The Healthcare Landscape

September 2016

# PSNC Briefing 045/16: An introduction to multispecialty community providers (MCPs) and the emerging contract framework

This PSNC Briefing summarises NHS England's document The multispecialty community provider (MCP) emerging care model and contract framework (July 2016), which describes MCPs - a new place-based model of care - and the emerging contract framework which NHS England is currently developing to support the rollout of this approach to health and care provision.

It is expected that many MCPs will develop over the next few years and pharmacy contractors and LPCs therefore need to engage in their development in order to shape how they will impact on community pharmacy services at a local level.

## What is an MCP?

A multispecialty community provider (MCP) is a new place-based model of care. It combines the delivery of primary care and community-based health and care services and serves as a new type of integrated provider. MCPs were first described in the NHS Five Year Forward View (5YFV) and they are one of the new models of care which are being developed in 14 of the Vanguard sites. MCPs are viewed as critical delivery vehicles for achieving the aims of the 5YFV and making a reality of Sustainability and Transformation Plan (STPs). In the future they are likely to be the new model of care which will impact most on community pharmacies.

An MCP is about integration and it serves the whole population, not just a cohort of patients, such as people over the age of 65, within the area it covers. It involves redesigning care around the health of the population, irrespective of existing institutional arrangements. It is about creating a new system of care delivery that is backed up by a new financial and business model. As such, MCPs are Accountable Care Organisations (ACOs); ACOs have evolved recently in the United States and they build on a much longer history of integrated care systems such as Kaiser Permanente and Intermountain Healthcare. An ACO brings together a number of providers to take responsibility for the cost and quality of care for a defined population within an agreed budget.

The MCP covers the sum of the registered lists of the participating general practices, plus the specified unregistered population. As the defining feature of the MCP is the general practice registered list, this provides the possibility of two or more MCPs operating in the same geography. In its most integrated form, an MCP holds a single, whole-population budget for all the services it provides, including primary medical services.

Across the country, NHS leaders have been developing STPs to implement the 5YFV. Nearly all of the STPs involve creating new models of accountable care provision. Some are planning MCPs, others the bigger primary and acute care systems (PACS) model, under which all hospital services are also included under a single form of integrated provision. The underlying logic of an MCP is that by focusing on prevention and redesigning care, it


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is possible to improve health and wellbeing, achieve better quality, reduce avoidable hospital admissions and elective activity, and unlock more efficient ways of delivering care.

General practice is experiencing unprecedented workload and workforce challenges and NHS England has been clear that when general practice fails, the NHS fails. A big reason to develop an MCP at a local level is to provide practical help to sustain general practice right now. An MCP supports practices to work at scale and also to benefit from working with larger community based teams. It offers general practice federations and super-practices the potential to combine with community services and create a broader, more holistic and resilient form of general practice. An MCP opens up new options for GP partners, clinicians and managers. Over time it should also help with managing demand for general practice, by building community networks, connecting with the voluntary sector, and supporting patient activation and self-care.

## Aspects of health and care covered by MCPs

An MCP is a new type of integrated provider. NHS England states that it is not a new form of practice-based commissioning, total purchasing or GP multi-fund, or the recreation of a primary care trust. An MCP combines the delivery of primary care and community-based health and care services – not just planning and budgets.

An MCP incorporates a wide range of services and specialists wherever required. This is likely to mean provision of some services currently based in hospitals, such as some outpatient clinics or care for frail older people as well as some diagnostics and day surgery; it will often mean mental as well as physical health services; and potentially social care provision together with NHS provision.

An MCP may provide some services currently provided in a hospital setting, including outpatient or diagnostic services, as well as extending access to urgent care services in the community. Under an MCP model the remaining hospital services will continue to be provided by the local hospital, under a separate contract.

## The building blocks of MCPs

The building blocks of an MCP are the 'care hubs' of integrated teams. Each typically serves a community of around 30-50,000 people. These hubs are the practical, operational level of any model of accountable care provision. The wider the scope of services included in the MCP, the more hubs are needed to connect together to create sufficient scale. Many MCP Vanguards have started small (e.g. based on one or a few 30-50,000 population units), but all 14 MCP Vanguards now serve a minimum population of around 100,000.

## The Primary Care Home

Primary Care Home (PCH) is a joint National Association of Primary Care (NAPC) and NHS Confederation programme. It develops NAPC's 'primary care home' model in line with the MCP care hub or neighbourhood approach. Supported by NHS England's new care models programme and other partners, there are currently 15 rapid-test sites with more planned for 2016/17. The most notable features of the PCH model are:

- provision of care to a defined, registered population of between 30,000 and 50,000 people;
- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care;
- a combined focus on the personalisation of care with improvements in population health outcomes; and
- alignment of clinical and financial drivers with appropriate shared risks and rewards.

## Development of MCPs

Establishing an MCP requires local leadership, strong relationships and trust. No system of accountable care will get

off the ground and be viable without the inclusion and active support of general practice, working with local partners. NHS England states that as expert generalists, with their registered lists of patients, general practitioners will always be the cornerstone of any system of accountable care provision.

The process of developing MCPs, from initial ideas to full maturity and effectiveness may take several years. It involves doing 10 things:


## MCP care models

Every MCP will be subtly different, growing from and reflecting the context of its own community. However, all MCPs are essentially seeking to achieve the same aims and objectives by applying the same core methods.

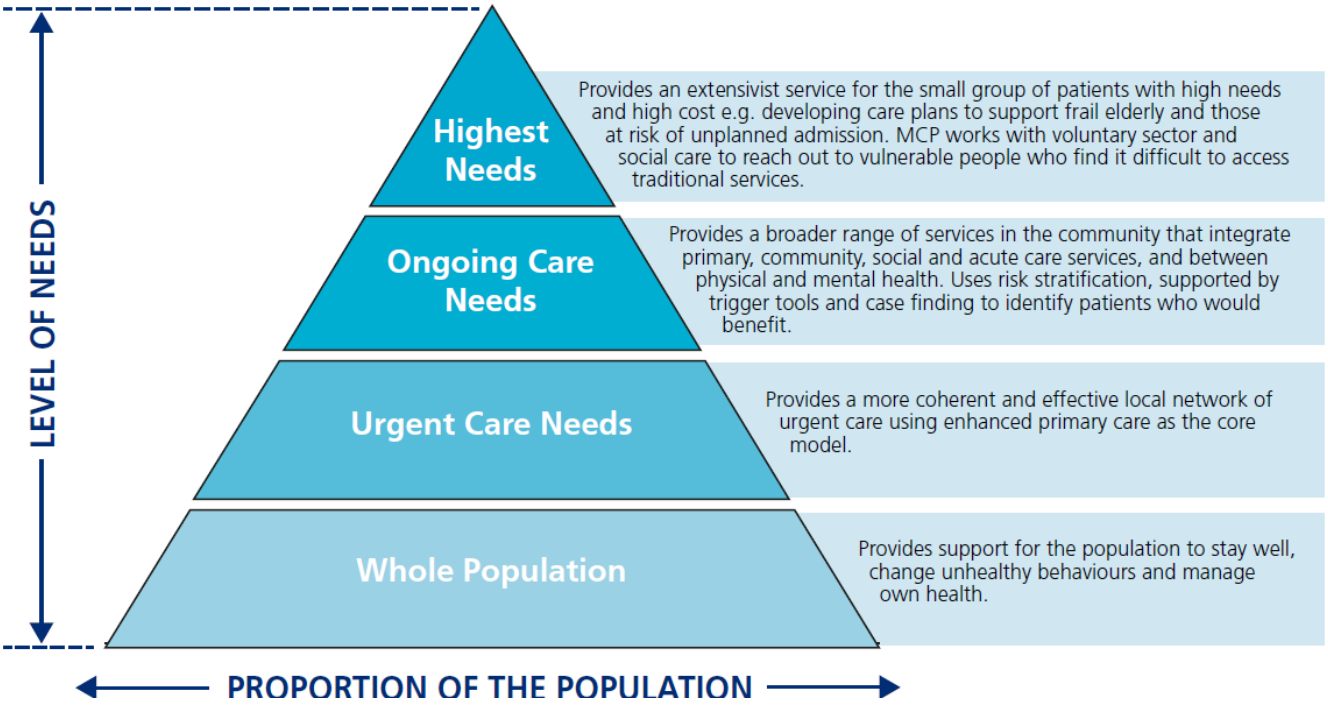
An effective MCP engages and activates patients, their carers, families and communities in helping to take control of their own care – rather than assuming that the main source of value is clinicians doing things to people. The success of an MCP will depend on how it grows and deploys its assets. The transformation of care involves major shifts in the boundary between formal and informal care, in the use of technology, and in the workforce.

MCPs will need to harness digital technology, not only to provide fully interoperable electronic records and real time data, but also to redesign the process of care delivery, for example through phone and Skype consultations, diagnostics, the use of apps and early adoption of innovative drugs and devices. STPs are expected to empower and engage staff to work in different ways by creating new multi-disciplinary teams; by redesigning jobs so that they are more rewarding, sustainable and efficient; and by implementing newer professional roles.

The MCP care model operates at four different levels:

1. at the whole population level, the MCP aims to bend the curve of future healthcare demand. It aims to address the wider determinants of health and tackle inequalities. It builds social capital by mobilising citizens, local employers and the voluntary sector;
2. for people with self-limiting conditions, the MCP helps build and forms part of a more coherent and effective local network of urgent care;
3. for people with ongoing care needs, it provides a broader range of services in the community that are more joined-up between primary, community, social and acute care services, and between physical and mental health, including for some, integrated personal commissioning (IPC) and personal health budgets (PHBs); and

4. for small numbers of patients with very high needs and costs, it delivers an 'extensive care' service - care which is led by an 'extensivist' (a consultant geriatrician or GP) and supported by a multidisciplinary team.




Source: The multispecialty community provider (MCP) emerging care model and contract framework (NHS England)

## MCP contract design

By far the most critical task in developing an MCP is to get going on care redesign, local hub by local hub. However, to be sustainable and fulfil their potential, all MCPs ultimately need to be commissioned rather than continue to rely on a shared vision and goodwill. In this way money flows and contracts and organisational structures all actively help rather than hinder staff to do the right thing. An MCP may start off as a loose coalition, but sooner or later it has to be established on a sound legal footing under contract.

A single contractual solution is unlikely to work best everywhere. Three broad versions are emerging:

1. **the virtual MCP** - under which individual providers and commissioning contracts are bound together by an 'alliance' agreement;
2. **the partially integrated MCP** - the scope of which excludes primary medical services, supported by contractual arrangements between the MCP and the GPs to achieve operational integration; and
3. **the fully integrated MCP** - contract model with a single whole-population budget across all primary medical and community based services.

These three versions serve to illustrate a spectrum of what is possible. All three are voluntary options and NHS England recognise that developing a new care model is an organic process, and a single national contracting solution will not work everywhere. Working with six MCP aspirant areas, NHS England is developing a draft of the fully and partially-integrated versions of the MCP contract. Some areas may choose to opt for and remain with an alliance model or the partially integrated model. Others may find this does not enable them to secure enough of the benefits of the fully integrated MCP.

The fully integrated MCP contract will be a new streamlined hybrid of the NHS standard contract and a contract for primary medical services. It will set national and local service requirements and standards. Contract duration will be much longer than is usual for an NHS standard contract: 10 or 15 years. Payment to the MCP will comprise three parts:

1. a whole population budget for the range of services covered;
2. a new performance element that replaces CQUIN (Commissioning for Quality and Innovation) and QOF; and
3. a gain/risk share for acute activity.

The contract could be held by entities such as a community interest company, a limited liability company or a partnership (e.g. building out from a GP federation or super-partnership), or by a statutory NHS provider. It opens up the prospect of new options for how GPs and other clinicians could relate to the MCP, but will not compel an existing general practice to leave the security of its general medical services (GMS) contract in perpetuity. NHS England states that it must be procured in a transparent and fair way, but this does not necessarily mean that procurement will involve multiple bidders. And it redefines the roles of provider and commissioner.

## Further resources

The following links provide further information on MCPs:

- NHS England – Multispecialty provider vanguards
- NHS England – The multispecialty community provider (MCP) emerging care model and contract framework (July 2016)
- NHS England, transformLDN, clevertogether & LondonCCGs - Future models of care – what makes a good multispecialty community provider? (June 2015)

If you have queries on this PSNC Briefing or you require more information please contact Zainab Al-Kharsan, Service Development Pharmacist.