BMA

New models for delivering care

Integrated provider models

MCPs and PACS

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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Integrated provider models
MCPs and PACS

What models are being developed for integrated care?

The NHS vision 'the five year forward view' describes five new care models for the NHS in England. This briefing focuses on the two models, MCPs (multi-speciality community provider) and PACS (primary and acute care systems), which are seeking to develop integrated providers. Both are forms of ACOs (accountable care organisations), where providers have responsibility for the cost and quality of all care for a defined population. MCPs and PACS are the models most frequently proposed in STPs (sustainability and transformation plans).

The other models in the five year forward view have different focuses. 'Acute care collaborations' look at ways of linking hospitals together to improve their clinical and financial viability. More information on this model is due to be published by NHS England during the first half of 2017. 'Urgent and emergency care' models seek to improve the organisation and coordination of services, and is part of NHS England's wider work in this area. The final model, 'enhanced health in care homes', looks specifically at services for residents of care and nursing homes. For more information, see NHS England's website.

MCPs

MCPs are a new type of integrated, accountable provider that can combine the planning, budgets and delivery of primary and community care services. GPs can determine the extent of primary care involvement. MCPs will seek to offer a wide range of community-based care, including shifting some services, such as outpatient clinics or diagnostics, out of hospital settings. This could also extend to mental health and social care services. The specific services provided by the MCP will be determined at a local level. They will use integrated, multi-disciplinary teams, working with GPs, and employ a range of health and social care professionals, including specialists from secondary care.

MCPs will provide care to the whole population, based on the registered lists of participating GP practices. They will be built around groupings of practices (often in federations or networks) that cover 30,000-50,000 people. These groupings are similar in size and concept to the primary care home approach.[a] The overall scale of an MCP will depend on local context, but it is likely to serve a population of at least 100,000.

The extent of primary care integration within an MCP will be determined by local GPs. Three voluntary contractual options have been developed, enabling different levels of integration between local practices, the MCP and primary and community care services. Two of the three options will involve a new contract, held by the MCP. The third option involves an alliance agreement. For more information, see our briefing on contractual models and the focus on the MCP contract.

MCPs may also operate a new payment model, based on a capitated, whole-population budget. It will include some element of payment-by-performance and a way to share risk across the local health economy. The model is intended to enable longer-term planning and a more flexible use of resources, with financial incentives to reward performance and discourage particular activity (eg unnecessarily referring patients to other providers). The extent of primary care integration within the payment model will again vary according to the contractual option chosen. For more information, see our briefing on payment models.

The organisational form of an MCP will vary, but it will need to be capable of bearing financial risk, with appropriate clinical and financial governance and accountability arrangements. Options are likely to include: a limited company or LLP (limited liability partnership), which could be a GP super-practice, federation, or new organisation formed for the purposes of delivering the MCP contract; a community interest company; or an existing NHS trust or foundation trust, potentially working with GPs.

a Primary care home is a model developed by the NAPC (National Association of Primary Care), being taken forward by a number of rapid test sites. It is highlighted by NHS England as one possible way of developing the 'building blocks' of an MCP. More information is available on the NAPC website.

PACS

The PACS model is similar in approach to an MCP, but also includes secondary care. PACS therefore have the potential to provide list-based primary care services, most secondary care services, along with community care, mental health and some social care services. As with MCPs, the intention is for PACS to bring a greater focus on prevention and integrated community-based care. But, they will have even greater scope to reshape services and use their workforce more flexibly. Given the inclusion of secondary care, PACS are likely to operate on a larger scale, covering the population of their local hospital as a minimum. PACS may also use the new payment approach, based on a whole population budget.

Contractual models will be similar to those being developed for MCPs, enabling three different levels of integration between providers. Local practices will again be able to determine the extent of primary care integration, with a new voluntary contract developed for the two highest levels of integration. For more information, see our briefing on contractual models.

Given the increased scale of the contract, covering secondary care and a larger population, a PACS will need to be more robust than an MCP, capable of bearing bigger financial risk. It could be an existing NHS provider, or a new entity, formed through a partnership or joint venture between a group of GPs, an acute trust and other local providers.

How are they being implemented?

The five year forward view new care models are being piloted through a national programme known as 'the vanguard'. This consists of 50 sites across England, including nine PACS and 14 MCPs. Being part of the vanguard has given sites access to technical and financial support from NHS England. For more information and a list of the vanguard sites, visit the NHS England website, or use the regional integration map on the BMA website.

NHS England's main emphasis to date has been on developing the MCP model further. Following the MCP framework document, a draft contract and guidance on payment, commissioning and organisational structures were published at the end of 2016, with revised versions due by April 2017.[1] More advanced MCPs may begin using these at some point during 2017/2018, and final amendments will be made following MCP feedback and a formal consultation process. The PACS contract and accompanying guidance will draw very heavily on work done for MCPs; building on the PACS framework document, first drafts are due during 2017 and will almost certainly follow a similar process of revision.

However, development of new care models is not limited to the vanguard sites. By 2020 NHS England is aiming for 50% of the population to be covered by an MCP or PACS. In 2016, all local health and care systems in England, working in 44 'footprint areas', were asked to develop an STP (sustainability and transformation plan). These set out how local areas intended to deliver the aims of the five year forward view, including the development of new care models. Building on learning from the vanguard sites, areas are already beginning to plan and to develop MCPs and PACS (some STPs also refer to them as ACOs or accountable care systems). The contracts and supporting documents described above will be made available for emerging sites to use over the next year.

What are the pros?

Encouraging and enabling different NHS providers to work together, collaboratively around the needs of patients could help deliver more joined-up services and thereby solve many of the problems faced by patients in their everyday interactions with the NHS. The proposed models represent a greater emphasis on integration in NHS policy than has been seen in recent years, which is to be welcomed.

Overall the evidence available suggests that community-based care improves patient access while maintaining a level of quality that is equivalent with services offered in acute settings.[2] The evidence also suggests that managed care programmes, emphasising preventative healthcare and home treatment would improve quality for patients with long term conditions.[3] These are all approaches that would likely be found in mature MCPs. In addition, patient experience is also likely to improve if more services are available in primary and community care settings.

A mature PACS model shares many features of ACOs in the United States, a model that serves an estimated 20 million people. There is some evidence from the United States associating ACOs with delivery of equivalent or improved quality and reduced costs.[4] PACS may therefore have the potential to reduce unnecessary hospital admissions and increase the number of patients seen closer to home.

What are the cons?

Any change, and especially change on this scale, must be evidenced-based. While vanguards were set up as pilot sites to test the models, the rollout of the models should be grounded in evidence. There is a widespread assumption that shifting care from hospital to community settings will save money, but the available evidence suggests that this may not be the case.[5] Transformation cannot take place without investment, but unless changes are evidence-based, they risk wasting time and money when the NHS is under severe financial pressures, without delivering clear benefits for patients.

If structural integration – where separate organisations merge to form a new organisation – becomes the main focus of these models, this will be insufficient to achieve better coordination and integration of services. Colocation of clinicians of different kinds is likely to be necessary but not sufficient: clinicians will need to transcend often difficult cultural and relational barriers for effective integration to be delivered.[6] Furthermore, the available evidence does not support any one organisational form over another in terms of performance in the NHS.[7] This suggests any large scale re-organisation is unnecessary.

The consolidation of services could have a negative impact on the sustainability of neighbouring providers. While some disruption and destabilisation is inevitable as new integrated provider models emerge, this should be carefully planned and monitored by commissioners and providers to ensure that there are no major unintended consequences for doctors, other NHS staff or patients. The new models might prove divisive for the profession and local health economy if they are perceived to be dominated by one sector over another, rather than as the product of genuine cross-sector collaboration. There is also the potential for confusion among patients and the public as new models emerge, particularly if there is a lack of early and continued engagement.

In addition to these overarching issues, there are a number of specific risks associated with the development of the new payment model and contractual options. These are particularly concerning from a general practice perspective. Further detail is available in our briefings on payment and contractual models, and our focus on the MCP contract.

What are the implications for doctors?

It is too early to know what extent the transformation described in STPs will be realised. Many of the vanguards are also still at an early stage. The scale of change across England will almost certainly vary from area to area and depend upon the specific model or arrangements that are being put in place.

With these variables in mind, the implications for doctors will range from having to adopt new ways of working with other providers/organisations, to a shift in where you see and treat your patients (ie hospital vs. community facilities), to a change in which organisation employs you. In addition, there may be more leadership and management opportunities available to doctors who are interested in taking them up. For more information, see our guidance on the practical implications for doctors.

What's the BMA's policy?

The BMA has been calling for greater integration and collaboration between different parts of the health service, health and social care, as well as more integrated working across the medical profession and other clinicians for a number of years. However, we do not support 'top-down' reorganisation or the imposition of new models of care.

The BMA's policy on STPs, and how new care models should develop, is based on the following principles:[8]

- plans must be drawn up and shared in an open and transparent way
- full and early consultation with the public, patients and clinicians across all care settings
- all proposals need to be realistic, evidence based and funded properly
- plans should be clinically-led and prioritise patient care, not savings
- ensure collaboration between the different sectors, not domination of one sector over another
- inter-organisational partnerships should be forged, rather than mergers
- focus on delivering services in an area, rather than competing with providers outside of the locality

We also have more specific concerns regarding the proposed contractual options and payment model. These are detailed in our respective briefings on these topics.

References

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5 Nuffield Trust (2017) *Shifting the balance of care – great expectations*. London: Nuffield Trust
6 Curry N & Ham C (2010). *Clinical and service integration: the route to improved outcomes*. London: The King's Fund.
7 Bramwell D, Checkland K, Allen P et al (2014). *Moving Services out of hospital: Joining up General Practise and community services?* London School of Hygiene and Tropical Research, University of Manchester and the Centre for Health Services Studies at the University of Kent.
8 BMA (2016-17) *BMA policy book* – **1358**; BMA (2016-17) *BMA policy book* – **1355**;

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