BMA

England

Focus on MCP Contract Framework

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Overview

In October 2015, the Prime Minister announced the intention to create a new 'voluntary' contract for GPs in England that would provide 'at scale' general practice (i.e. over populations of at least 30,000-50,000 patients, but possibly larger depending on the services they cover). Over the last 6 months this has been developed by NHS England via the MCP Contract Development Group, resulting in the publication of the multispecialty community provider (MCP) emerging care model and contract framework. It is expected that the draft contract will follow at the end of September.

It should be noted that whilst the GPC has a seat on this group, that should not be interpreted as endorsement for the proposals under development. Whilst supporting the principles of integrated care, the GPC remains concerned by the apparent longer-term movement away from the national GMS contract, particularly outside of any formal negotiations, and continues to believe that the key aims of the MCP contract can be met within the existing framework and protections of the national GMS contract.

This paper summarises the main contractual elements contained in the MCP contract framework, the key concerns about the contract and the GPCs proposed alternative.

Background

What is the MCP voluntary contract?

NHS England's Five Year Forward View set out a number of NMCs (New Models of Care) that NHS England believes represent ways to provide integrated care to patients, and which are being trialled at 50 'Vanguard' sites across England.

MCPs (Multi-speciality Community Providers) are one of these new care models (and there are 14 MCP vanguards): a population based model of care that integrates primary and community health services, built upon the GP registered lists of the practices involved. In order to do this, individual practices will have to combine together, either through a GP network organisation or a super-practice, to create a combined patient list and bid for an MCP contract from their local commissioner. The MCP contract will be aimed at practices who wish to work within this new integrated care model, covering populations of at least 30,000-50,000 patients, and, as currently constructed, will run entirely separately to the national GMS contract.

The MCP contract framework document sets out the way in which MCP the contract is envisaged to work by NHS England, along with how NHS England expect aspirant MCPs to develop towards qualifying for full MCP contractual status, or a partially-integrated MCP.

What are the contract proposals in the framework?

Contractual Form

The framework outlines 3 contractual paths for practices:

- Virtual MCP
- Partially integrated MCP
- Fully integrated MCP

NHSE will develop two model contracts, one for partially integrated MCPs and one for fully integrated MCP.

Virtual MCPs

Providers of services that come within the scope of an MCP would enter into an 'alliance agreement' with the commissioning body, which would overlay (but not replace) regular commissioning processes, setting out an agreement to achieve greater integration of these services (e.g.. shared managing of resources, governance arrangements, risk sharing agreements, operational delivery of services). The services themselves would remain governed by the regular commissioning procedures and contracts.

Partially integrated MCPs

This model would provide a single contract for everything that would otherwise be in scope of the full MCP, outside of core general practice. This could include some aspects of local enhanced primary care services, and by agreement could also include QOF and some DESs. Whilst practices may still hold their GMS/PMS contracts, anything beyond that would require them to form a joint legal entity in order to bid for the contract for any services beyond it. The legal agreement between the practice and the MCP would set out the additional obligations to each other, beyond those contained within the practice's core contract (for example, the MCP could subcontract services to non-member practices). The contract holder would then be required to integrate these services directly with core primary medical services.

Fully integrated MCP

This will see primary care and community services procured in a single contract between a single legal entity and the relevant commissioning bodies, holding a single whole population budget. It is understood that the full MCP contract will take the form of a hybrid of GMS/PMS or APMS and the NHS Standard Contract, held between the legal entity of the MCP and the commissioning bodies relevant to the respective service specification (CCG/NHS England/Local Authority). It is proposed that the contract will run for a limited period of 10-15 years, and include an early break opportunity (e.g. at 2 or 3 years), to allow for a break right or evaluation of the development of the MCP and the services provided under the contract.

GPC has continually highlighted the importance of practices being able to maintain their GMS/PMS contracts. NHS England has investigated an amendment to primary care legislation, which, for full members of the MCP, will allow for the existing GMS/PMS contracts of the member

practices to be 'suspended' for a defined period of time that aligns to the MCP contract term, and with an option to reactivate them at a later date should the respective contractor so wish. This does not address any related practical implications of such a switch which may still exist e.g. estate ownership. Further details on this are awaited.

Service Specification

The individual contract will define the exact range of services to be covered within the boundaries of nationally set minimum and maximum parameters- i.e. a 'core' service specification upon which local variations can be added – and with a process to allow this to be varied over time. The specification will consist of national requirements, core elements of the MCP care mode, and local service requirements and standards. To maintain some degree of consistency nationally, any local variation will need to follow a set of standard terms, effectively providing the MCP with a menu from which they can tailor their individual service specification.

Potentially all health services that do not need to be delivered from a hospital could be in the scope of the MCP. The MCP will also become responsible for managing hospital activity levels within their geographical area. This is stated as aiming to incentivise population health management by the MCP.

Funding

MCP funding is proposed to comprise of 3 main components that combine to create an 'MCP contract sum':

i) A base £ per head for the MCP's registered list (i.e. the combined lists of all constituent practices) to create a single whole population budget (WPB). This will initially be calculated based upon the current commissioner spend over the scope of the service specification. The intention is for WPBs to be multi-year and to be adjusted in line with changes in CCG allocations. There is also the expectation that MCPs will become more efficient over time and that this is reflected in the funding.

ii) Performance pay. Whilst the MCP will not be subject to QOF, there will be a performance related pay system in place. This will be set for the MCP as a whole, with the details of how it fulfils the criteria internally up to the MCP itself. The MCP pay for performance scheme will recycle monies from the existing CQUIN and QOF schemes. This could constitute up to 10% of the MCP contract value (QOF currently accounts for 8%). The scheme will consist of a nationally designed framework, with scope for local tailoring.

iii) The effect of any risk sharing agreements with local acute providers, which will complement the whole population budget (WPB). This is "to ensure that the payment system does not inhibit the path to transformational, system-wide change"[1]. An example would be an aim to reduce avoidable activity in secondary care.

[1] The multispecialty community provider (MCP) emerging care model and contract framework

Procurement

The procurement of a full MCP contract would seem to open up a number of problems. Under EU law, from 1 April 2016 anything over £750,000 must go to open tender. This presents a number of possible risks – not least that the GP led MCP organisation may not necessarily win the MCP contract for their area and the framework mentions that procurement law would need to allow a range of organisations to set up MCPs or PACS, including non-GP led bodies (such as acute Trusts or commercial organisations).

To counter this to some degree, NHS England proposes that the initial PIN (Prior Information Notice) put out to advertise the contract would, amongst other things, encourage prospective bidders to demonstrate that they had the support of local GPs (GPs could support more than one bid if they so wished). NHS England acknowledges that "this does not mean that GPs have preferred provider status for the MCP contract", but also that "under no outcome would they lose their right to continue to provide primary medical services[2]".

It is understood that NHS Improvement is minded to retain these procurement rules, despite the UK's decision to leave the European Union.

Right of return

NHS England proposes that MCP practices retaining their existing contracts in a 'suspended' form would enable a right of return to their previous arrangements should they wish to leave the MCP. The reality, however, is likely to be far less straightforward. Once a practice joins an MCP, it is hard to envisage how it could effectively or easily disentangle itself, unless the legal structure of the MCP legal entity has been very carefully constructed, to ensure that a practice can disentangle its patient list, finances, premises and staff from the group, especially a few years into the project. Even then, if a single, or small number of practices choose to leave, they would effectively be in competition with a much larger rival provider within their immediate local area.

NHS England has confirmed that it will be working with GPC and vanguards to establish how a right of return could work.

Other Considerations

The following topics are either not covered directly, or are mentioned very briefly in the framework.

Employment models & conditions

There is no explicit mention of what employment models should be utilised within MCPs. NHS England is clear that each MCP will be allowed to organise its workforce as it feels best fits with its organisation structures, meaning locally negotiated employment contracts. As the contract will not be GMS, it will presumably not retain the requirement to offer terms equal to the model salaried contract for any employed GPs, unless they are employed by an individual practice which maintains an active GMS contract.

[2] The multispecialty community provider (MCP) emerging care model and contract framework

Regulation

It is proposed that the CQC could inspect the MCP as a whole, rather than the individual practices, and includes governance structures and accountabilities within its assessment criteria. This would aim to reduce the burden on individual practices, but a decision would depend on the exact organisational model of the MCP.

Indemnity

NHS England and the Department of Health will work with the NHS Litigation Authority to provide information to potential MCP providers on their options of securing cover.

This would remove indemnity costs from individuals, transferring them to the MCP's corporate body. The framework document lacks detail on this as well as the treatment of VAT.

Pensions

There was a concern that income derived under arrangements where the MCP is lead provider and GPs and others are engaged under sub-contracting arrangements would not be pensionable for the purposes of the NHS pension scheme. It has been agreed that the regulations will be amended to allow GMS/PMS contractors to pension subcontracted income subject to certain conditions.

GPC View

GPC believes that it is vital that practices are able to be involved in an MCP while retaining their national GMS/PMS contracts, and NHS England's proposals for the option for a 'virtual' MCP and 'partially-integrated' MCP are therefore extremely important. GPC retains a number of concerns about the MCP contract proposal. The key aspects of its concerns are summarised below:

Move away from national contracting

Using national specifications to stipulate basic elements of general practice which must be provided by all MCPs does not go far enough in ensuring a consistent standard of care to patients regardless of postcode. The national GMS contract for essential services underpins fair and consistent health service delivery in England. The NHS has benefited over the years from a registered list based contract, which has provided continuity of care through perpetuity. Anything which threatens to disrupt this needs to be considered with great care.

We therefore believe it would be inappropriate for flexibilities and freedoms from national standard contract requirements to apply to core general practice. History demonstrates that a national contract provides a straightforward and transparent vehicle for the implementation of national policy objectives, providing consistent quality care for patients and flexibility to build on locally.

A significant move towards a locally determined contract could undermine the collective bargaining rights for remaining GMS practices, and the disparate forms of locally determined employment models would likewise do so for the nationally negotiated model contract for salaried GPs.

Procurement

Under current procurement law, all proposed healthcare contracts over 750,000 Euros must be advertised. Consequently, an MCP contract is likely to be required to go through an open procurement process. Whilst NHS England has tried to put in place some measures to account for this (the need for GP support within the PIN), it raises the very real prospect of general practice being outsourced to private corporate entities via MCPs, with no guarantee that such an open procurement process will result in local GP led organisations winning the resultant contract. In such a situation local practices would potentially find themselves set in competition for patients against the emerging MCP body commissioned by NHS England to provide a much wider service than available through traditional general practice. It is understood that NHS Improvement is minded to retain these procurement rules, despite the UK's decision to leave the European Union.

Right of Return

Should GPs leave the national contract to move to separate MCP contracting arrangements GPC is, in theory, supportive of the creation of a binding right of return to GMS or PMS contracts. However, we believe that such as right of return is likely to continue to be illusory in practice. To name just a few complicating factors:

- Practice premises might have changed hands or be leased out.
- Practice staff may have been transferred to the MCP organisation.
- In a full MCP the registered lists will have been merged. It is not clear how these could be subsequently disentangled.
    - There would be no guarantee for practices to return to their contracts for services beyond core GMS, for example local primary care services contracts.
- Practices leaving poses a threat to stability of remaining MCP. NHS England's proposal to counter this by only allowing a right of return to coincide with a contractual break point 2-3 years into the contract severely limits its scope and effectively creates a point of no return for practices.
- Practices that do manage to successfully leave will find themselves in direct competition for patients from a much larger organisation

This raises questions about how feasible a right of return would really be.

Funding

NHS England's proposal for a fully-integrated MCP is predicated on a single population-based budget covering all primary medical services and various integrated community services. As detailed below, we are convinced that it is right to build MCPs around a national core contract which would entail specified levels of funding for core (essential) services.

Should GPs decide to move away from existing GMS and PMS contracts to new locally-defined arrangements for the delivery of general practice, we would argue that spending on core services should be defined and ring-fenced within the wider budget. Without this basic level of protection, core services to the population could be put at risk by debts in other parts of the health service, budgetary constraints or unforeseen overspends on non-core services. This risk is profound under the proposals for utilisation risk at MCP level where the utilisation risk for primary and community health services will be held by the MCP and where utilisation risk for acute care is shared between MCP, commissioner and acute providers. We have repeatedly highlighted how the percentage of NHS funding spent on general practice has fallen since 2006 and the likelihood is that without protection this would get worse. Ring-fenced spending for core services, like the continuation of a national core contract, does not preclude the designation of a single overall population budget to the MCP, particularly if funding for core general practice is not the largest component of the overall spend. As the MCP budget will likely be calculated in the first instance partly on the basis of current commissioner spend, a ring-fenced budget would be straight-forward to implement. A ring-fenced floor for core general practice spending would allow MCPs to invest additional resources in essential services as needed.

We believe that a failure to ring-fence primary care spending will act as a disincentive for GPs to join/engage in MCPs.

Organisation and Employment

It is expected that the structure and makeup of an individual MCP will be left to local discretion. Practices will therefore have to be extremely careful in ensuring that an MCP arrangement into which they enter is based upon a solid organisational and legal foundation, and that they are fully informed of its proposed structure and any potential implications that may arise further in the MCP's development. For example, with the lack of organisational direction, it is unclear how any partnerships and employment roles will be arranged and practice partners will need to pay careful attention to how principals in an MCP would be paid, as well as the potential for GP principals being put at personal risk of bankruptcy because of the wider deficit of the organisation for which they are now accountable.

Similarly, GPs employed within an MCP will need to ensure that they are clear about their role and terms of employment. The GPC recommends that all GPs, regardless of employer or when employed, should be employed on terms and conditions of service that are no less favourable than the BMA salaried model contract. The salaried model contract represents good employment practice and helps to ensure good recruitment and retention of staff.

Many MCPs are being built upon the foundation of a largely salaried service and strongly promoting the use of the salaried model contract by MCPs is important for the future for all GPs, not just current salaried GPs.

What practices should do now

Practices should not feel pressured to make any hasty decisions at this stage. Furthermore, it's important to reiterate that any local contract is **voluntary.**

Our advice is that practices should be wary regarding relinquishing their national G/PMS contract, and together with their LMC, should put forward proposals for participation in MCPs under their current contract. We have consistently argued that participation in, and the success of MCPs does not logically depend on practices moving away from their standard contract, since the wider integrated delivery of services sits above the core contractual responsibility of practices. It is vital that NHS England has recognised this is one of three MCP type models.

Whilst the MCP contract is currently aimed at being voluntary and, in the short term will only affect practices within the area of one of the 6 MCP pilot sites, there exists the possibility now or in the future that practices may feel pressured into signing up, either by commissioners or as other practices in the area have already done so. If your practice does feel uncomfortable with proposals being put to them, you should contact their LMC or the BMA for advice. GPC will be producing further guidance once details of the full MCP contract are confirmed.

GPC's Proposed Approach

We have continually highlighted that we believe what NHS England wants to achieve through the MCP model can be implemented without practices having to give up their existing national GMS/PMS contracts, as NHS England has now recognised through two out of the three MCP contracting options - the proposed 'virtual' MCP, and 'partially integrated' MCP. We believe that MCPs could flourish if built on the foundation of a continuing national core contract for general practice and it is vital that the proposals which have been put forward by NHS England enable this.

Greater collaboration and integration is demonstrably feasible with a national core contract in place. The service delivery element of the MCP proposals – functional integration between primary and community care - is already partially delivered in some areas under current contractual arrangements with practices working very closely with community teams. This indicates that full structural integration is less critical than functional integration and collaborative working as the document itself recognises. In many cases spending time on restructuring diverts those involved from focusing on meaningful service change.

Putting core services aside for national contracting does not prevent many services currently commissioned from general practice being directly provided or commissioned by the MCP. We have previously suggested that this is most straight-forwardly achieved by GPs working collectively through networked arrangements – either as the foundation for or partner in an MCP, or as a subcontracted provider – to provide a range of additional and enhanced services and we are pleased that this is recognised as two of the three MCP type models proposed. Through membership of a GP network individual GPs can already get involved in the provision of a wider range of services, multi-disciplinary work and greater specialisation. In the context of an MCP structure, collaborative or leadership input from a GP network also allows GPs a chance to manage patient pathways and redesign services and workforce.

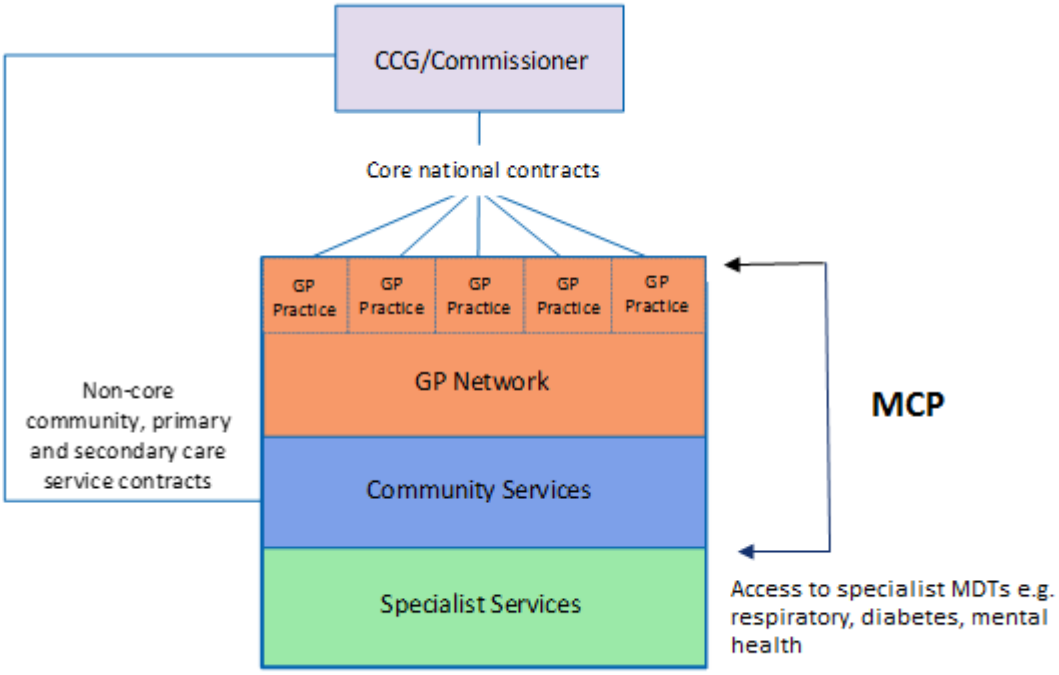
We believe GP networks could provide all the financial incentive needed to fulfil the MCP's objectives without any need for the MCP to subsume core contracts for general practice, particularly if elements of practice or network income are outcomes-based. These possibilities have been acknowledged by the National Association of Primary Care's (NAPC) Primary Care Home proposals which said 'where staff are salaried or on sub-contracted arrangements, an equity stake or incentives payments will be needed to foster an inclusive approach to the delivery of high standards of response care'.

Preserving current core contracting arrangements at practice level does not prevent the MCP being defined by the combined sum of individual registered practice lists. Nor does it prevent the MCP from choosing to redistribute resources to move more care out of hospital. This model does however preserve the personal, local provision and continuity of care valued by GPs and patients.

An alternative model

The GPC produced a discussion document in April 2015 General practice and integration: Becoming the architects of new care systems. This set out a proposed model for the integrated provision of collaborative care, which incorporates separate contracts for core services but uses GP networking as a foundation for integration between primary, community and secondary care.

Many GPs are already shareholders in GP networks. Responding to the BMA's 2015 survey of GPs, 37% of GPs said their practice had already joined a network or federation. 43% said this was to bid for or deliver contracts, 40% hoped to have more influence on healthcare delivery through networks and 39% were networking for the long term security of their practice. 52% of all respondents said that their preferred model for the future was working in networks more collaboratively with other healthcare professionals. We therefore have good reason to believe that our network-based proposals are broadly acceptable to the profession.



[An illustrative example of how MCPs can be built around the continuation of core national GP contracts. Note that this model does not preclude MCP employment of GPs or MCP management of GP practices where individual GPs and practices make these choices.]

Practical arguments for preserving the national contract as a foundation for MCPs

Subsuming contracts for core GP services in MCP contracting will require complex local negotiations between MCPs and practices either as employees or subcontractors. This could prove to be a significant distraction from the more important task of redesigning patient pathways and the delivery of collaborative care, as well as acting as distracting form patient care. It would also mean that some GP-led MCPs – those for example which are network based – would be in the position of designing their own contracts for essential services creating potential conflicts of interest. NHS England recognises this and will be launching guidance on managing conflicts of interests with relation to GPs participation in MCPs this summer.

Maintaining the national core contracting and using new contracting methods for other services, as now with enhanced services, would help NHS England to meet its tight deadlines, whilst providing a foundation in which GPs can have some measure of confidence. Building MCPs on the foundation of the national core contract will help attract GPs to the new organisations, giving them a sense of stability and reassurance which will allow them to act boldly in service redesign for other services.