Late last year NHS England launched a great flotilla of new papers on MCPs (“a raft” doesn’t quite do justice to the sheer scale of the release), providing lots of significant new detail on how the new providers will be constituted and contracted.

You can find them here. The documents include the draft contract, a lot of things explaining what the contract means, a template alliance agreement for people who don’t want to go the whole hog, and a couple of papers aimed at GPs who might be considering getting involved.

Here’s what we’ve learned:

The ‘mixed economy’

- Some CCGs are considering a “mixed economy” in which some practices opt for full integration and others retain their independence. This is a bit like the Yeovil PACS model, where some practices are absorbed into the trust’s GP provider arm, while others stay separate but still implement the new model of care. This adds complexity to future MCP arrangements but also realism. It’s not likely that all GPs will want to fully integrate at once, and it makes no sense to progress the model at the pace of the slowest. A mixed economy allows full integration where possible, and independence where GPs want it.

The point of singularity

- Fully integrated MCPs will have to be a member of their CCG. This makes perfect logical sense once you think about it, as they will be providers of core primary care, and CCGs are membership organisations for primary care providers. But imagine a CCG (let’s call it Ludley) commissions a fully integrated MCP covering its entire patch. The instant the contract goes live, Ludley CCG would only have one member: Ludley MCP Ltd, raising a set of entertaining head scratchers about CCG leadership, governance, conflicts of interest and the practicalities of contracting. New care models and STPs are “stretching” the legislative framework for the NHS in all sorts of ways already, but does the Ludley scenario mean we are approaching a point of singularity, with the system looping back and collapsing in on itself? NHS England is promising to join hands with the Department of Health
and leap into that particular black hole to consider the implications for CCG governance.

- Not unrelated, further guidance on managing conflicts of interest is due this month.

**Role of the private sector**

- It looks highly likely that the private sector will play a role in delivering new models of care. A Q&A in the MCP documents poses the question: “Is this privatisation of NHS services?” Presumably the issue has been raised by enough GPs for NHS England to want to answer it. But the answer is some distance short of an unequivocal “no”. The document says: “The objective of the new care models programme is not to privatisate the NHS. Regardless of organisational form, MCPs will offer free healthcare at the point of use. The MCP model is about integrating health and care services across a range of sectors and bringing together the best elements of these to deliver holistic, personalised care that improves local population health.” If your definition of privatisation includes the private provision of publicly commissioned services, this won’t reassure you.

- Here is a non-exhaustive list of organisational form options for MCPs: “hosted” by a trust with decisions made via a forum of partner organisations; a foundation trust or NHS trust, potentially with GPs on the board, in committees or as governors; a corporate joint venture; or a GP owned company.

- A virtual or partially integrated MCP won’t have implications for patient choice, as GP practices will remain separate and independent (although collaborating more than they used to). However, full integration has a clear impact on choice. Here’s what NHS England says: “The MCP offers patients a choice of location from which to receive primary care and a preference for a named GP.” I wonder whether that will be enough to keep the competition authorities away?

**Emerging finance and governance rules**

- MCPs will be subject to financial controls beyond those imposed on NHS trusts currently. NHS England directly asks the question (without supplying an answer): “Will these [controls] be effective in minimising the risk of failure, but without stifling local innovation?” Controls on MCPs might relate to liquidity, financial transparency, and even whether the ability of an MCP to distribute profit should be restricted.

- National leaders appear to be considering allowing MCPs to take on the financial risk for their entire systems. CCGs will not have to hold a 0.5 per cent contingency fund “in cases where the MCP holds the entire system utilisation risk (including that for the acute provider)”. What is a system utilisation risk? We don’t know. If you Google the phrase, only two results come back. One is the MCP financial strategy, the other is this, which is even more opaque, but seems to be about trains in Australia.

- Existing provider deficits will complicate the establishment of MCPs. If an MCP is being set up where the community or acute trusts have deficits, there are basically two options: leave the deficits in the trust, or transfer it (or part of it) to the MCP. Leaving it all with the trust seems a bit unfair if the MCP is going to take over some of its work. But that makes it even more important that the MCP is a big organisation with a serious balance sheet. (See above on the role of the private sector.)
Under the fully integrated model, MCPs will run a “whole population budget” made up of: primary care; social care; and local authority public health budgets. I was surprised not to see NHS community service funding in there, and by the sensible but highly ambitious inclusion of public health. It means MCPs in their most developed form will fully meld NHS and council commissioning.

MCPs will have to conform to NHS identity guidelines. Hopefully that means they won’t have stupid names.

Coaxing GPs

NHS England is working with the British Medical Association on a new option enabling GPs to “suspend” their contract – effectively creating a route back to independence if they don’t like being in an MCP. That might help convince GPs to give it a try, rather than having to commit upfront to giving up their practices forever. Subject to DH agreement, this will be effective from April. Practices will be able to leave the MCP by jumping out through a special contractual “window”, which will open once every two years. “GPs [wanting to leave the MCP] will of course want to carefully consider the options available to them and balance their personal interests with those of their patients”, the document adds, in a tone that is certain to charm sceptical GPs.

Any other business?

The MCP will have to be devoted “exclusively to the business contemplated by the contract”. So that’s one MCP per contract. However that doesn’t mean that a parent company (or foundation trust) can’t back multiple MCPs.

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