BMA

New models for delivering care

Contractual models for integrated care

MCP and PACS contracts

Introduction

This series of briefings is designed to help members understand the different models of care that are emerging in the NHS in England, their associated contractual and payment models and the practical implications for doctors.

Providers of acute, community and primary care tend to operate separately at present. But increasing emphasis on new, integrated models of care across the sectors, and greater networking within sectors, has the potential to change the provider landscape over time. Be informed.

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Background
The NHS vision 'the five year forward view' describes a number of new care models for the NHS in England that aim to break down the traditional divides between primary, secondary and community care, mental health and potentially social care. These models may involve multiple providers and commissioners working together to provide services, under a shared budget, for a given population. The main contracting route in the NHS – the NHS standard contract – is relatively rigid, having been designed for use between one commissioner and one provider. NHS England is therefore developing a new voluntary contract for two of the models, MCPs (multispecialty community providers) and PACS (primary and acute care systems). For more information on MCPs and PACS, see our briefing on integrated provider models.

This briefing outlines the theory of a prime provider model and summarises the three voluntary contractual options that have been developed. A forthcoming briefing will explore the implications for commissioning.

A prime provider model
MCPs and PACS are both based on the idea of a prime provider contractual model. This is where a commissioner contracts with a single entity, which then provides services. It may not necessarily provide all of the services within the contract, but it will be solely responsible for managing any other providers through individual sub-contracts. As integrated providers, MCPs and PACS may therefore have responsibility for the budgets, planning and delivery of a wide range of services across their populations.

MCPs and PACS will need to be a formal legal entity, or a group of entities formally working together. The precise organisational form will be for local areas to determine, but the entities must be capable of bearing the financial risk associated with taking on a large contract, with appropriate clinical and financial governance and accountability arrangements.

MCP and PACS contracts
NHS England has developed three **voluntary** contractual options. While the scope of MCPs and PACS varies – PACS include acute care – the general practice options described below apply to both. For more information on general practice and the MCP contract, see our focus on the MCP contract.

Virtually integrated model
Providers and commissioners enter into an 'alliance agreement', which would overlay (but not replace) existing commissioning arrangements. The aim is to improve integration within and between the services they have agreed to develop, without requiring any contractual change. For example, through shared management of resources, risk sharing agreements, or sharing the delivery of services.

Partially integrated model
All in-scope services are commissioned as part of a new, single MCP/PACS contract, except for core primary medical services. Practices will therefore retain their existing core contracts. However, local enhanced primary care services may be included within the MCP/PACS contract. Practices will also enter into an 'integration agreement' with the MCP/PACS to ensure primary care services are sufficiently integrated into the wider MCP. The MCP/PACS contract will run for a limited period of 10-15 years.

Fully integrated model
All services, including primary medical services, are procured under a single contract, to be held by the MCP/PACS. The MCP/PACS can then: subcontract general practice provision back out to practices or super-practices; run practices directly, as individual units or super-practices; employ GPs directly to provide primary care services; or use a combination of these approaches. The contract will run for a limited period of 10-15 years, but will include periodic breaks to allow for an evaluation of the services provided. NHS England has also proposed that the existing core contracts of participating practices can be 'suspended' for a defined period of time, with an option to reactivate them at a later date; however, in reality, the practicalities make this unlikely (for more information, see our focus on the MCP contract).

How are they being implemented?

NHS England's emphasis to date has been on progressing the development of MCPs. Draft MCP contracts and integration agreements were published at the end of 2016, with revised versions due by April 2017. Some of the vanguards – sites which have been piloting MCPs – have been working with NHS England to develop the contracts. Some of the sites may begin using these during 2017/2018, and final amendments will be made following MCP feedback and a formal consultation process. They will then be available to emerging MCPs across the country. The PACS contract will draw very heavily on the MCP contract; a first draft is due during 2017 and will almost certainly follow a similar process of revision.

Prior to the emergence of MCPs/PACS, prime provider models have been used, on occasion, in some local health economies within the NHS in England. But, perhaps as a result of their relative newness, a robust evidence base examining the impact of these contracting models is not yet available. It remains critical for all partners involved in new models of contracting to develop effective working relationships. Adoption of a new contracting model alone should not be regarded as an instant solution. Indeed fixating on the particular form chosen can be an unhelpful distraction in the development of more integrated care.[1,2,3,4]

What are the pros?

A prime provider contract reduces the risk of fragmentation by removing the need for the introduction of an additional organisation to manage the integration of services. In addition, there are clear advantages for successfully managing the contract if the prime provider has direct control over at least a portion of the services being delivered. It enables a single organisation to be accountable for delivering outcomes, keeping complexity, in theory, to a minimum, and should give the provider greater flexibility.

What are the cons?

There will be considerable technical complexity involved in establishing the appropriate contract value. For example, it will be difficult to calculate the value of a capitated budget when the costs of various components of that contract are 'hidden' within an existing block contract payment arrangement, which are still widely used for community care and mental health services. There are also a number of risks in entering into a payment system based on a whole population budget, particularly for general practice. For example, GP partners or practices operating as providers within an MCP would be accepting a level of direct responsibility and accountability for the whole population budget, in the context of severe financial pressures across the NHS. For more detail see our payment models briefing and focus on the MCP contract.

If an MCP/PACS is delivering only some of the services, and subcontracting to other providers to deliver the remainder of services, as a prime provider it needs to have strong contract management expertise. It is an open question as to whether many provider organisations will have access to the skills required to effectively manage a contract of the scale envisaged. It may be more appropriate for providers without access to this expertise to operate on a consortium or partnership basis.

There are risks regarding the commissioning of MCPs/PACs. There may be potential conflicts of interest for GPs who are part of a CCG (clinical commissioning group), and therefore put in the position of designing their own contracts as a provider of core services within the MCP. 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. It is also highly likely that any MCP/PACS contract will be required to go through an open procurement process, meaning services, including general practice, could potentially be outsourced to private corporate entities.

The fully integrated model would require GP practices to relinquish their national contract for core primary medical services. Doing so may undermine the consistent provision of core services to patients, regardless of postcode, and risk unintended consequences for patients, practices and GPs. As described above, NHS England has proposed that practices will have a 'right of return' to national core contracts at certain points in time. However, in reality there are a number of issues which put in doubt the practicalities of this. For example, practices would have no right of return to other contracts for local enhanced services. It is also worth highlighting that GPs would lose the benefits of nationally negotiated terms and conditions.

What are the implications for doctors?

The uptake of the MCP/PACS contractual options will vary from area to area. The implications for doctors will differ according to your employment status and place of work, although as with many of the changes associated with new care models, doctors will be required to adopt new ways of working with other providers and organisations. For more information, see our briefing on practical implications for doctors. GPs should also refer to our focus on the MCP contract.

What's the BMA's policy?

The BMA has been calling for greater integration and collaboration between different parts of the health service, doctors and other clinicians for a number of years. In theory, this new model of contracting offers a greater opportunity than current arrangements for multiple providers to work together, collaboratively and around the needs of patients. Nevertheless, structural and contractual integration should not become the main focus of any new care model, as this alone does not guarantee more joined up services for patients. Indeed, there are examples of care models already in operation that facilitate integrated services, but build on current contractual models.

As outlined above, we have strong concerns about the fully integrated model that has been proposed, not least because it requires practices to relinquish their national core contract. At this stage we also have concerns over the potential implications of signing up to integration or alliance agreements as part of the partially or integrated model. Practices should ensure they are fully informed before making any decisions, remembering that **the contractual options outlined above are voluntary**, and should not feel pressured into making a decision. We believe the key aims of the MCP contract can be met within the existing framework and protections of the national contract. Our advice is that practices interested in pursuing an MCP/PACS model should avoid relinquishing their national core contract and, together with their LMC, put forward proposals for participation under their current contract. We would also advise practices to avoid signing any integration or alliance agreements until the BMA has obtained further legal advice. In the first instance please see our focus on the MCP contract for more information.

References

1 Addicott R (2014). *Commissioning and contracting for integrated care*. London: The King's Fund.
2 Addicott R & Ham C (2014). *Commissioning and funding general practice: making the case for family care networks*. London: The King's Fund.
3 Gauld R (2014). What should governance for integrated care look like? New Zealand's alliances provide some pointers. *Med J Aust*, **201** (3 Suppl): S67–8.
4 Ham C & Smith J (2010). *Removing the policy barriers to integrated care in England*. London: Nuffield Trust.

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