BMA

England

Focus on the draft MCP Contract

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Overview

In October 2015 the Government announced the intention to create a new 'voluntary' contract to be used by GPs in England, working with others, 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 year 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 in July 2016 followed by the full MCP contract. Whilst supporting the principles of integrated care, the GPC remains concerned by the apparent longer-term movement away from the national GMS contract 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 elements pertaining to the MCP contract and GPC's key concerns.

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: 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-partnership 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 which 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 NHS England proposals?

Contractual Form

NHS England's MCP framework outlines 3 different paths for practices:

- Virtual MCP
- Partially integrated MCP
- Fully integrated MCP

a) 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.

b) 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.

c) 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. The full MCP contract is based upon a hybrid of APMS and the NHS Standard Contract, and will be held between the legal entity of the MCP and the commissioning bodies relevant to the respective service specification (CCG/NHS England/Local Authority). The contract will run for a limited period of 10-15 years, and include a break period every 2 years, to allow for 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 proposed an amendment to primary care legislation, which, for practices operating under the full MCP contract (option c above), 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.

The following pertain to models of MCP operating under the proposed MCP contract:

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 and will be expected to do this within a defined budget. This is stated as aiming to incentivise population health management by the MCP.

Funding

Funding under a fully integrated MCP is proposed to comprise of 3 main components that combine to create an 'MCP contract sum':

i) A capitated budget based upon 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 including funding from current G/PMS areas such as global sum, QOF, seniority, MPIG, DES, LES. 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 subsequently reflected in the funding although it is not clear how this may be put into practice.

ii) Improvement Payment Scheme. Whilst a fully integrated 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 and will include a mix of national and local elements. The MCP pay for performance scheme will recycle monies from the existing CQUIN and QOF schemes and could constitute up to 10% of the MCP contract value (QOF currently accounts for 8%) which will be top-sliced from the WPB. The targets used under the scheme could change on a regular basis in order to align with national and local health priorities, with old outcomes targets replaced once they have been met. Under a partially-integrated MCP practices will still be part of QOF.

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, public procurements over €750,000 must be advertised and will likely go to open tender[2]. 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, require 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[3]". It is still unclear exactly how the process will run in practice.

Returning to GMS/PMS

NHS England has proposed that practices signing up to the full MCP contract will retain their existing GMS/PMS contracts in a 'suspended' form that would enable a practice to exit the MCP and return to a GMS/PMS contract should they wish. Practices would then be able to utilise the biennial break periods to leave the MCP and 'reactivate' their original GMS/PMS contract. 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 find themselves in competition with a much larger rival provider within their immediate local area, and in relationship with a commissioner that may no longer be inclined to commission local enhanced services or other contracts with single practice providers.

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 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.

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[2] Contracts may be awarded without a competitive tender process in certain circumstances, including where no suitable tenders have been received to a contract notice and where competition is absent for 'technical reasons' provided 'no reasonable alternative or substitute exists and the absence of competition is not the result of an artificial narrowing down of the parameters of procurement.'

[3] 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 as they currently do for hospital trusts, 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 and place greater responsibility on those who were managing the MCP, 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. GPs would, however, be required to pay individual 'run off costs to cover continued protection for the period prior to joining the MCP, and, as with doctors working in secondary care, may continue to need and pay for personal indemnity arrangements to cover them for any activity that takes place outside the MCP.

Pensions

Under current regulations 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. NHS England state that there is an in principle agreement to allow access to the NHS Pension Scheme as a sub-contractor when an NHS Standard Sub-contract is used. These changes, however, are not yet in place and are subject to public consultation in 2017.

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. However, GPC retains a number of concerns about the proposals under the full MCP contract. The key aspects of these 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. It would also represent an embedded postcode lottery for primary and community care services.

By amalgamating patient lists from across a much wider geographical area it also risks breaking the personal relationships and care with a locally defined community that is valued by patients and which has consistently resulted in general practice being the most popular public service.

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. This has already been the case for a number of large NHS community contractors who are now managed by commercial companies and it is reasonable to assume that this could also be the ultimate outcome of this process for MCPs. 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.

Returning to GMS or PMS contracts

Should GPs leave the national contract to move to separate MCP contracting arrangements GPC is, in theory, supportive of the creation of a route to exit a fully integrated MCP and return to GMS or PMS contracts. However, as things currently stand, we believe that such as right of return will be illusory practice and whilst practices may be able to return to a GMS/PMS contract they will find themselves in a very different position to the one that they originally left. To name just a few complicating factors:

- There would be no guarantee for practices to return to their contracts for services beyond GMS/PMS, for example local enhanced services and previous CCG funding streams. It is likely that these will be contracted to as part of the MCP contract, and so the practice would need to come to a subcontracting arrangement with the MCP if it wished to provide services beyond GMS/PMS.

- In a full MCP the registered lists will have been merged. It is not clear how these could be subsequently disentangled. NHS England propose that at the first 2 year break point patients on the original practice list would revert back to the practice should it choose to leave, with an option of staying within the MCP if they so wish. However, any patients who joined after the practice signed the MCP contract would have to express a wish to move to the departing practice. After this initial break point all patients would stay with the MCP by default and would need to actively choose to move with the departing practice. This will make it extremely difficult for practices to make an informed decision and set up an effective 'point of no return'.

- Practice premises might have changed hands or be leased out and practice staff may have been transferred to the MCP organisation. NHS England has acknowledged that details of how this may be resolved in practice are still uncertain.

- 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 practical exiting the MCP and returning to GMS/PMS would really be, especially a number of years into an MCP contract.

Funding

NHS England's proposal for a fully-integrated MCP is predicated on a capitated 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 believe that it is essential that spending on core services should, as a minimum, be ring-fenced within the wider budget, ideally with the opportunity within a GP led MCP organisation to actually increase funding for these core services ensuring stability and viability for the wider MCP. Without a basic level of protection, however, 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. 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.

The use of a single capitated whole budget covering the whole MCP population and services could also result in a number of other unintended consequences. Where income for members of MCP are linked directly to the organisational budget, or indirectly via shares in the company, the need to run an overall profit in order to provide adequate income could, for example, incentivise a clinically inappropriate reduction in referrals to services provided by the MCP in order to maximise the profit margin. Similarly, a basic need for consideration of organisational finances could produce a similar effect if GPs in the MCP are required to meet internal fiscal targets. This would endanger the role of the GP as an independent patient advocate and impact upon the ability of the patient to receive timely and appropriate care.

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. Again, the need for GPs within the MCP to adopt a much more corporate approach, factoring in the requirements of the wider MCP organisation could seriously impact upon their ability to independently advise and refer patients as clinically required.

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 GPC would encourage all salaried GPs to check their contracts via the BMA's free service. 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. We will continue to campaign for the recognition of the Salaried GP model contract as a bench mark for terms and conditions of employment.

Retaining GMS/PMS contracts

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. 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 note that this is recognised as two of the three MCP type models proposed. With the right commissioning arrangements practices can already get involved in the provision of a wider range of services, multi-disciplinary work and greater specialisation. There are currently many examples of single practices or groups of practices working collaboratively delivering extended scope community based services, including the secondment of community and secondary care staff to work within GP led organisations, providing an alternative to hospital based provision of care. This has been made possible because of the inherent flexibilities and solid foundation provided by the current GMS/PMS contract. 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 and super-partnerships 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.

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, the development of sustainable at scale structures for General Practice and the delivery of collaborative care, as well as acting as distracting from 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. It is understood that NHS England will be releasing guidance on managing conflicts of interests with relation to GPs participation in MCPs at a later date.

Maintaining the national core contract 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.

Alternative approaches

MCPs are not the only way of achieving greater integration, improving collaboration and of expanding the provision of community-based care. There are numerous models already in operation that build on existing separate practice contracts for core services, but use other arrangements to support and encourage the expansion of practice and/or community based extended services. This has led to a wide range of specialist services, such as dermatology, ENT, gynaecology and cardiology being delivered by practices and GP networks.

GP practices working in a networks, federations and super-partnerships have, in an increasing number of areas, already provided a foundation for integration between primary, community and secondary care. As our recent survey highlighted, half of GPs in England believed the current independent contractor model should be supported, but with the resources to collaborate in the form of GP federations/networks or super-partnerships.

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.

There are different approaches to forming networks, federations, and super-partnerships and working at scale, with a variety of models and structures within each approach. The main approaches are:

- companies limited by shares, where each member practice holds a shareholding

- companies limited by guarantee, where each member practice is a “member”
- community interest companies, which have a protected community purpose, where each member practice has a shareholding or membership
- super-partnerships, formed through practice mergers or takeovers
- contractual joint ventures between providers (at practice or network level)

GPC has produced guidance on setting up a GP network, common legal structures and guiding principles for networks, and practices can obtain legal advice from BMA Law. The RCGP also has a webpage on supporting federations, with examples of different organisations.

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 MCP contract is **voluntary.**

Our advice is that practices should avoid 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 may 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 in due course.