiting, family nurse partnership, substance misuse and sexual health services;
- services currently commissioned and/or provided by Dudley Metropolitan Borough Council in relation to adult social care;
- activities currently carried out by the CCG including, in whole or in part, service redesign; financial management; information technology; business intelligence, patient and public engagement, safeguarding, complex case management; NHS Continuing Healthcare and intermediate care assessment; and medicines management.

12. In the first instance, this may involve the MCP sub-contracting with other service providers in order to maintain service stability. Other services will be phased in over time, depending upon the expiry date of existing contracts and subject to the agreement of a suitable mobilisation plan.

13. Whilst currently out of scope, the MCP will be expected to develop effective working relationships with the emergency ambulance service with a view to reducing unnecessary conveyances and resultant admissions, through gate keeping, triage and the development of alternative services.

C. Population to be served

14. The MCP will receive a single, whole population budget for patients registered with those practices who are part of the MCP and non registered patients resident in Dudley (page 28). On the assumption that every practice is part of the MCP through either a "partially" or "fully" integrated model (page 6 and pages 20 – 21), the MCP will cover 46 practices and a population of c 315,000 (page 5). The relevant practices are set out in the supporting documentation.

15. For public health and social care services, the population served will be the Dudley resident population.

D. Joint Strategic Needs Assessment

16. Our JSNA sets out a number of key messages:-

- nearly 20% of our population have a limiting long term illness or disability, this has increased since the 2001 census and is worse than the national average;
- the gap in life expectancy for the least and most deprived areas of Dudley has widened, mostly due to CHD, COPD and lung cancer in men;
- the mortality rate in the 60 -74 age band is significantly higher for males;
- female life expectancy is 82.7 years – similar to the national average, whilst male life expectance is 78.5 years – lower than the England average of 78.9;
- male life expectancy varies across Dudley. Halesowen South has the highest at 82.1 years, Netherton, Woodside and St. Andrews have the lowest at 73.9 years – a gap of 8.2 years;
- female life expectancy varies across Dudley. Belle Vale has the highest at 86.7 years, Castle and Priory has the lowest at 79 years – a gap of 7.7 years;
- nearly a quarter of deaths in the 40 – 59 age band are due to cardiovascular disease, smoking, obesity and lack of physical activity;
- mortality from respiratory disease is significantly higher than the national average. Lower respiratory tract infection is the major condition;
- mortality rates for alcohol related diseases are significantly higher than the national rate and the years of life lost in the under 75s from chronic liver disease, including cirrhosis, is significantly worse than the England average;
- emergency admissions for alcohol specific conditions increases from the 40-59 age group;
- 12.1 % of adults aged 16+ participate in sport for 30 minutes, 3 or more times per week, showing a downward trend and below the national average of 17.4%;
- the percentage of people aged 16+ with a high BMI is significantly worse than the England average;
- nearly two thirds of ED attendances are for people living in the 40% most deprived group in Dudley;
- the next two decades are forecast to see an additional 25,100 people over the age of 65 and an extra 9,900 over 85;
- uptake rates for both cervical and breast cancer screening are below the national target of 80%;

- disease prevalence rates as determined by primary care disease registers are low compared to modelled prevalence, however, these have improved – most markedly for COPD;
- the rate of delayed hospital discharge attributable to social care is higher than the national rate;
- the CCG is in the worst performing fifth of CCGs for the percentage of ED attendances that result in emergency admission;
- emergency admissions for gastroenteritis and lower respiratory disease are increasing for the 60 – 74 age band;
- emergency admissions for gastroenteritis in the 75+ age band are increasing;
- 20% of single person households are in the 60+ age group;
- there are an increasing number of older people who are carers of older people, or who are carers of adult children with learning or physical disabilities;
- the rate of deaths at home or in care homes has fallen from 53.05% to 51.9% but there is a higher percentage of terminal admissions that are emergencies than England;
- Marmot indicators show that Dudley has a higher rate for long term claimants of Job Seeker's Allowance than the rest of England and a higher percentage of high fuel cost households in fuel poverty.

17. For our children and young people:-

- the infant mortality rate is 4.5 per 1,000 live births, compared to 4.3 for England and Wales;
- male babies born in the most deprived areas of Dudley are up to 4 times more likely to die than those from the more affluent areas;
- the percentage of pupils in school Reception and Year 6 with a healthy weight is significantly worse than the England average;
- emergency hospital admissions for 0 – 4 year olds have risen. This is particularly prominent for lower respiratory tract infections in the most deprived areas;
- the proportion of 9 and 11 year olds with a high self-esteem score has risen, though 25% of pupils reported bullying. The proportion of 13-15 year olds reporting being bullied has risen to nearly 20%;
- the CCG is in the worst performing fifth of CCGs for the rate of young people aged 0-18 with 3 or more mental health admissions per year;
- the looked after children prevalence rate is significantly higher in Dudley and double the national rate;
- smoking at delivery was 14.3% in Dudley, higher than both England and

the West Midlands;

- Marmot indicators show that Dudley is significantly worse than the rest of England for children achieving a good level of development by age 5;
- the percentage of pupils achieving 5 or more GCSEs at grades A*-C; percentage of pupils eligible for free school meals achieving 5 or more GCSEs at grades A*- C;
- breast feeding initiation rates at birth and at 6-8 weeks are lower than in England. These are also lower in the more deprived parts of Dudley and in younger mothers.

18. Further detail can be accessed through the "All About Dudley Borough" web site http://www.allaboutdudley.info/AODB/navigation/home.asp.

E. Characteristics of the MCP

19. Discussions have been held with members of the public in Dudley and the feedback received consistently was that any local transformational change led by the MCP should deliver the following broad based outcomes:-

- **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.

20. The MCP is responsible for 4 key aspects of population health management (page 5) because it will:-

- improve health status;
- provide accessible urgent care (access);
- provide joined up care for people with continuing needs (continuity);
- provide intensive care for patients with the highest needs (coordination).

21. The key characteristics that would help define the MCP are set out below. The characteristics are not exhaustive and should be viewed as a minimum. It is expected that through a process of competitive dialogue, the aspirant MCP will provide further definition.

F. The Organisation

a) Single legal entity

22. The MCP will be a single legal entity (pages 25 – 26), commissioned by the CCG and Dudley Metropolitan Borough Council and holding a single contract, based upon a whole population budget. It is not a partnership or alliance of separate providers.

23. Where services which are the responsibility of Dudley Council are either within the scope of commissioned services, or Council staff are seconded to the MCP, appropriate joint commissioning arrangements will be developed using Section 75 of the Health and Social Care Act 2006.

24. The contractual form entered into will have the flexibility to provide for the inclusion of primary medical services currently provided under GMS, PMS or APMS contracts, in accordance with the national MCP framework, through a "partially integrated" or "fully integrated" service model (pages 23 – 24).

b) Commissioned to deliver outcomes

25. The MCP will have a compelling vision and clear strategy for managing and delivering clinical, patient and service user outcomes as specified in its contract. The MCP will have the "right of decision" in terms of determining how the whole population budget is allocated to deliver contracted outcomes.

c) Quality and safety

26. The MCP will be expected to demonstrate the highest level of commitment to service quality and patient safety.

d) List-based general practice at the centre

27. The MCP is population-based and founded upon list based general practice (pages 4 and pages 26 and 27). A core function of the MCP will be to support a primary care led model of care incorporating GPs as a significant component of the leadership model for the MCP. The MCP will be an engine for the strengthening, renewing and sustaining general practice. The MCP brings together a wide range of integrated services around general practice, removing historic barriers to care delivery.

e) Governance, leadership and public accountability

28. The MCP is based upon the principle of mutuality:-

- clear accountability to the public for the delivery of high quality care within the resources available;

- emphasis on co-production of care and maximising the potential of the individual;
- promoting responsibility for individuals to manage their own health and wellbeing and to access services appropriately.

29. The MCP is a community based organisation. Unlike any other existing NHS organisation of this scale, patients will register with it. Its success, in part, will be based upon the development of strong local relationships with and trust from the community it serves. Beyond the provision of integrated health and care services the MCP will have wider responsibilities as:-

- a catalyst for improving the health and wellbeing of the local population;
- a good "corporate citizen" and agent of social value;
- a good employer;
- a significant player in the local economy.

30. It will be accountable to key local stakeholders through a variety of mechanisms. Stakeholders will include:-

- patients
- the public
- its staff
- the CCG
- the Council
- regulatory bodies
- local employers
- civil society

31. This will begin with a clear and transparent governance structure and set of ethical standards consistent with the 7 Nolan Principles of:-

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

32. The governing body, consisting of executive and non-executive members, will be reflective of the community served. The executive element will recognise the clinically led nature of the organisation and the range of "specialties"

constituting the MCP. The non-executive element will be recruited on the basis of:-

- a full audit of the skills necessary to fulfil the non-executive function;
- recognition of the diversity of the population served;
- a recognition of the Davies Report's recommendations on gender balance and the "25% target" for boards.

33. Meetings of the governing body, regardless of legal form, will be conducted in public, in accordance with the principles of the Public Bodies (Admissions to Meetings) Act 1960.

34. Other accountability mechanisms, aside from contractual responsibility to the CCG and Council, regulatory accountability to NHS Improvement/the CQC and the exercise of the Council's scrutiny function, will include:-

- clear statements to patients and the public of the service standards they can expect;
- an annual report which will include its performance in meeting these;
- a "contract" with the Health and Wellbeing Board to improve the health status of the population through the use of a population based budget and agreed outcome measures;
- reference groups derived from the local population to help determine how limited resources should be spent and how community assets can be mobilised to create resilience (page 12);
- clear links to the voluntary sector and a role for the sector in decision making;
- the use of patient feedback to enhance the care experience.

35. The CCG has engaged the Good Governance Institute to work alongside the successful MCP bidder to develop its systems of governance.

G. People

a) Values

36. The MCP will be a values based organisation, where strong patient centred values are a mechanism to drive improvements to the quality of care and the experience of the patient. Organisational values, staff values and societal values will be congruent and consistent with the finest features of public service in general and the NHS in particular.

b) The best place to work

37. The MCP will be a major local employer. Its employment practices will make

it the employer of choice for staff. It is anticipated that it will seek to recruit, train and develop staff from amongst the local population.

c) Workforce development

38. The MCP will identify, recruit and retain an appropriately skilled and adaptable workforce ensuring there is on-going commitment to workforce development and an emphasis on joint working, supported by a culture of collaboration, quality and patient care. Staff will be empowered through a model of distributed leadership where they take responsibility for their performance and hold each other to account. Clinicians and managers will be supported to work in different ways as part of multi- disciplinary teams, making use of new roles (page 10).

H. Relationships with the local system

39. The contract will place a requirement upon the MCP to cooperate with local partners and stakeholders. Key local relationships are described below:-

a) The Clinical Commissioning Group and Dudley Metropolitan Borough Council – The Commissioners

40. The CCG and the Council will be the MCP's co-commissioners as part of an evolving partnership between these bodies. Subject to the outcome of consultation by NHS England on the national contract, a single contract will be held with the MCP as a defined legal entity. Appropriate arrangements will exist where services are commissioned jointly with the Council. The contract term will be up to 15 years. The MCP will be held to account for the delivery of the outcomes set out in the contract through appropriate contractual management mechanisms. In addition, a number of existing CCG functions will be delivered by the MCP including: -

- safeguarding
- patient and public-engagement
- medicines management
- financial management
- business intelligence
- service redesign
- NHS Continuing Health care and intermediate care assessment

b) Primary medical service providers

41. As a list based entity the MCP will have general practice at its heart. The aggregation of the populations of those practices opting to integrate with the

MCP through the partially or fully integrated route, together with non-registered Dudley residents, will constitute the MCP's population upon which its budget will be based.

42. For Council commissioned services, the MCP will serve the resident population of Dudley Borough.

43. Whilst it is the clear intention of the CCG that all Dudley responsible practices should be "members" of the MCP, where this is not the case, the CCG will contract separately with the MCP to deliver services to the populations of those "non-member" practices.

c) Other providers

44. The contract will define the nature of the relationship the MCP will have for those providers delivering non MCP services to the Dudley population. This will include appropriate gain/loss share agreements.

45. In some instances, the MCP will have sub contract arrangements in place with these providers. In other instances services with contracts which run beyond 1 April 2018, will be within the scope of this procurement with those services becoming the responsibility of the MCP upon the expiration of existing contracts. These will include: -

- Dudley Urgent Care Centre
- Contracts with NHS providers for services in scope
- End of life care
- Intermediate care
- NHS 111
- Voluntary sector organisations providing scope services
- Dudley MBC commissioned health services

d) Dudley MBC

46. Children's social care will not be provided by the MCP at the present time.

47. The MCP will recognise, value and promote the role of social care and social work in the delivery of the service model and the contribution both can make to overall health and wellbeing.

48. Dudley MBC employed staff responsible for the provision of adult social care may be seconded to the MCP using arrangements under Section 75 of the NHS Act 2006.

49. Dudley CCG and Dudley MBC will develop a plan setting out how health and

social care will be integrated by 1 April 2020, in accordance with national requirements. The MCP will be the main delivery mechanism for achieving this change.

50. The MCP will be subject to scrutiny by Dudley MBC's Health and Adult Social Care Scrutiny Committee and have a relationship with the Health and Wellbeing Board (see above).

e) The local community

51. The MCP will empower and mobilise patients, their families, carers, communities, local employers and the voluntary sector (page 12).

52. There is a growing body of indicators which estimate the economic value of contributions made by different elements of voluntary activity, including:-

- volunteers;
- carers;
- voluntary and community sector organisations.

53. The MCP will work effectively and collaboratively with the voluntary and community sector ensuring there is parity of esteem between sector led services and initiatives and traditional health and care services.

54. The MCP will work in partnership with the Council and other stakeholders to tackle the wider determinants of health; health inequalities; and build community capacity and resilience.

55. In addition, it will work with other public service partners such as the police and fire services to develop innovative solutions to improve health and wellbeing.

56. Through active patient engagement and community involvement, the MCP will support participation by both individuals and communities in decisions about their health and care services, as well as promoting education, self-management and peer support (page 12). In this respect the MCP will be expected to work closely with Dudley's Young Health Champions.

57. The MCP will have a clear community identity and presence consistent with Dudley's 5 localities. Services will be delivered from accessible community based locations consistent with the CCG's estates strategy (page 5). 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 stigmatisation. Some of these services may be the responsibility of other providers but they will be co-located with MCP services.

58. Subject to agreement about the eventual legal form of the MCP entity, any surpluses generated by the MCP will be reinvested into services in the local community through an "asset lock". The MCP must have the capacity to generate alternative sources of funding outside of NHS contracts.

f) Social value

59. The MCP will operate in accordance with the requirements of the Public Services (Social Value) Act 2013 and identify opportunities to secure wider social, economic and environmental benefits from its activities.

I. Service delivery

a) Processes

60. The MCP will:-

- bear financial risk and will ultimately be able to bear wider hospital utilisation risk through a gain/loss share arrangement with secondary care;
- ensure appropriate financial and risk management controls and processes are in place to identify and manage clinical safety, financial and reputational risks. These will be mitigated through early identification and action;
- ensure and demonstrate effective and responsive performance measurement, analysis, reporting and improvement processes aligned across all partners;
- ensure clear processes are in place, enabling coordinated service delivery and alignment across partner organisations delivering health and care services (page 15).

b) Key principles for team working

61. Effective integrated and coordinated care will be underpinned by a robust operational model (page 15). Common working principles will be established to enable teams to operate on the basis of:-

i) Shared values

62. Values are important to ensure the teams are working in a unified, collaborative and cohesive manner. This entails ensuring mutual respect and working as equal partners to a common goal and ensuring that this translates into patients' experience of health and care.

ii) Shared vision

63. This principle covers how teams visualise the impact of their input and develop a common understanding of the objectives to be achieved including the steps or processes the team has to put in place to achieve them. Working collaboratively requires a common perspective or orientation, a shared understanding of the issues and possible solutions. This generates the enthusiasm that is required to fuel the team towards their objectives and outcomes.

iii) Shared population

64. Teams will be responsible for a defined population – a sub-set of the MCP population – in effect the registered population of a general practice, or a derivative of this.

iv) Shared decision making

65. There will be a process and culture of problem solving and patient goal setting which is consistent with patient values and the values of the team itself. Decision making should be driven primarily by the needs of patients rather than the construct of organisations which can often constrict the response.

v) Shared responsibility

66. Working for the same population gives the team a shared responsibility for the outcomes for that population, for which they will be held to account individually within the team and collectively within the MCP.

J. Use of Digital Technology

67. Technology will be used to redesign care, provide interoperable records, modern business intelligence and data analytics (page 10).

68. Technology and integrated care systems are used to enable the delivery of outcomes, ensure that care is centred on the patient and information is used to support and manage service improvement.

69. Additional key characteristics are as follows:-

- a single central repository of shared information accessible by all members of the MCP and patients;
- integrated care records, updated in real time and centred around the individual;
- multiple access channels;
- able to support multiple teams and extend to meet future service

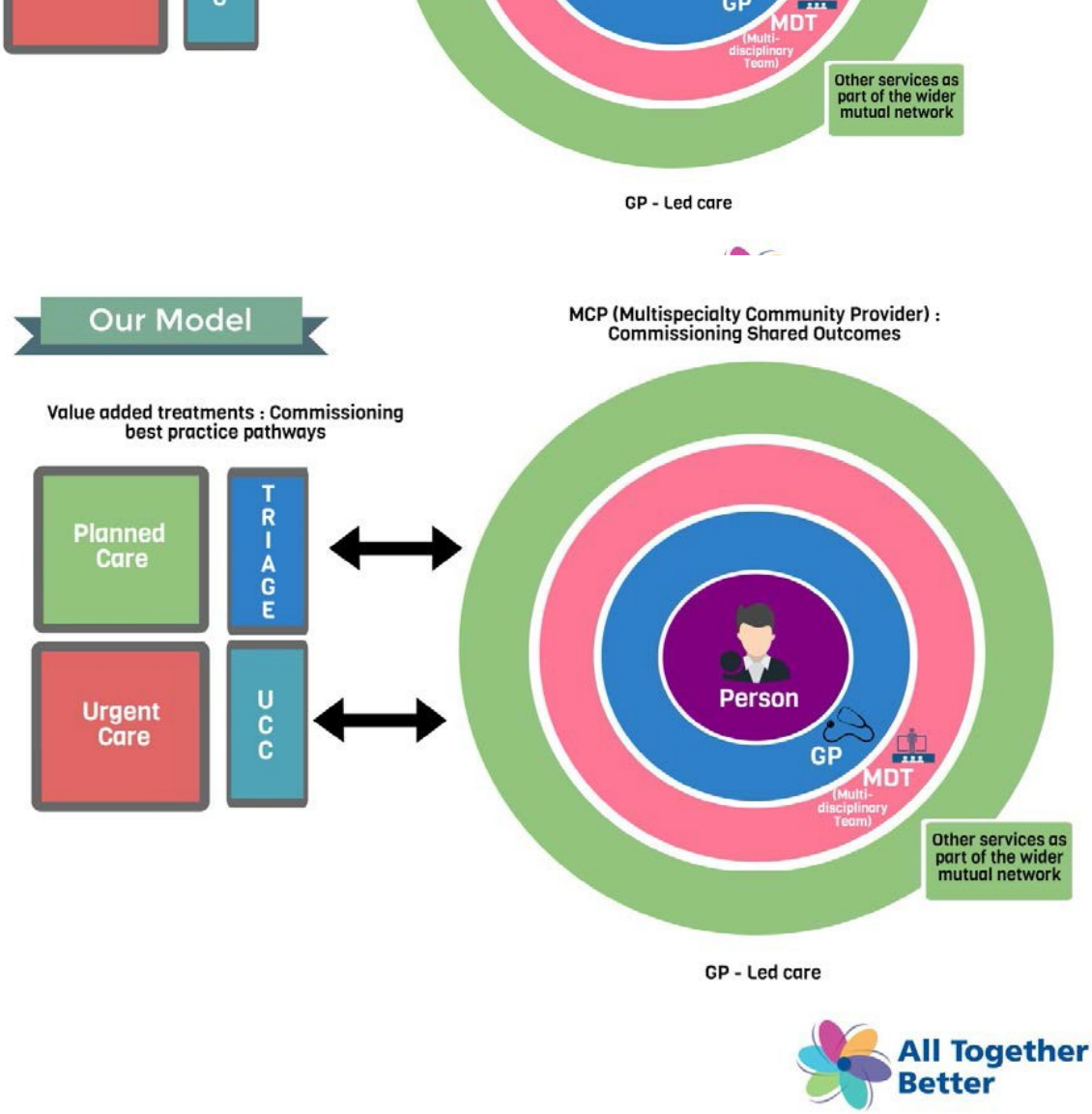
integration supporting collaboration across teams and organisations;

- risk stratification to include primary and secondary care data;
- advanced analytical capabilities enabling pattern and anomaly detection;
- clustering and building predictive models to improve patient outcomes and reduce costs;
- capability to support integration with emerging technologies and apps;
- single sign on and role based access controls;
- electronic delivery of documentation across the system;
- scalable infrastructure solutions with inbuilt resilience, preferably in the cloud;
- high data quality standards, policies and processes applied across the system, ensuring data quality principles are adhered to;
- flexible and powerful business intelligence and reporting tools to meet current and future reporting requirements, including performance, financial and management data both internally and for the CCG;
- data sharing enabled via a system wide Information Governance Protocol and data sharing agreements with Information Governance standards meeting NHS IG framework requirements;
- implement Epacs system in line with digital roadmap timescales;
- implement processes and technological solutions for the Integrated Referral and Information System;
- meet all requirements to support the local digital roadmap.

K. Service delivery model

70. The model of service delivery will be built on the three pillars of access, continuity and coordination (page 15):-

- the majority of our population want **enhanced access** to care. They want more flexibility in the time and mode of access;
- many, especially those with long-term conditions (LTCs), want **improved continuity** of care. They want more consistent and proactive services that support them to manage their conditions and achieve their goals. They have needs (mental and physical) that are independent and that change; they expect services to do the same;
- some, notably those with multiple co-morbidities, those with frailty and those nearing the end of life, want **better coordinated** care. They want the services that are supporting them to work closely together, integrating (rather than duplicating) care closer to home and improving the experience of it.



a) The centrality of general practice

71. This represents a fundamental shift in providing care to an ageing population with multiple chronic conditions in an integrated manner, as opposed to supplying the predominantly episodic and curative interventions that typifies care at present.

72. The MCP's service delivery model addresses these imbalances. It is based upon the unique position of primary care - starting with the person, registered with the practice with the role of the GP being fundamental. General practice takes overall responsibility for the care provided by other services. These services will include multi-disciplinary teams (MDTs), a wider network of community based and voluntary sector services organised around Dudley's five localities, and the services provided on referral to secondary care.

b) Pathway management

73. The diagram above illustrates this. Outside the MCP the CCG will commission value-added treatments provided from secondary care services. We are changing the way that we commission these services. This means

moving away from current item-of-service payment mechanisms to commissioning best practice pathways of care. We expect this to form part of a gain sharing arrangement between the CCG and the MCP in the future as the MCP takes on the demand management of value added treatment services (page 18).

74. In essence, the MCP will be the catalyst to shift the locus of care from the hospital to the community.

c) Continuity and coordination at every level

75. Dudley's population requires improvements in access, continuity and coordination. This understanding therefore provides a set of organising themes for the MCP. These themes can then be used to inform improvements at multiple levels: from the individual, up to the GP and the practice, to the locality and whole system. Indeed, we see acting at multiple levels as a pre-condition for our success. The table below shows the types of change needed to be delivered by the MCP at different levels – and the outcomes that will result.

	General population	People with LTCs	People with frailty and those nearing the end of Life
System	New Urgent Care Centre; specialist triage services; single patient portal	Consultants providing advice / support working in the community to the same outcome basis	Geriatricians supporting MDT-led frailty pathway, removing all transfers of care
Locality	Estate solution: developing community-hubs to improve accessibility 7 days a week; community MRI Near patient testing;	Telehealth; direct access to services; Connecting to other public services and the voluntary sector	Lead GP co-ordinating locality approach; Falls prevention; telecare; dementia gateways, integration plus, care homes, palliative care
Practice	Avatar and centralised systems for enabling	Named primary point contact	MDT as the locus of of coordination
GP	GMS +	LTC framework, outcome based, prioritising hypertension and depression	GP as Lead co-ordinator of care
Person	**Access**	**Continuity**	**Coordination**
Outcomes	*Improved patient experience, more efficient and effective utilisation, healthier lifestyles*	*Stable management of conditions, reducing risk, reducing variation and the health inequalities gap*	*Reduced social isolation, improved EOL care, enabling individuals to remain connected to their community in their*

76. This implies significant additional activity in primary and community settings. The MCP starts with the person, registered with the GP who then brings in and coordinates services in the community – including those provided by the voluntary sector.

d) Empowering patients to set their goals and manage themselves

77. The MCP will reshape the relationships between services and citizen. Healthcare's success has been founded upon the specialist training and knowledge of clinicians. However, we have not made sufficient use of the specialist knowledge and experience of our patients. Only they can define the

goals that matter to them - and only they will know whether and how possible courses of treatment will fit with their lives. The MCP will combine these types of knowledge, especially when it comes to managing long-term conditions and combinations of mental and physical health needs.