New care models

GP participation in a multispecialty community provider

Supporting document to draft multispecialty community provider Contract

Our values:
clinical engagement, patient involvement,
local ownership, national support

December 2016

GP participation in a multispecialty community provider

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Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Dr Nigel Watson

GP; Chair Better Local Care (Hampshire) vanguard; Chief Executive Wessex Local Medical Committee

"For many our current system has led to general practice being under resourced; with general practice, community services, hospitals and social care increasingly fragmented with perverse incentives that create barriers to collaborative working and developing a more efficient and effective system.

MCPs are starting to remove barriers, allowing resources to be put where they are most effective and testing ways to reduce the workload in general practice. For some, change can be a threat but in my view the MCP creates opportunities for general practice.

One thing that is clear is that 'no change' is not an option. GPs need to ask themselves whether working together with a greater focus on outcomes for a defined population, within a natural community of care (i.e. a population of 30 - 100,000) with the potential to hold a budget for that population is an opportunity or a threat?"

Dr Joanna Bayley

GP; National Medical Advisor on Urgent Care, Care Quality Commission (CQC); Chief Executive of Gloucester GP Consortium Ltd; Clinical Lead and Business Manager, GDoc Ltd; Clinical Associate for New Care Models Programme

"GPs have always co-operated locally, but have lacked a contractual framework to share work between practices. Many practices have difficulties recruiting and retaining other specialist clinicians. MCPs will provide the structure for a larger primary care team within a single organisation – the MCP. The whole team will be managed within the MCP, which will be able to design how it operates to ensure that it meets their patients' needs. So, for example, an MCP could employ specialist nurses, pharmacists and health coaches to support all people with diabetes in the MCP area. This team would be supported by GPs with expertise in diabetes, allowing these doctors to develop their professional interest and providing patients with expert care."

Dr John Ribchester

GP; Senior & Executive Partner, Whitstable Medical Practice; Clinical Lead and Chair, Encompass (Whitstable, Faversham, Canterbury, Ash and Sandwich) MCP vanguard

"The Encompass MCP paramedic practitioner scheme has been an early success. GPs triage visit requests and hand on appropriate ones to attached paramedic teams together with the electronic patient record and care plan. Patients are grateful for a rapid and informed response, and GPs gain some much needed extra time."

"The development of community multidisciplinary teams, responding to patients' needs in real time, is showing promise. People are being managed better in the community as gaps in their care are being identified and addressed. This is taking some pressure off GPs and also reducing unnecessary admissions to hospital."

Dr Mark Williams

GP; Clinical Associate, New Care Models Programme, Clinical Director for Primary Care, North Staffordshire Combined Healthcare NHS Trust

"The MCP Contract will give GPs greater influence over financial and staff resources plus a broader range of services in the community. GPs will then be able to work with their colleagues in the community in a model that improves the quality of care, promotes joy in work and supports a good work/life balance. This will make general practice more attractive and increase recruitment and retention in general practice."

1. Introduction to multispecialty community providers

1 This document describes the benefits the multispecialty community provider (MCP) model can offer GPs and gives clarity and detail on common technical questions. It is designed to support GPs as they consider what participating in an organisation that takes on an MCP Contract might mean for them (whether as an employee, sub-contractor or (part) owner).

2 The document is part of a package of documents which support a working draft of the MCP Contract. GPs should read this document in conjunction with this package and with the MCP Framework https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf (July, 2016).

3 Significant progress has been made on many of the issues that GPs have told us are important to them but there is still work to do in some areas. This document presents the most current position. An updated version will be published alongside the MCP Contract early in 2017 following further discussions with stakeholders.

4 In April 2016 NHS England published the General Practice Forward View https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf, recognising that 'British GPs are under far greater pressure than their counterparts, with rising workload matched by growing patient concerns about convenient access', and committing to invest in strengthening and reforming general practice.

5 The MCP model is a key part of our strategy to deliver the vision of the General Practice Forward View: the model creates a new clinical model backed by a business model that supports the integrated provision of primary and community care. MCPs aim to offer GPs a future working in a strengthened model of primary care. This document describes how MCPs can deliver the infrastructure, scale and integration to improve population health whilst addressing the pressures facing general practice.

6 Key benefits for GPs include:

- Care model with primary care at its centre that can give GPs a more manageable and rewarding workload
- Access to a broader, more in-depth range of services in primary care settings
- True multidisciplinary working that reduces handoffs to and from general practice
- Wider development opportunities for GPs that enable greater job satisfaction, including the opportunity to influence the wider system
- Potential to increase recruitment and improve retention for general practice

Overview of the MCP model of care

7 As set out in the MCP framework and the General Practice Forward View, an MCP is a population–based care model which aims to improve the physical, mental and social health and wellbeing of the local population. It is based around the general practice registered list and it adopts a new model of enhanced primary and community care.

8 MCPs can invest resources appropriately to deliver an enhanced primary care offer which builds on core general practice by:

- Increasing the breadth of primary care services delivered (e.g. by following standardised protocols / operating procedures where appropriate and by integrating primary, community, mental health, social and urgent care services) and,
- Increasing the depth of intervention delivered within the primary care setting (e.g. by increasingly providing services that traditionally have been delivered within outpatient or hospital settings), supported by funding shifts between sectors.

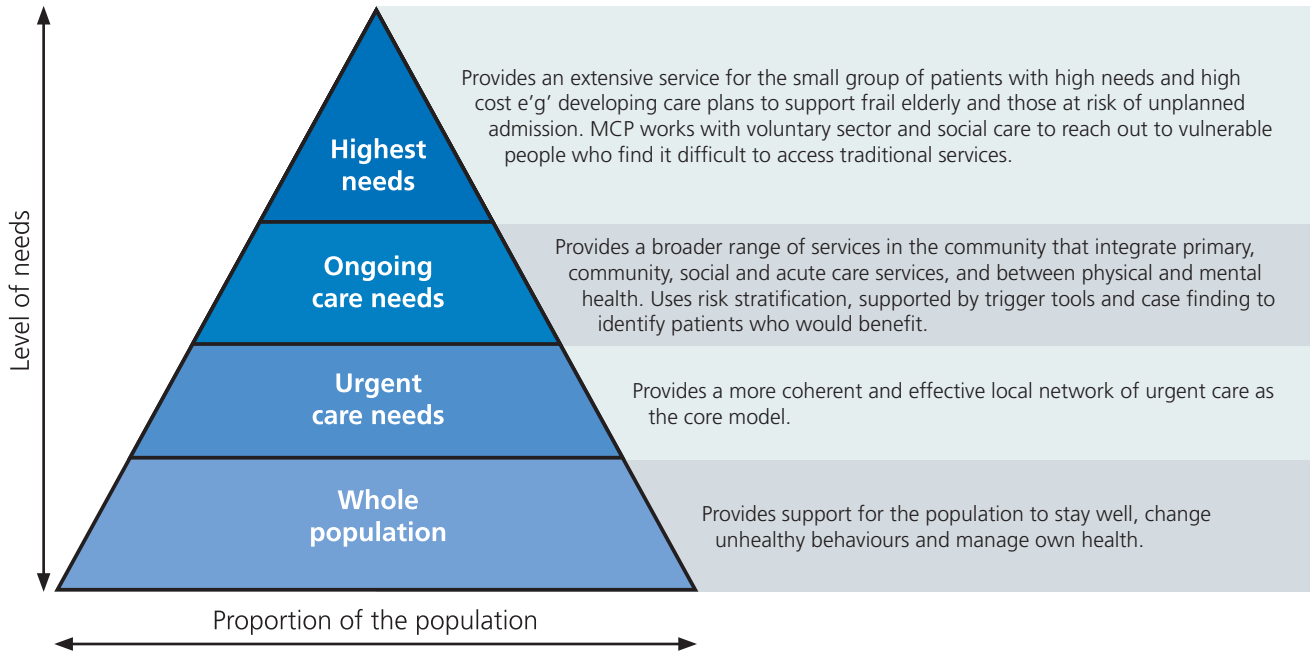
9 Within its remit, the MCP will carefully analyse the health and care needs of its population, an MCP will evolve to plan and deliver quality, and evidence-based health and care services. With a core of primary care and community services, these models will, in most cases, include the integration of social care, public health, some hospital services, mental health services and services provided by the voluntary sector. They will ensure that people receive care aligned to their needs as an individual as opposed to treating each element of their condition separately.

10 The MCP care model is neighbourhood-based with care being delivered through 'care hubs' to a natural unit of circa 30,000 to 50,000 population; both MCP and Primary Care Home (PCH) sites have demonstrated the benefits of operationalising primary care at this population size. Each hub is supported by a core multidisciplinary team, which can span health and social care and the voluntary sector, and which includes GPs who ensure continuity of care for their patients. A number of these natural operational hubs will combine to form the broader MCP footprint: we anticipate that CCGs will expect a footprint of at least 100,000 when looking to award an MCP Contract to ensure sustainability and efficiency.

11 The local community will be encouraged to work together with health and care professionals to improve the lives of local people. This partnership between the caring professions and the community will focus on community activation; the spread of public health messages; the active participation of the voluntary sector and the importance of an individual's ability to self-care when appropriate.

12 The bedrock of the MCP is the segmentation of its population into four levels of need. The core purpose of the MCP is to develop services across the population to improve outcomes across all of these levels:

Figure 1
The four levels of the MCP care model



The contractual model

13 As described in the General Practice Forward View, practices are increasingly coming together to work at scale in networks, federations or super practices. The National Association of Primary Care's Primary Care Homes (PCH) now have 15 rapid test sites operating at the same size (30 – 50,000) as the 'natural hubs' described above. These sites are already realising the benefits of working at scale with a multidisciplinary team to deliver integrated care tailored to their registered population. The MCP Contract offers practices the opportunity to work collaboratively with other organisations, whilst maintaining their in-depth understanding of the local population at the 30 – 50,000 hub level.

14 General practice is fundamental to the MCP model. To support voluntary GP participation a number of contractual models have been created with different implications for how core general practice relates to the MCP. The models outlined below provide important context for the rest of this document:

- The first contractual model is the **'virtual' MCP**. In this model core general practice remains commissioned under GMS, PMS or APMS contracts. Practices would sign an 'alliance agreement' with commissioners and other providers to facilitate joint working, which sits over the top of (but does not supersede) traditional contracts. This builds on the growth of GP federations, which represents a stepping stone to this model. In this model a new MCP Contract is not awarded.
- The second is the **'partially-integrated' MCP**. The commissioner awards an MCP Contract for the services within scope of the model except core general practice. GPs / practices would remain on GMS / PMS contracts. The crucial primary care contribution to the care model will be described via an Integration Agreement, which practices would sign with the MCP provider.

- The final option is the **'fully-integrated' MCP**. In this model the commissioner awards a contract for a full range of services in scope, including core general practice. GPs would be able to suspend their GMS or PMS contracts (with right to reactivate) and move into the MCP as owners and /or employees.

15 Each model could deliver the outcomes envisaged by the MCP care model, and where outcomes are delivered some areas may choose a virtual or partially-integrated model as their endpoint whilst others will prefer to move towards fuller integration. What is important is that the chosen model works for the local system. Local areas will need to work through the trade-offs between:

- the degree of formal integration they want to achieve and the strength of governance and decision making required for implementation of the model
- their appetite for change and the pace at which they are able to proceed.

The MCP Contract

16 The new national MCP Contract will be used in the partially and fully-integrated models. It is designed to enable an integrated provider to deliver care to its local population. By awarding an MCP Contract commissioners can ensure that the integrated working and aligned incentives that providers have built through the model are sustainable and that organisational siloes are truly dissolved. If a commissioner intends to award an MCP Contract this will have to go through a formal procurement. The Public Contract Regulations (PCR 2015) require that contracts for clinical services with a lifetime cost over the £590,148 threshold must be advertised in the Official Journal of the European Union (OJEU) and in Contracts Finder, and that commissioners run a compliant and transparent procurement process.

17 Before deciding to procure an MCP Contract commissioners will need to engage with primary care providers to develop the clinical model and consider the contractual models that GPs and others could be interested in. During procurement GPs will negotiate how they will work with the MCP to deliver services and whether (and how) they might share in financial incentives.

18 To allow for the contracting and provision of primary medical services (which is done under general medical services (GMS), personal medical services (PMS) or alternative provider medical services (APMS) and other health services (which is done under the NHS Standard Contract) together, the MCP Contract will need to be a combination of the NHS Standard Contract (for non-core primary care) and a contract which is legally appropriate for the commissioning of core primary medical services.

19 We are working with the Department of Health to review the current APMS Directions, with a view to securing new MCP Directions which will enable us to reduce and simplify the content to be included in relation to primary medical services specifically, and to be less prescriptive generally than is the case under current APMS contracts.

20 Importantly, it must be a contract that both commissioners and providers would be willing to sign. With this in mind we are working with GP stakeholders and others to shape the contract. The contract balances the desire to be as clear and streamlined as possible, with the need for a legally robust contract which will safeguard patient safety and service quality.

MCP funding

21 The MCP financial strategy has been shared as part of the draft MCP Contract package. It gives detail on the three parts that comprise the contract sum. More details can be found on pages 30 to 32:

- The Whole Population Budget (WPB) – a payment covering all services in scope, which the provider deploys flexibly according to the needs of the population.
- The MCP Improvement Payment Scheme – formed from a top-slice of the WPB that replaces commissioning for quality and innovation payments (CQUIN) and (in the fully-integrated model) the quality and outcomes framework (QOF) and pays against targets for agreed care quality, outcomes and transformation metrics.
- A gain/loss share arrangement – an arrangement designed to align financial incentives across health services provided for the MCP population.

Organisational form

22 To hold an MCP Contract, local providers will need to either use an existing organisation or form a new organisation that is capable of holding the contract and delivering or coordinating the delivery of the care model. It is the role of commissioners to define the service scope and be clear what they want to buy but it is for providers to propose which organisational form they will adopt and how they will work together to deliver the service. In all organisational models we would expect GPs to play a leading role in shaping the clinical approach.

23 There are a number of organisational forms that providers could adopt. All organisations will need to demonstrate financial robustness, clear governance and present an attractive offer to their workforce. Some of the forms available are:

- **GP-owned MCP**
  This organisational form has the potential to offer GPs control and influence over the organisation. The organisation might take the form of a company limited by shares or a limited liability partnership. GPs can participate as salaried employees or partners / shareholders.
- **Corporate joint venture**
  In this scenario GPs and, for example, a Foundation Trust could come together to form a new (non-NHS) legal entity capable of holding the contract. If, in this scenario, the joint venture was a limited company, GPs could be shareholders and control of the entity would be shared between the GP body and the Foundation Trust.
- **Existing NHS body (i.e. foundation trust or NHS trust)**
  In the fully-integrated contractual model GPs could join this sort of MCP provider organisation as employees. GPs could take on leadership and management roles for new and existing services such as: director roles at board level, roles on board committees or role as a governor (subject to election and in an FT only).
- **Host arrangement**
  One organisation, for example an NHS foundation trust, hosts the MCP Contract on behalf of a group of providers where decision making is mediated through a discussion forum of partners which could unanimously make decisions. GPs could be represented on this forum.

24 This is not an exhaustive or recommended list of organisational form options. The organisational form providers choose may have particular consequences in terms of for example:

- the types of roles which GPs may want to take in leading or working within a new organisation
- opportunities for taking an ownership stake in a new organisation or in its governance structures
- access to different forms of clinical negligence cover which may be available.

25 NHS England and NHS Improvement make available a webinar on organisational forms. Full consideration should be given when deciding on the most appropriate organisational form, including seeking legal, tax and accounting advice where appropriate.

2. What does this mean for me?

26 This chapter looks in detail at how the MCP could impact GPs' working lives. We have worked with GP stakeholders to understand their motivations and listened to their concerns. Given the complexity of the topic, we have broken the content down into subsections: my patients, my role, my practice and my contract. Where implications differ depending on the model we have been explicit about this. This model is not exhaustive and work is ongoing. An updated version will be published in early 2017.

My patients

27 The MCP model is designed to improve patients' experience of care across the local system, not just in one particular service. Based around the GP registered list, the MCP builds on the in-depth understanding GPs have of their patients so that it can both improve population health outcomes and deliver a highly personalised service that meets the needs of the whole population.

Will continuity of care be protected?

28 One of the great strengths of the general practice model is the relationship between GPs and their patients. GPs know their patients, particularly those with long term or complex conditions who they see regularly. The MCP model draws on other professionals and economies of scale to free GPs from the treadmill of 10 minute appointments so that they have the time to deliver high-quality, personalised, primary care that is founded upon the relationships they have with their patients, their families and carers.

29 In an MCP GPs can ensure continuity of care across different pathways and services. MCPs will adopt fully interoperable records, align the system to one set of outcomes and improve communications at the interface between services, meaning that patients should only have

to tell their story once. Hubs (30 – 50,000 patients) will be supported by an integrated core multidisciplinary team (MDT). GPs are a key member of these teams, bringing in-depth knowledge of the patient's circumstances, family and carers, needs and preferences, to make sure the MDT arrives at the best decisions for the individual. Care coordinators feed into the MDT providing dedicated support to patients and carers who have multiple interactions with different care settings. The effect is coordinated care, delivered by professionals who communicate regularly and collectively to agree the best way forward for their patients.

30 Continuity of care is especially important for a small cohort of patients with the highest needs who have traditionally had to navigate a system of fragmented services and disconnected providers. The extensivist model will see a team of professionals from across medicine, social care, pharmacy and psychology take on clinical responsibility for a patient and design a highly personal, holistic service around that individual's needs. In all cases, the team will work closely with the patient's GP.

Case study

Freeing up GP time to give continuity to those that need it most, Gosport same day access service – Dr Donal Collins, GP lead in Gosport

"GPs in Gosport have surveyed patients to understand preferences for continuity and access. The survey of over 1600 patients asked whether for an urgent problem, it mattered if patients saw their named GP or attended their usual practice. 80 per cent of people with an acute urgent condition responded no, signalling that access was more important than continuity, a sentiment that was also reflected in responses from people with long term conditions.

Building on these findings, four practices have set up a Same Day Access Service (SDAS) that serves around 40,000 patients. Appointments are conducted via phone or patients are directed towards the appropriate practitioner. Patient satisfaction levels are consistently high (96per cent in August). The SDAS has released GPs' capacity back in their surgery. GPs know that the list for surgery that day is actually the list they are seeing: there won't be a sudden influx of people at the door. They have time to focus on patients with ongoing or complex needs, who benefit from continuity of care. They have space to be flexible: appointment times can be extended for patients that need more time with their GP.

In the MCP the SDAS could offer access to specialists in the primary care setting. For example, if a patient comes in with recurrent Ear Nose and Throat (ENT) problems, they can be seen by the appropriate clinician with the right diagnostic kit. The service can screen patients who otherwise may have had a two week referral wait, improving access and the pick-up rate for ENT clinic. Working in this way would reduce the burden on general practice and mean the patient sees the right person the first time."

How will patient choice be maintained?

31 Patient choice is enshrined in legislation and will be protected in MCP arrangements, for example through the new MCP Contract.

32 In the virtual and partially-integrated MCP there will be no major implications for choice, as current primary care contracting arrangements are maintained and practices remain distinct from the MCP. We hope, and expect, that the larger range of services and improved access and quality within an MCP means that patients will prefer to have their care delivered in services provided by the MCP. Where all services including core primary care are being delivered by a fully-integrated MCP the contract ensures that the MCP offers patients a choice of location from which to receive primary care and a preference for a named GP.

How will the MCP improve patient access?

33 For a long time, practices have been struggling to meet patient demand. GPs have told us their workload is unsustainable. The system needs a service model that is fit for purpose in the 21st century: MCPs support the NHS England ambition to link extended access with the vision for general practice at scale, working as part of a wider set of integrated services.

34 The MCP Contract will reflect the primary care access requirements set out in the 2017 to 2019 Planning Guidance. In an MCP the economies of scale, integrated multidisciplinary workforce and improved technologies should reduce the amount of time GPs spend on work that can be handled elsewhere and give them greater flexibility.

35 A key component of an MCP is an integrated, accessible and responsive urgent care system. These systems provide a single point of access for patients seeking an appointment outside of normal general practice working hours. Active signposting will help to ensure the patient is connected more directly with the most appropriate source of help or advice. This is not always the GP.

36 Enhanced primary care will offer a broader range of services – including some traditionally delivered in hospital – in the primary care setting. With a broader skill mix available within the team, GPs will be able to pull in expertise to meet patient needs without the delays and poor patient experience often associated with referring out to separate services.

37 In line with the 'Ten High Impact Actions' for releasing practice time described in the General Practice Forward View, MCPs will harness technological innovation to improve access through new consultation types. Patients will be able to book appointments, order repeat prescriptions and view their record. They will be able to easily find information about their health and receive support to take greater control of their own health and wellbeing, through access to up to date information and the provision of digital applications. Technology will supplement, rather than replace, face to face or phone support.

Case study

Extending access to relieve the pressure on general practice in Greater Manchester – Dr Tracey Vell, Associate lead in primary and community care GMHSC and Chief Executive Manchester Local Medical Committee (LMC)

"In Greater Manchester we see primary care as being at the very heart of our transformed health and care system. As part of this our 12 CCGs have made a commitment to provide extended local access to primary care – seven days a week, confirming the intention that "everyone living in Greater Manchester, who needs medical help, will have same day access to primary care, supported by diagnostic tests, seven days a week". Across Greater Manchester, CCGs and their partners have been working to develop their service to meet the needs of their local population.

Rather than stretch individual practices to provide enhanced services, we have provided additional resources: We now have 40 hubs in operation, delivering additional access over seven days, with further hubs due to open. This not only provides additional access to the 2.8m population of Greater Manchester but also supports core general practice, Monday to Friday, to respond to and proactively manage more complex patients, for example offering longer appointments and targeting the most vulnerable groups.

These additional resources have helped to relieve practices' workloads, supporting their resilience and enabling them to have more flexibility. It is envisaged that the additional access will flex to support discharge of patients from hospital at weekend."

How can the MCP help me to improve the health of my local population?

38 GPs working as part of the MCP model will be able to support people to look after their own health. The MCP will harness community assets and build in social prescribing so that GPs can refer to local voluntary sector services, for example befriending services, sports clubs, and community groups, to support people to live healthier but also more fulfilling lives.

39 MCPs are place-based models of care, meaning they invest in the health and wellbeing of the whole population they serve. At one end of the spectrum of need (see figure 1) MCPs will deliver health education to support people to stay healthy and promote wellbeing. At the other end of the spectrum they will identify high-risk patients and deliver proactive, personalised care to prevent avoidable episodes for people with the highest needs.

40 MCP leaders will want to understand the needs of their population, then analyse the quality, equity and efficiency of the care that is being provided, before identifying opportunities for improvement. In the partially-integrated MCP GPs will agree to via the integration agreement (see page 25) to an MCP-wide risk stratification approach and how this will be applied at practice level.

41 MCPs will invest in patient-level population datasets and capacity command centres (which track all resources available to the MCP). The new care model team is establishing a population health analytics network. Members can use this network to support peer to peer learning and to help them to become intelligent customers of data and analytics services. Three phases of support will be offered: 1) learning from each other, 2) development of a maturity matrix, 3) establishing and reaching minimum requirements for population health analytics.

Case study

Improving population health outcomes in Tower Hamlets – Dr Shera Chok, GP and Director of Primary Care at Barts Health NHS Trust

"We have improved population outcomes in East London significantly by working in multidisciplinary networks with consultants, GPs, allied health professionals and nurse specialists and placing patient care at the centre of service redesign.

Networks of up to five practices covering populations of up to 50,000 are incentivized to deliver care packages for chronic diseases. Practices use a web-enabled computer system which facilitates IT interventions. Standard data entry templates were developed and monthly performance 'dashboard' reports are produced for networks and practices to provide GPs with a visual tool to assess their performance. A GP-led clinical effectiveness group analyses data and provides in-practice support. Standardised searches of electronic records improve recall of 'off target' patients. Practice culture has changed as network practices share performance data and support each other by combining expertise and resources.

The introduction of the managed clinical networks was associated with moving from the bottom national quartile of performance in 2009 to the top national quartile in three years across a range of outcomes. Improvements over three years included:

- a 10 per cent increase in high blood pressure prescribing
- an improvement of 6 per cent in reaching the target of less than 150/90mmHg for those on hypertension registers (compared to less than 2% nationally)
- an 18 per cent greater reduction in chronic heart disease (CHD) mortality (45 per cent in Tower Hamlets versus 25 per cent nationally)

The MCP model of care reinforces this approach: practices work closely together, population health, health analytics and interoperable systems are a key component of the model and professionals work in larger, multidisciplinary teams that are equipped with the skills, resources and autonomy to improve outcomes for their local population. "

My role

42 The General Practice Forward View sets out a commitment to invest in and reform the system to recognise and support the vital role of GPs, who underpin the NHS. The MCP model provides the platform for this: As a GP participating in an MCP model you will be part of a diverse team encompassing community, mental health and social care professionals and some hospital-based colleagues. Economies of scale will lead to greater

Figure 2
Ten High Impact Actions to release capacity

freedom of resources and time and if you are a GP leader in the MCP you will have significant influence over resource allocation, population health and service design.

How will this improve my work life balance?

43 General practice is under unprecedented strain. Many GPs recognise that the status quo is no longer viable. Some GPs will prefer to move to the MCP as employees to improve their work life balance. Whether GPs participate as shareholder, partner or an employee, MCPs will harness economies of scale and streamline processes to reduce unnecessary bureaucracy and administrative burdens on GPs.

44 Through access to a broader team and commitment to collective working, new consultation methods, streamlined and efficient workflows and support for self-care and social prescribing, MCPs naturally build on the 'Ten High Impact Actions' to release capacity described in the General Practice Forward View. NHS England is committed to supporting practices to release time and the MCP model creates the right conditions for this.

45 As a member of a multidisciplinary team spanning a range of services and specialities that are wider than general practice, with community facing specialists working in primary care, GPs will have easier access to clinical advice. Regular multidisciplinary team (MDT) meetings to discuss a defined caseload will provide timely advice without unnecessary referrals, facilitating joint decision-making and making follow-ups easier.

46 The broad multidisciplinary team in primary care, which can include advanced nurse practitioners, physician associates, district nurses, pharmacists and paramedics, and community facing specialists, will mean patients can be directed to the most appropriate professional, reducing urgent workload and allowing GPs to spend more time doing what only they can do.

47 A focus on prevention and self-care will support patients to manage their own health and wellbeing, reducing the number of unscheduled visits to GPs. MCPs employ care navigators to support signposting and social prescribing, reducing the burden on GPs whilst improving patients' access to local services both in and out of the health sector.

Case study

Developing the role of community pharmacy to deliver enhanced services and relieve the pressure on GPs – Dr Tracey Vell, Associate lead in Primary and Community Care GMHSC and Chief Executive Manchester Local Medical Committee

"Greater Manchester is collaborating with GP practices to pilot a pharmacy-based service for all individuals identified as being at risk of medicines-related hospital attendance or admission. Pharmacists will develop a pharmacy care plan to tackle the continuous cycle that GPs see of patients with long term conditions attending their practice, having a script, going home and their condition exacerbating resulting in a hospital admission.

Pharmacists will offer wider support, advice and interventions such as inhaler checks, falls prevention, medicines optimisation and synchronisation as well as referring to other services such as stop smoking. Pharmacists will undertake 'patient activation measures' in order to effectively

engage patients in their treatment and care. Patients will be supported to set up tangible goals to help improve their health and wellbeing. Suitable patients will be recommended for electronic repeat dispensing.

The programme will utilise the skills, experience and capacity of community pharmacy, working collaboratively with general practice to improving outcomes for patients; keep them well and stopping the cycle of hospitalisation. It will also assist practices to manage patients and reduce unwarranted pressure on GPs. We see this as an exciting opportunity to develop integrated local working pharmacists in GP practices. We envisage that as MCP models develop across GM we will have more opportunities to pilot integrated working with health and care professionals working in practices to support GPs to cope with demand and deliver tailored services to their patients."

48 The interface with hospital services will be streamlined and communications greatly improved. Integrated care records that span all services in scope and link with the acute will enable electronic communication between professionals and online referrals: reducing unnecessary administrative burdens on GPs and improving communications.

Will this increase my job-satisfaction?

49 MCPs will offer GPs more choice and influence in the local health and care system and a more manageable workload. They can provide GPs with professionally and intellectually satisfying roles, whatever their preferred way of working, and the opportunity to develop their clinical and managerial interests.

50 Economies of scale and team-based working will free up GPs' time to use their skills as expert generalists on more clinically complex cases. General practice has been innovative in its ways of working, with almost all practices employing practice nurses with expertise in chronic diseases. MCPs will build on this innovation to support GPs in working with a primary care team with a wide range of clinicians, including advanced nurse practitioners, pharmacists, physiotherapists and mental health workers. This will allow GPs to direct patients to the clinician best able to manage their care, allowing GPs to focus on more complex, higher risk cases such as patients with multiple long term conditions. In an MCP model GPs should be able to get off the 'treadmill' of 10 minute appointments and flex their time to suit patient needs. Collaboration with public services, voluntary sector and local community groups supports GPs to deliver holistic, person-centred care that looks after patients physical, mental and social needs.

51 Many MCPs will shift demand away from hospitals; moving parts of, or at times, the whole patient pathway into the primary care setting, with the accompanying resources. This offers new opportunities for GPs to develop clinical skills and deliver interventions that would traditionally be provided by hospital-based doctors.

52 GPs will have a strong voice in both the partially and fully-integrated models. Depending on the organisational form there is a range of ways in which the GP voice can be represented in an MCP. In a GP-led MCP GPs could be partners or shareholders (depending on the entity) and can sit on the executive board. In other forms, such as a foundation trust-led MCP, a primary care director could represent the collective GP voice at board level. In the partially-integrated model the integration agreement can describe shared governance and decision making processes, including how the GP voice will be represented within the MCP.

Will this open up new career opportunities for me?

53 The MCP will provide flexibility for GPs to carve out a career that suits them. Some may choose to join the MCP as an employee, giving them time to focus on their clinical work. Moving a range of services into an MCP presents a clear opportunity for GPs with a special interest (GPwSI). Some outpatient clinics, for example dermatology, could be delivered by GPwSI in dermatology. Similarly, integration with mental health and social care present opportunities for GPwSI roles in specialities such as dementia, learning disabilities, safeguarding children and young people. With care pathways increasingly delivered in primary care and operational integration of services from across health and social care there will be greater exposure to advice from consultants and training opportunities for GPwSIs.

Case study

Providing GPwSI led outpatient clinics in the community – Dr John Ribchester, Clinical Lead and Chair, Encompass (Whitstable, Faversham, Canterbury, Ash and Sandwich) MCP vanguard

Encompass is developing a range of GP with a special interest (GPwSI) community outpatient clinics with the aim of providing more local services whilst also reducing the burden on, and cost of, hospital outpatient services. A GPwSI led ear nose and throat clinic has already commenced in a practice, in addition to one previously created in another practice. This is fully equipped with nasal endoscopy and aural microscopy. Patient satisfaction is high, and onward referrals to secondary care are very low. GPwSI led clinics to other specialities are under development.

54 Many GPs are choosing to develop a portfolio career. MCPs can facilitate this. GPs may choose to take on managerial or executive roles within the MCP itself, or they may choose to use the improved flexibility to work outside of the MCP. MCPs can offer GPs the chance to take on leadership roles in a large, integrated organisation. GPs may apply for non-clinical managerial roles or they could sit on the board as a clinical voice.

My practice

55 For the majority of early MCPs, particularly those operating in a virtual or partially-integrated way, there may be no significant change to the way in which a practice is run. We are however keen to ensure that any transition to an MCP is as smooth as possible, retaining the best of the previous system with new flexibilities and advantages for practices.

How will my practice be regulated?

56 The Care Quality Commission (CQC) is committed to working with providers to make sure that their approach to regulation supports innovation; is tailored to different models of care and continues to evolve as MCP models begin to provide services. They recognise that as providers become more integrated they also become more complex and they want to tailor their regulatory approach to the individual provider.

57 All providers carrying on regulated activities must be registered with CQC. Existing providers need to ensure that they have made any necessary changes to their registration and statement

of purpose to reflect changes to the way they are organised or the care they are providing. CQC recommends that you talk to them early during the development of the care model to facilitate a smooth registration process. To discuss CQC's work on new models of care and the implications for your practice, please contact enquiries-newmodelsofcare@cqc.org.uk.

58 As signalled in their strategy http://www.cqc.org.uk/sites/default/files/20160523_strategy_16-21_sector_summary_final.pdf inspections will be intelligence driven and when relevant (i.e. for fully-integrated MCPs), they will include an assessment of 'well-led' above practice level (i.e. provider/ corporate level). Sampling of locations across the MCP will be dependent upon intelligence.

59 For virtual or partially-integrated MCPs, including where an MCP is sub-contracting services to an existing GP practice or other health and social care organisation, those practices and providers need be registered with CQC. GP practices in this model will continue to be regulated as set out in the CQC strategy (for example, moving to a maximum interval of five years for inspecting GP practices rated good and outstanding). Depending on the degree of integration, CQC may also adopt an approach similar to this for fully-integrated MCPs for example, taking a sampling approach to practice level inspection. In the fully-integrated MCP it is the MCP provider, rather than the individual practice, that would need to be registered.

60 Where new providers apply to be registered or existing providers need to make changes to their registration, there is currently no separate charge for these applications. The annual fee that providers pay will be as set out in the CQC fees scheme. They will closely monitor the costs of regulating new types of service provision and ensure they make appropriate changes to their fees scheme to reflect this.

61 When inspecting providers in transition, CQC will expect that providers are able to demonstrate how they meet the regulations and mitigate risks to quality associated with the changes that are taking place.

What will happen to my premises?

62 How GPs handle their practice premises when moving into an MCP is likely to depend on the contractual form they and their MCP partner organisations choose and the estates plans they develop with the MCP.

63 In the partially-integrated and virtual models, there will be no compulsory changes to how primary care estate is run and managed. The Integration Agreement will set out a locally agreed estates strategy agreed between the practices and MCP. For example, this could should how certain community services could be provided directly from primary care premises, or how community premises will be made available for a wider range of GP-led services.

64 A fully-integrated model would imply that the use of existing estate across primary and community care would be managed and coordinated by the MCP (and its partners). This means that the options available to GPs will depend on their local situation. For example where a GP has a leased premise there may be options in the lease to sub-let a property to the MCP for a period of time. Local advice will be required to work this through, and the options available will depend on current ownership, terms of existing leases, and local negotiation between the MCP and GPs.

65 For GPs who wish to go further, there may be an option to explore the sale of their premises to the MCP on mutually acceptable terms, though we would expect this to only take place in limited circumstances where there was clear value for money.

66 In the event that a practice does enter into a fully-integrated MCP it is clearly vital that existing funding streams to cover estates costs continue to be made available. Funding for estates is generally provided by primary care commissioners as financial assistance principally in respect of rates and notional rent to GMS (and where local agreement has been reached for PMS) contractors under the premises costs directions (PCDs). Premises payments will not enter the Whole Population Budget at the start of the year but will flow to the MCP throughout the year as is currently the case for GPs. GP estate holders in the fully-integrated model will agree with the MCP the terms on which these payments will be passed on.

Case study

Taking a proactive approach to GP estates strategy in Greater Manchester – Dr Tracey Vell, Associate Lead in Primary and Community Care GMHSC and Chief Executive Manchester Local Medical Committee (LMC)

"In conjunction with the wider strategic estates programme in Greater Manchester, a task and finish group has been established in order to consider a number of options to support general practice in respect of their estates. We know we must address the fundamental issue of existing GP estates and facilitating the transition to more fit for purpose estates, which deliver the integration strategy for GM and enable delivery of the MCP model of care.

Initial considerations being worked through include:

- Assisting GPs to relocate out of existing premises they own – developing a GM policy or process with LMC backing to support those GPs who wish to move out of poor quality premises and help them to overcome blockers (such as valuation) to such moves.
- Helping GPs to move into underutilised space – maximising available space is a 'must do' for GM but we know we must be cognisant that GPs pay service charges (utilities and cleaning etc.) and moving from a small poor quality facility to a larger modern estate could result in a significant increase in cost. These costs are already being picked up by the health economy so we need to identify a model that enables this to happen. It could include a subsidy which could be time limited or taper off over a few years (there is good evidence that practice list size grows when a GP relocates to a new facility resulting in a more sustainable practice);
- Sale and lease back of GP premises by third party developers/investors – this is attractive to some practices that do not wish to own a property and can support with the associated risks of buying out retiring partners.

We are ensuring that all options considered are in line with locality strategic estates plans and the overall vision for GM to deliver truly placed-based integration with primary care at the heart."

What are the implications for IT and data?

67 MCPs facilitate the improvements to technology that are described in the General Practice Forward View, namely: enabling self-care and self-management for patients; helping to reduce workload in practices; helping practices to work together at scale; and supporting greater efficiency across the whole system. They will harness technology to improve patient

experience and streamline communications and administration for clinicians. Ultimately there will be one patient record. All staff will have access to the appropriate information about the patients in their care, in real time (or as close to real time as is necessary) and where appropriate this will include the ability to update the records and share this with everyone involved in their care, including patients and carers.

68 Given the desire for improved integration, participating practices will agree with the MCP how they create the appropriate integration of IT systems. In the partially-integrated model the integration agreement will set out requirements for practices which will likely include: data quality requirements, agreement from practices to make their booking system accessible to the MCP under agreed protocols, agreements to supply business intelligence and a commitment to a 'data sharing agreement'. Ultimately, the ambition should be for all systems to have the ability to receive information from others, remove the need for multiple logins and reduce time wasted on manual communication.

Case study

Innovations to improve efficiency and functionality for GP IT systems – Dr Naresh Rati, GP and Chief Executive of Modality Partnership Group

"Technology has been a key enabler in supporting practices to deliver our new care model. We have developed a new digital platform, and introduced a new website, mobile app and Skype to enable patients to interact with our clinicians outside of the traditional face to face and telephone consultations. This has resulted in about 70% of requests for GP appointments being dealt with remotely without the need for patients to visit their surgery.

Our tele-dermatology service enables patients, through their GPs, to send digital photographs of lesions or rashes to dermatology specialists. This advice and guidance service has meant that 60% of patients can be treated by their GPs without the need to be referred. It has also meant effective triage of those patients that do need to be seen, so they are seen by the right specialist first time.

All our practices are on a single GP system with data sharing agreements in place. Our in-house IT team ensure all clinical templates across all surgeries are identical which helps reduce unwarranted variation in clinical practice and gives our clinicians confidence if they are working from a different site. We have created an internal clinical dashboard which tracks key outcome metrics for all our practices updated on a monthly basis; enabling our GPs to have informed peer to peer discussions on their practice outcomes.

There remain IT hurdles to overcome before we can truly create integrated and streamlined platform. We are working to resolve questions around information governance or interoperability across providers but we remain positive and committed to IT innovation. Working in an MCP there is a clear need for this interoperability but also the opportunity to develop the relationships and integrated working practices that enable IT innovations to realise these efficiencies and improvements for GPs."

How will this affect my staff?

69 Your workforce should find that there are opportunities for personal development and new careers for them in a larger, multidisciplinary organisation. For example, nursing staff might take on more clinical responsibilities or train to be nurse prescribers; administrators might train to deliver call and recall services.

70 Practice staff will be affected in different ways depending on the contractual model and to some extent the service scope of the MCP. If your practice is part of a virtual MCP it is unlikely that much will change in the way your staff are employed, though they may be some changes to their ways of working if you are sharing activities with other providers. Your practice will remain their employer and their terms and conditions will remain unchanged. If the clinical model leads to some staff roles being shared between providers TUPE may apply.

71 If your practice is part of the partially-integrated model your practice may remain your workforce's employer, or if practices choose to merge or create a new at scale organisation this could become the employer. The integration agreement between practices and the MCP will likely cover how integrated teams will work together, how practice staff will work as part of a wider team to deliver the care model, and how a broader range of specialist skills will be made available to patients.

72 Finally, if your practice becomes part of the fully-integrated model, your staff will almost certainly see changes. The new MCP organisation would take responsibility for providing the services and your staff could well transfer under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE). If you became a sub-contractor to the fully-integrated MCP, this may not be true but TUPE would likely apply if you created a new legal entity to hold the sub-contract. Under TUPE any employees that are transferred to a new employer will be able to retain their job role, their terms and conditions of employment, and their continuity of service.

73 In all cases, GP practices will have individual responsibility for engaging and consulting with their own staff regarding any possible transfer under the TUPE Regulations. There may also be an obligation to provide information about any transferring staff to the receiving organisation, which could be either the MCP or another practice.

74 GP practices and partners should seek legal advice if they are considering changing the way their staff are employed or engaged, or if they are considering changing their roles or terms and conditions as a result of their participation in an MCP.

Will my indemnity cover change?

75 In virtual and partially-integrated MCPs, GPs would not generally make any changes to the way in which their clinical indemnity is purchased. Similarly where a practice continues in current form as a sub-contractor to an MCP, it will likely continue on existing indemnity arrangements.

76 In a fully-integrated organisation, all employees will be covered by the MCP's indemnity, which means that both GPs and practice staff moving to the new MCP organisation (whether an NHS body or a non-NHS body) as employees will have the cost of their cover paid for, or reimbursed, by the employing organisation. The type of clinical negligence indemnity options available for the MCP will depend on its organisational form, but the type of cover – provided by clinical negligence scheme for trusts (CNST), medical defence organisations (MDO) etc. – will not impact on the obligation of the provider to cover all employees.

How will this help me to streamline back office services?

77 GPs working in federations or super practices have already demonstrated how economies of scale can streamline back office services and help manage resource pressures. Working at-scale, practices can share admin and management staff; can consolidate reception services and can benefit from purchasing discounts when buying in bulk.

78 MCPs can go further, offering opportunities to invest in training back office and patient-facing services such as call and recall or to create a single business function to manage human resources, IT, finance, contracts, public engagement etc. across the MCP. The MCP will need a back office function capable of supporting a large-scale, integrated organisation – presenting opportunities to upskill staff and leading to new career opportunities.

My contract

Is the MCP Contract compulsory?

79 Participation in an MCP is entirely voluntary. GPs can choose whether, and how, they wish to participate in an MCP model. NHS England and Department of Health have further agreed a suspension option, so that where GPs do choose to work directly for the MCP or as sub-contractors, they are able to set aside current primary care contracts with a view to returning to these if they decide to leave the MCP at a future date.

80 It is important to note that whilst the MCP Contract will be required to be used where a commissioner wishes to develop a partially or fully-integrated MCP, the Contract itself is not a contract with GP practices. GP participation with the MCP would be underpinned either through an alliance agreement or the Integration Agreement in addition to an existing GMS / PMS / APMS Contract, or through moving directly to work as employees for, or sub-contractors to an MCP.

81 The intention is to make MCPs as attractive to GPs as possible, and offer them more control and influence over their local health system – GPs will (understandably) only sign up to arrangements that offer them terms and conditions that are right for them.

What happens to my GMS / PMS in an MCP?

82 Where practices wish to be part of an MCP model there are, as outlined above, a number of options available to them. In most early MCPs particularly, there will likely be no change to current GMS / PMS contracts.

83 The first option is the 'virtual' MCP. In this option practices keep their active GMS, PMS and APMS contracts with the commissioner and sign an 'alliance agreement' that sits over the top of their traditional contracts.

84 The alliance agreement enables integration between providers. Through the alliance GPs and other providers can sign up to a shared vision, make operational and resource commitments and they may agree to a form of gain / loss share (see page 32). The terms of the alliance agreement are for local determination and can go as far as providers choose. NHS England has published a template alliance agreement with the draft MCP Contract package.

85 The 'virtual' MCP enables practices and other providers to sign up to a shared vision and agree how they will work together, agreeing criteria such as adherence to common standards; data sharing; common referral pathways; participating in MDTs. It is important to note that the virtual MCP is not a legal entity capable of holding the MCP Contract, meaning that providers cannot benefit from the same level of resource flexibility or contractual integration and alignment as those adopting other contractual forms.

86 GPs also remain on their active GMS / PMS contracts in the 'partially-integrated' MCP. In this option the commissioner would procure an MCP Contract for all services in scope but excluding core primary medical services. GMS / PMS contract holders would sign an 'Integration Agreement' with the new MCP provider, setting out how they will work together and on what terms. We are working on options for GPs to repurpose QOF to a set of metrics aligned with the MCP improvement payment scheme taken up by the wider MCP. In addition to the paid for element of the quality incentive scheme, we will set out a range of metrics against which the MCP's performance will be published. NHS England has published a template Integration Agreement with this draft MCP Contract package.

87 Participation in the MCP model is voluntary for individual GPs. Where GPs wish to participate in a partially-integrated MCP model, they will need to sign up to an Integration Agreement to underpin the integration of primary care with the community services delivered by

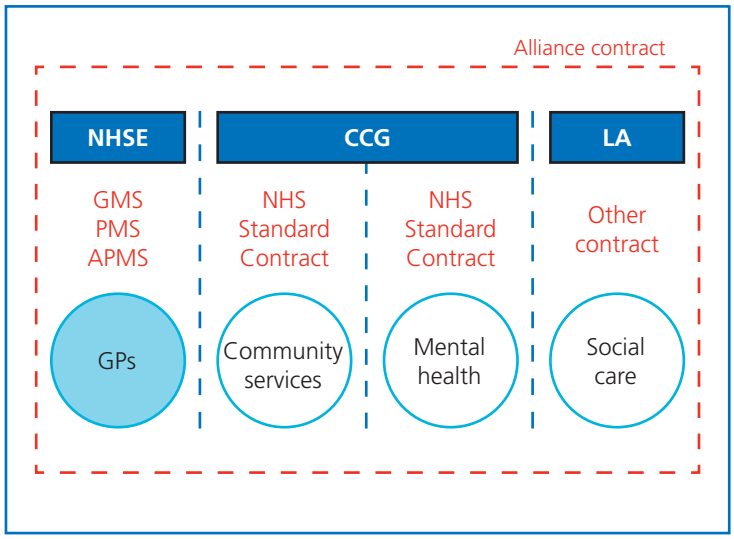


Figure 3 - The 'virtual' MCP

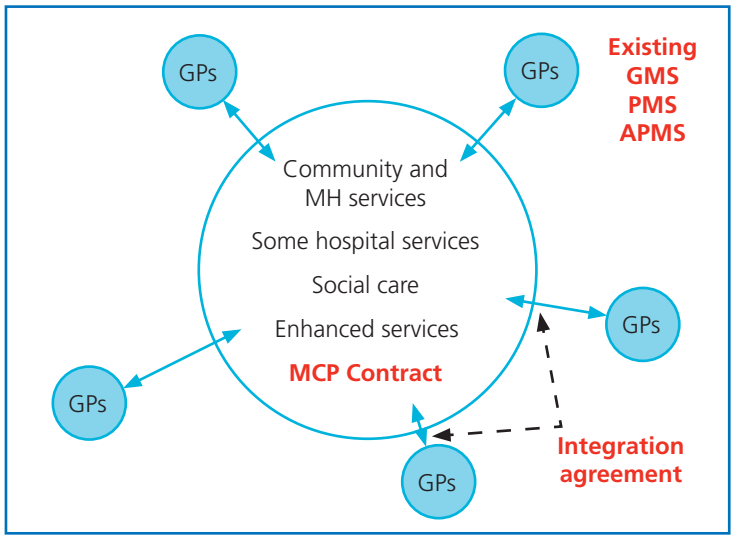


Figure 4 - The 'partially-integrated' MCP

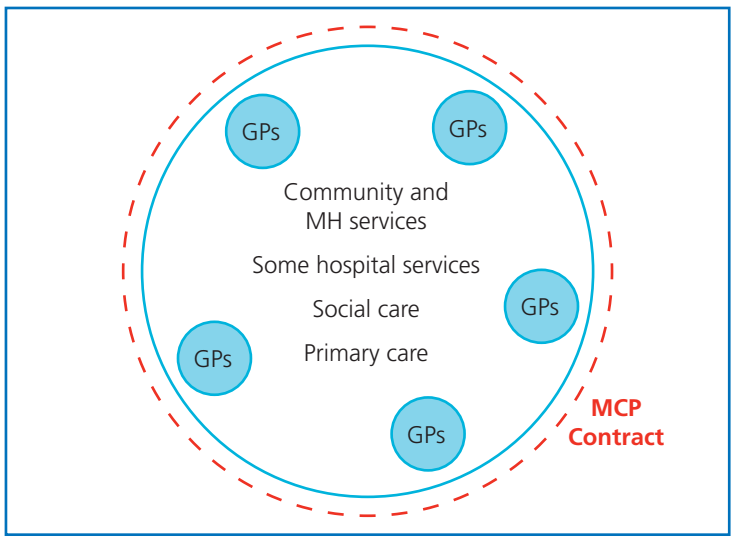


Figure 5 - The 'fully-integrated' MCP

the MCP provider. It will be for the MCP Contract bidder to demonstrate that agreement has been reached with local practices on the Integration Agreement.

88 Local commissioners will decide what the scope of the MCP Contract will be, based on their engagement. We recognise that some GPs are concerned about the potential to lose non-core income and whether Local Enhanced Services would be included in the MCP Contract scope to ensure that their delivery is managed in an integrated way with other MCP services. If they are, local agreements could well see GPs delivering these, or additional services, as sub-contractors to the MCP. Local discussions will need to take account of these issues as GP participation in the model is agreed, including the maintenance of appropriate practice income. In the partially-integrated option GPs could still come together, perhaps with wider partners, to bid for the MCP Contract whilst keeping their GMS / PMS contracts outside of the MCP's contractual arrangements.

89 The third option is the 'fully-integrated' MCP. In this option a contract is awarded which includes core primary medical services, specifically where GPs have agreed to work in the MCP as employees, or as sub-contractors to the MCP. GPs may also have a stake in the ownership of the MCP organisation. In order to do this practices will need to suspend their GMS or PMS contracts as otherwise the core primary care services would be commissioned twice. This would only be for a limited period of time, and practices would be able to reactivate their contracts either at the expiry or termination of the MCP Contract, or at regular intervals throughout its lifetime. The CCG would not be able to award a fully-integrated contract until partners have agreed terms on which they and their employees will work, either within the MCP or as a sub-contractor to it.

Can GPs choose different contractual models in the same locality?

90 Yes. It is possible, and in some places likely, that GPs in the same locality will make different choices about how they wish to participate in an MCP, resulting in a 'mixed economy'. This could be the case where some practices have chosen to suspend GMS / PMS whilst others have chosen to participate in a partially-integrated way. It's important that individual GPs have a choice and do not feel pushed into a particular contractual model because it is preferred by the majority. In many of the emerging MCP localities GPs are expressing interest in a range of contractual models in the same locality.

91 If a GP wished to move from fully-integrated involvement in an MCP to partially-integrated, they would need to reactivate their GMS /PMS in line with the terms set out below and then sign an Integration Agreement with the MCP. Should they wish to move from a partially-integrated to a fully-integrated model they will need to negotiate the terms and conditions of such a move with the MCP.

If I change my mind, how would I leave the fully-integrated MCP?

92 We have sought the views of the GPC on the mechanism for suspending and reactivating current contracts, in order to allow GPs to join and leave a fully-integrated MCP. This section describes the latest position reached in those discussions, but is subject to final agreement (and formal consultation with GPC) on changes to GMS regulations, which would be effective from April 2017.

93 As described, setting aside a contract is not required for either the virtual or partially-integrated MCPs; the suspension option only applies where GPs have decided that they would benefit from working within the fully-integrated MCP organisation. The 'suspension' option we have developed for practices is designed to offer GPs the choice of joining without requiring this decision to be final. In summary, it allows practices to reactivate their GMS / PMS contracts at two-year intervals throughout the life of the MCP Contract, or on expiry or termination of the MCP Contract. The assurance process should provide enough checks and balances in the procurement to protect the system against the MCP failing, however if the MCP did fail, GPs have the safety of knowing they can reactivate their GMS / PMS at this point.

94 We will work with the Department of Health to create this option by amending the relevant legislation, in effect removing the responsibility of the practice for providing essential services to their registered list. As GPs move into the MCP, either as employees or sub-contractors, their patients will follow them or in effect become part of the MCP's registered list. The Whole Population Budget will reflect this, channelling the majority of primary care funding directly into the MCP.

How would reactivation work in practice?

95 As outlined above, GPs can reactivate their GMS / PMS at two year intervals or at the termination or expiry of the MCP Contract. The reason for the two year time frame is to balance the need to provide regular windows for practices to leave the MCP, whilst providing some stability for the MCP so that its registered list is not constantly fluctuating as practices join or leave. Each contract can be reactivated once, and the partners must decide to do so together as an organisation, partnership or collectively where individuals hold a PMS Contract. For example, if half a partnership wished to reactivate and half preferred to stay in the MCP, the partners together would have to agree on their preferred course of action. Upon reactivation, GPs would return to the GMS contract (and the corresponding Statement of Financial Entitlements) in effect at the time of reactivation or if on PMS, a local discussion would take place to finalise the terms of a reactivated PMS Contract. For PMS GPs choosing to reactivate, the right to revert to GMS on the same terms as other PMS Contractors will remain in place. The MCP and commissioner would write to all patients who are resident in the practice's former boundary to advise them of the GP's move and their right to choose to stay in the MCP or join the new practice.

96 There are a number of practicalities that would need to be worked through locally. Clinical Commissioning Groups commission local community services /LES and will decide how these should be commissioned in future. GPs returning to GMS / PMS would need to show that staff roles have moved back to the practice as a result of reactivation, at which point staff could TUPE back. What happens to estates will depend on the arrangements agreed when the practice entered the MCP. GPs should, therefore, consider the likelihood that they will wish to return and the points in the contract at which they can reactivate, when coming to an agreement with the MCP over estates.

97 GPs have expressed concern that upon reactivation they could find themselves in competition with the MCP. A GP considering a return to GMS/PMS will need to articulate how the care the patient will receive from the new practice will compare to the care provided by the MCP. A GP may wish to reactivate GMS / PMS and sign an Integration Agreement to become partially-

integrated with the MCP. GPs will of course want to carefully consider the options available to them and balance their personal interests with those of their patients.

98 NHS England understands that GPs need more detail on how reactivation could work in practice. We also understand concerns that reactivation will become less practical as time passes, though we believe that this is an inevitable consequence of change and integration over years within a fully-integrated MCP. We will update this section in future versions of this document accordingly.

Will I have to make a financial commitment?

99 MCPs may require capital for three areas:

- Start-up costs: to develop the infrastructure to deliver the care model
- Working capital: to pay salaries etc. prior to receipt of revenue
- Contingency reserves or guarantees: to ensure the MCP has a reasonable level of resilience to the down-side risk of holding the contract.

100 Depending on their organisational form MCPs will access capital from different sources. If GPs are looking to participate as partners or owners in a new legal entity, then that may require a financial commitment.

What happens when the Contract ends?

101 NHS England expects the MCP Contract duration to last for a period of up to 10-15 years. Towards the end of the contract commissioners will need to decide how they wish to re-procure services within scope of the contract. If they decide to keep the MCP model they would be obliged to re-procure.

102 GPs who had suspended GMS / PMS will have a choice at this point: if they had suspended their primary care contracts they could chose to reactivate these and return to independent contractor status, or be involved in a future MCP for the new contract. Individual GP involvement will remain voluntary.

Will my pension be affected?

103 GPs should not lose access to the NHS Pension Scheme because of a move to an MCP. Access to the NHS Pension is dependent on the type of contract held by the GP's partnership / employer, and their status within that organisation. Where a GP is a partner in a practice their primary care income is eligible for the NHS Pension Scheme assuming it is received under a GMS, PMS or APMS Contract. Where they are employed they are able to access the NHS Pension Scheme through their employer, which would likely be a practice (i.e. they are a salaried GP), NHS Body, or Independent Provider (assuming IP status in the NHS Pension Scheme had been applied for under the 2014 Regulations).

104 Under a virtual or partially-integrated MCP this situation does not change, as current primary care contracting arrangements do not change. Under a fully-integrated MCP the GP will move out of the practice model into a much larger organisation, where their routes to access will be either as a sub-contractor or employee. We have worked through two broad changes to the

NHS Pension Scheme Regulations, to ensure that rights to a pension under the NHS Pension Scheme are not affected in either of these situations. These are:

- Recognising the MCP Contract as eligible for access to the NHS Pension Scheme in the pension regulations
- Agreement in principle to allow access to the NHS Pension Scheme as a sub-contractor, assuming that an NHS Standard Sub-contract is used (it should be noted that this agreement in principle that the current IP access rules be extended to include income derived from a recognised sub-contract is not yet provided for under NHS Pension Scheme Regulations – it is to be consulted on in late 2016 / early 2017 and will allow IPs to Pension income from a recognised sub-contract (e.g. an NHS Standard Sub-contract or an NHS MCP Sub-contract) even where they do not hold any other NHS contracts). The intention is that GP practitioners working in practices which move to become sole sub-contractors to an MCP (for example), would therefore be able to access the NHS Pension Scheme for their sub-contracting income as before, on the basis that earnings from an MCP standard sub-contract would be eligible to be pensioned. Practice staff would also retain access to the NHS Pension Scheme where the practice is granted IP status through the relevant regulations.

105 Collectively these changes allow GPs employed in MCPs access to the NHS Pension Scheme, because the employing organisation will hold an MCP Contract, and therefore will be able to access the NHS Pension Scheme as above, no matter whether the employer is an NHS or non-NHS organisation. Where a GP decides to become an owner of a larger (non-NHS) company or partnership, they should ensure they have an employment position within the MCP to continue to access the NHS Pension Scheme (although as an officer). This will ensure consistency with the current access rules which do not allow the shareholders or partners of independent sector providers of NHS services to access the NHS Pension Scheme directly.

106 Where a GP is sub-contracted to an MCP, the changes stated above will allow the partner(s) to pension primary care income under the practitioner rules, as they do currently.

How will my personal income and benefits be affected?

107 Participation in the MCP is voluntary, and GPs will therefore need to be happy with their role and package of benefits within a fully-integrated MCP before they will agree to participate. In a fully-integrated MCP GPs' personal salaries and other earnings will therefore reflect their local negotiation with the MCP provider and the roles and responsibilities they choose to take on within the MCP.

108 In a partially-integrated MCP, practice income will depend on the services that the practice provides outside of the MCP and any sub-contracting arrangements they agree with the MCP to deliver services.

How does general practice funding work in the whole population budget?

109 In the virtual and partially-integrated MCP, core general practice remains outside of the whole population budget, operating under existing GMS / PMS / APMS contracts and funded accordingly.

110 In the fully-integrated MCP the majority of all GP funding for participating practices, will be included within the Whole Population Budget baseline. Under current regulations there are a small number of GP funding streams that cannot be pooled within the whole population budget at this point in time.

111 GP funding will therefore flow to the fully-integrated MCP model in one of three ways:

- **a)** Pooled within the whole population budget at the start of the year (including global sum, QOF, seniority, MPIG, DES, LES)
- **b)** Funding flows through the MCP over the course of the year, as a direct result of primary care activity (e.g. vaccinations payments)
- **c)** Remains outside of the MCP, as current legislation prevents funding from flowing to the MCP (dispensing) – we are continuing discussions with the Department of Health as to how dispensing doctors may relate to the fully-integrated MCP.

112 The Whole Population Budget is a form of payment; designed to incentivise providers to work together towards outcomes. The funding entering the whole population budget for primary care will be calculated on the basis of current commissioner spend on the GP funding streams that will enter the WPB for the population served by the MCP. We are committed to maintaining national investment in primary care. For CCGs commissioning an MCP we will expect primary care funding at CCG level to be uplifted in line with nationally set primary care allocation growth. As such, where the MCP is aligned to the geography of the CCG its primary care funding will be uplifted at least in line with growth in primary care allocations. Where the CCG and MCP geography are not directly aligned the CCG will maintain discretion to assign growth in primary care funding to geographical areas where there is the greatest need, whether practices are inside or outside of the MCP. The MCP provider will be expected to deploy the whole population budget flexibly across the range of local health services to meet the needs of their defined population.

How will the performance payment work for GPs?

113 The MCP Contract will include a new MCP Improvement Payment Scheme which is designed to support delivery of the care model.

114 In the fully-integrated MCP, this MCP Improvement Payment Scheme will replace QOF and CQUIN and funds will be sourced from a top-slice of the Whole Population Budget in which, what was QOF and CQUIN funding will be included. The MCP Improvement Payment Scheme will be designed to replicate the balance of financial risk and incentives that exist in the current national performance pay schemes to ensure that the level of risk is manageable for providers. In the fully-integrated MCP this equates to circa 4%.

115 In the partially-integrated model, where core general practice sits outside of the MCP, GPs will, as a default, still be part of QOF. We have already seen changes to QOF in some localities where GPs and commissioners have agreed local variations; we are exploring options for similar arrangements to support the delivery of MCP objectives.

How will GPs relate to the gain-risk agreement?

116 If the MCP is successful, demand in the acute sector should fall against projections. The gain / loss agreement incentivises the MCP to reduce demand in the acute. This agreement will not incentivise individual GPs or practices in the fully-integrated model but rather it will incentivise the MCP as a single provider. The terms of any agreement would be for local negotiation and based on what can realistically be achieved under local circumstances.

117 In the virtual or partially-integrated models where GPs remain on GMS/ PMS /APMS contracts, they would only be party to a form of gain / loss share if they chose to be. In this arrangement GPs themselves would not be party to the MCP gain / loss agreement. Instead they could agree in the Integration Agreement how they participate in the gain/loss share, for example, they might share in the savings arising in the acute sector. GPs in some areas are exploring the possibility of agreeing a gain-only agreement with the MCP. We will be working up national framework with case studies for how this might work in practice.

Conclusion

118 This document is intended to support GPs to consider if and how they might choose to participate in an MCP. The MCP model is fundamental to delivering the vision of stronger and resilient primary care as described in the General Practice Forward View. Key benefits for GPs include: joined up working and economies of scale release time in general practice; a wider multidisciplinary team and prevention focus relieves pressure and improves job satisfaction; more services and associated resources in primary care mean greater career opportunities and more flexibility which supports recruitment and retention.

119 GPs are fundamental to the MCP model but we are clear that GP participation is entirely voluntary. For this reason we have worked to create a range of options to give GPs choice. It is important to note that in the virtual and partially- integrated MCP model not much will change for GPs contractually. The MCP Contract is the mechanism by which MCPs, and the organisational integration that underpins them, can be made sustainable, allowing for the commissioning of non-primary care and primary care services in a single contract. The Contract funding is designed to align incentives and reward demand management.

120 We hope this document will stimulate interest in the MCP model and we encourage interested parties to use it to support local discussions. We are still working through some of the detail and are keen to hear from GPs across the country. We would like to bring the document to life using further case studies from MCPs. You can send us comments via an online survey https://www.engage.england.nhs.uk/survey/mcp-contract-package. If you would like to discuss please contact our team at England.mcpcontractintensivesupport@nhs.net.

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England
- Care Quality Commission
- Health Education England
- The National Institute for Health and Care Excellence
- NHS Improvement
- Public Health England

Our values: clinical engagement, patient involvement, local ownership, national support

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