Commissioning of general practice services under MCPs: a paper for NHS England

The GPC is grateful to be represented, through Chaand Nagpaul's presence, on the MCP contract development group. We believe it is vital, as the representative body of GPs, to maintain this link and to be able to contribute to the discussions in a meaningful way. We are open minded about new contracting methods and support closer working between providers. The MCP contract development is not however a negotiating forum and our involvement in the group should not be interpreted as endorsement for the proposals under development.

Following the first meeting of the MCP contract development group, and in response to your 'strawman' papers, we would like to make a few important points, which we trust the group will take into consideration and build on over the coming months. This paper focuses on 3 main points:

1. Building MCPs on a foundation of a national core contract
2. Ring-fencing spending for general practice
3. Considering a binding right of return to GMS/PMS contracts.

Building MCPs on a foundation of a national core contract

We note the proposal to use a hybrid NHS Standard Contract/APMS contract for MCP contracting and to include mandatory core primary medical care specifications. We are concerned by this apparent movement away from the national GMS contract.

The value of national contracting

Using national specifications to specify basic elements of general practice which must be provided by all MCPs does not go far enough in ensuring a consistent standard of care to patients regardless of postcode. The national GMS contract for essential services underpins fair and consistent health service delivery in England. We therefore believe it would be inappropriate for flexibilities and freedoms from national standard contract requirements to apply to core general practice. History demonstrates that a national contract provides a straightforward and transparent vehicle for the implementation of national policy objectives, providing consistent quality care for patients and flexibility to build on locally. In effect, local PMS contracts have mirrored GMS contracts.

Building MCPs around the national contract

We believe that MCPs could flourish if built on the foundation of a continuing national core contract for general practice.

Greater collaboration and integration is demonstrably feasible with a national core contract in place. The service delivery element of the MCP proposals – functional integration between primary and community care - is already partially delivered in some areas under current contractual arrangements with practices working very closely with community teams. This indicates that full structural integration is less critical than functional integration and collaborative working. In many cases spending time on restructuring diverts those involved from focusing on meaningful service change.

Putting core services aside for national contracting does *not* prevent many services currently commissioned from general practice being directly provided or commissioned by the MCP. We have previously suggested that this is most straight-forwardly achieved by GPs working collectively through networked arrangements – either as the foundation for or partner in an MCP, or as a subcontracted provider – to provide a range of additional and enhanced services. Through membership of a GP network individual GPs can already get involved in the provision of a wider range of services, multi-disciplinary work and greater specialisation. In the context of an MCP structure, collaborative or leadership input from a GP network also allows GPs a chance to manage patient pathways and redesign services and workforce.

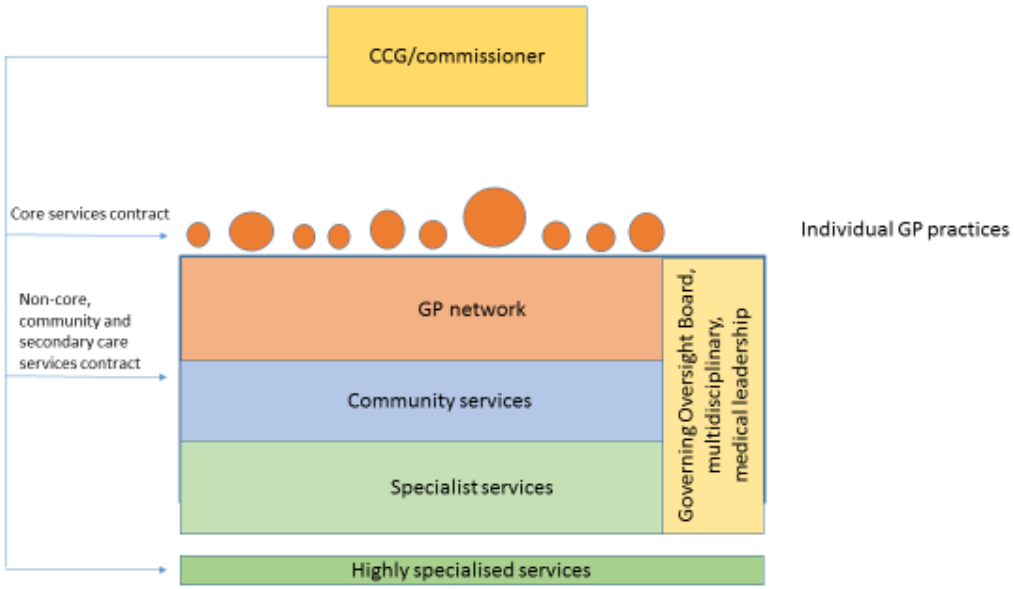
We believe GP networking could provide all the financial incentive needed to fulfil the MCP's objectives without any need for the MCP to subsume core contracts for general practice, particularly if elements of practice or network income are outcomes-based. These possibilities have been acknowledged by NAPC's Primary Care Home proposals which said 'where staff are salaried or on sub-contracted arrangements, an equity stake or incentives payments will be needed to foster an inclusive approach to the delivery of high standards of response care'.

Preserving current core contracting arrangements at practice level does not prevent the MCP being defined by the combined sum of individual registered practice lists. Nor does it prevent the MCP from choosing to redistribute resources to move more care out of hospital. Conceivably, individual GMS and PMS contractors could even work with the MCP to redefine staff roles, block-back staff time to the MCP or lease premises. This model does however preserve the personal, local, provision of care valued by GPs and patients.

Our suggested model

The GPC produced a discussion document in April 2015 *General practice and integration: Becoming the architects of new care systems.* This set out a proposed model for the integrated provision of collaborative care, which incorporates separate contracts for core services but uses GP networking as a foundation for integration between primary, community and secondary care.

Many GPs are already shareholders in GP networks. Responding to the BMA's 2015 survey of GPs, 37% of GPs said their practice had already joined a network or federation. 43% said this was to bid for or deliver contracts, 40% hoped to have more influence on healthcare delivery through networks and 39% were networking for the long term security of their practice. 52% of all respondents said that their preferred model for the future was working in networks more collaboratively with other healthcare professionals. We therefore have good reason to believe that our network-based proposals are broadly acceptable to the profession.



[Note that this model does not preclude MCP employment of GPs or MCP management of GP practices where individual GPs and practices make these choices.]

Practical arguments for preserving the national contract as a foundation for MCPs

Subsuming contracts for core GP services in MCP contracting will require complex local negotiations between MCPs and practices either as employees or subcontractors. This could prove to be a significant distraction from the more important task of redesigning patient pathways and the delivery of collaborative care. It would also mean that some GP-led MCPs – those for example which are network based – would be in the position of designing their own contracts for essential services creating potential conflicts of interest.

Maintaining the national core contracting and using new contracting methods for other services, as now with enhanced services, would help NHS England to meet its tight deadlines from April 2016. Building MCPs on the foundation of the national core contract will help attract GPs to the new organisations, giving them a sense of stability and reassurance which will allow them to act boldly in service redesign for other services. As NHS England has acknowledged, practices asked to give up their existing GMS/PMS contracts to move into MCPs as employees or subcontractors would face many uncertainties including uncertainty about the financial effect in terms of income, premises and pension rights which "present significant barriers to rapid acceptance of the MCP model".

The simplest approach is to keep core GMS and PMS contracts in place between NHS England and individual practices. Alternatively, we understand it would also be technically possible for the GMS contract to be held between the MCP and individual practices. This could possibly be achieved via a novation agreement whereby the MCP agreed to assume the rights and responsibilities of the Board, with the GMS contractor giving consent to the same.

Note that if there is feeling that the current GMS contract is currently too prescriptive, GPC would be willing to review the contract with NHS England to focus more squarely on the provision of core services.

Ring-fencing spending for core general practice

NHS England's current proposals are predicated on a single population-based budget covering all primary medical services and various integrated community services. As noted above, we are convinced that it is right to build MCPs around a national core contract which would entail specified levels of funding for core (essential) services.

Should GPs decide to move away from existing GMS and PMS contracts to new locally-defined arrangements for the delivery of general practice, we would argue that spending on core services should be defined and ring-fenced within the wider budget. Without this basic level of protection, core services to the population could be put at risk by debts in other parts of the health service, budgetary constraints or unforeseen overspends on non-core services. This risk is profound under the proposals for utilisation risk at MCP level where the utilisation risk for primary and community health services will be held by the MCP and where utilisation risk for acute care is shared between MCP, commissioner and acute providers. We have repeatedly highlighted how the percentage of NHS funding spent on general practice has fallen since 2006 and the likelihood is that without protection this would get worse. Ring-fenced spending for core services, like the continuation of a national core contract, does not preclude the designation of a single overall population budget to the MCP, particularly if funding for core general practice is not the largest component of the overall spend. As the MCP budget will be calculated in the first instance partly on the basis of current GP spend, a ring-fenced budget would be straight-forward to implement.

We note the suggestion that 'the MCP will have clear decision rights over reshaping care and the flexible use of resources across different pathways, services and settings'. This could still be the case with a ring-fenced ***floor*** for core general practice spending which would allow MCPs to invest additional resources in essential services.

We believe that a failure to ring-fence primary care spending would act as a huge disincentive for GPs to join/engage in MCPs

Considering right of return

In principle *should GPs leave the national contract to move to separate MCP contracting arrangements (note above that we do not believe this to be necessary or desirable)* we would, in theory, be supportive the creation of a binding right of return to GMS or PMS contracts. However, we believe that such as right of return is likely to be difficult or illusory in practice. To name just a few complicating factors:

- QOF may well no longer be in existence once MCPs have come into being
- premises might have changed hands or be leased out
- staff employment models might have changed considerably
- there may have been mergers of registered lists.

This raises questions about how feasible a right of return would really be and whether such a right would be time limited or allowable only after a certain amount of time had elapsed. How would a

single practice in an MCP area exercise a right of return? As the papers acknowledge, any right of return could threaten the future stability and viability of the MCP.

NHS England has suggested that a binding right of return to GMS or PMS might help allay concerns felt by GPs considering moving into an MCP contracting arrangement. However, a right of return from an MCP arrangement to P/GMS is completely different from the current right of return for PMS practices to GMS. For the reasons stated above, we do not believe that we could support a right of return as sufficient reassurance for GPs contemplating moving from the GMS contract. This is another reason why we would argue that it would make much more sense simply to maintain a core GMS contract with MCP arrangements built around this solid foundation. This would negate any need to construct complicated right of return arrangements facilitating the timely creation of MCPs.