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NHS ENGLAND – BOARD PAPER

Title: The Multi-Speciality Community Provider (MCP) emerging care model and contract framework
Lead Director: Ian Dodge, National Director, Commissioning Strategy
Purpose of Paper: This paper updates the Board on the MCP framework, and highlights the main features. Its development and publication by NHS England is a significant milestone in the new care models programme and the implementation of the Forward View. We are defining the MCP model and the emerging approach to contracting, based on what the vanguards have been doing. We are inviting comments on the framework by 2 September, prior to publication of draft MCP contract at the end of the month. The paper also summaries how we are supporting and challenging the MCP vanguards.
Recommendation: The Board is invited to: • endorse the publication of the MCP framework documents; • note the key elements of the model; and • support the ongoing work with vanguards and delivery partners to implement the MCP model both among the vanguards and through subsequent spread.

The Multi-Speciality Community Provider (MCP) emerging care model and contract framework

Introduction

1. The Multi-Speciality Community Provider (MCP) framework is being published on 28 July. It is a significant staging post for the new care models programme.

2. Last July, the Board agreed the support package for the new care models. Over the past year, we have begun to see what an MCP looks like on the ground. Rather than first produce the national policy, and then ask the NHS to implement, the MCP framework is a pattern drawn from the collective acts of 14 local MCP vanguard sites, working with national support. The care model is not set in stone and will continue to come into ever sharper view. But we are now defining the model: this is what being an MCP means, here's how you do it, and these are the implications.

3. Through STPs, we see very significant interest in developing new models of "accountable care provision", whether an MCP or a PACS – as new delivery vehicles to deliver better population health.

4. First the MCP framework covers care redesign, then commissioning contracting and organisational design. Care redesign is by far the most important job. No system can just procure or restructure its way to transformational change through transactional processes. But every MCPs and PACS does, sooner or later, need to be commissioned. A new care model will not be sustainable, or achieve its full potential, unless financial flows and organisational governance actively support people to do the right things, rather than hinder them.

5. National help with commissioning and contracting was one of the main requests from local vanguard leaders. Through work with 6 local systems we now have a way forward on commissioning, contracting, financial flows and organisational form. At the end of September we will be publishing a draft of the MCP contract. Feedback is being invited by 2 September. We will be providing intensive assistance, challenge and backing to the leaders in the six early adopter systems to progress their plans and overcome barriers to change. NHS England and NHS Improvement are committed to doing this in tandem.

6. The MCP framework is the first in a suite of care model framework documents that define each of the new care models. The next will cover the Primary and Acute Care Systems (PACS), Enhanced Health in Care Homes (EHCH) and Acute Care Collaborations (ACC).

The MCP care model

7. An MCP is what it says it is - a multi-speciality, community-based, provider, of a new care model. It is a new type of integrated provider. It is not a new form of practice-based commissioning, total purchasing or GP multi-fund, or the recreation of a PCT. An MCP combines the delivery of primary care and community-based health and care services – not just planning and budgets. It also incorporates a much wider range of services and specialists wherever that is the best thing to do. This is likely to mean provision of some services currently based in hospitals, such as some outpatients clinics or care for frail elderly people; it will often mean mental as well as physical health services; and potentially social care provision together with NHS provision.

8. The fully integrated MCP has a single whole population budget across the range of services it providers. It creates a new care model, backed by a new business model, based on the GP registered list. No accountable care provider is viable without the full support and engagement of general practice.

9. The MCP model is a critical enabler of the GP Forward View. When general practice fails, the NHS fails. A big reason to develop an MCP is to provide practical help to sustain general practice right now. It supports practices to work at scale and also to benefit from working with larger community based teams. It offers 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 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.

10. 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 you need to connect together to create sufficient scale. All the 14 MCP vanguards now serve a minimum population of around 100,000.

11. An MCP or a PACS is a place-based model of care. It serves the whole population, not just an important subset such as people over the age of 65. The MCP covers the sum of the registered lists of the participating practices, plus the specified unregistered population. As the defining feature of the MCP is the 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. As long as it has sufficient decision rights to deploy that budget flexibly, the MCP can reshape the local care delivery system around what really would work best for different groups of patients.

12. The MCP care model operates at four different levels:
    - 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;
    - for people with self-limiting conditions, the MCP helps build and forms part of a more coherent and effective local network of urgent care;
    - 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; and
    - for small groups of patients with very high needs and costs, it delivers an 'extensive care' service.

13. The success of an MCP depends on how it grows and deploys its assets: building social networks, community resilience and patient activation; harnessing technology; and empowering and engaging staff to work in multi-disciplinary teams. The workforce component is critical to the delivery of the MCP model in each local system. It takes time and effort to develop a new workforce culture, build skills and develop roles to support multi-professional working between health and social care teams. A test of whether an MCP is actually working is whether anything feels different, on a daily basis, clinician by clinician, manager by manager and of course patient by patient.

Commissioning and contracting for an MCP

14. A single contractual solution is unlikely to work best everywhere. Three broad versions are emerging. The first is the 'virtual' MCP, brought about through an alliance contract. The second is the 'partially integrated' MCP contract, which means that whilst general medical services (GMS) are an integral part of the MCP model of care, the GPs retain their GMS contract, which 'sits alongside' the MCP contract.. The third is the 'fully integrated' model with a single whole population budget across all primary and community based services. These versions illustrate the spectrum of what is possible. All three are voluntary options. Working with six systems, NHS England is developing a draft of the fully and partially-integrated versions. Some areas may choose to opt for and stick with alliancing or the partially integrated model. Others may find this doesn't enable them to secure enough of the benefits of the fully integrated MCP. It is too early to say; national and local thinking will continue to evolve.

15. The fully integrated contract will be a new simpler hybrid of a standard NHS contract and a contract for primary medical services. It will set national and local service requirements and standards. It will last much longer than a normal NHS contract: 10 or 15 years. The contract sum comprises three parts: (i) a whole population budget for the range of services covered; (ii) a new performance element that replaces CQUIN and QOF; and (iii) a gain/risk share for acute activity.

16. The contract could be held by a community interest company, a limited liability company or partnership (e.g. building out from a GP federation or super-partnership), or 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 practice to leave the security of its GMS contract in perpetuity. It must be procured in a transparent and fair way, but this does not necessarily mean that there will be a competitive procurement involving multiple bidders; and it redraws the boundary between what activity takes place in a provider and commissioner.

Delivery support

17. The new care models team are supporting the journey that all fourteen MCP vanguards are making from their current status as "aspirant MCPs" towards achieving full maturity over the next few years. This includes implementing all the core components of the framework; and achieving an agreed and clear return on investment through a combination of demand moderation and provider efficiencies. This work is led by Louise Watson who runs the MCP part of the NCM programme.

18. Other support includes:
    - ongoing evaluation of impact against national and local metrics
    - developing a suite of impact studies. There will be three types of case studies: type 1 – specific interventions in a single vanguard where there is early evidence of impact; type 2 – innovative and broad types of interventions or services, perhaps including examples from several different vanguards; type 3 – whole vanguard, looking at population and system-level change.
    - apply rapid cycle learning/improvement techniques
    - delivering technical and hands on support across the national support package including on technology, workforce and system leadership

19. A dedicated MCP contract development team under Ed Waller is leading the complex and interrelated policy and implementation questions on new commissioning, contracting, organisational forms and funding methodologies. This team is working intensively with six sites. The sites are: Dudley, West Birmingham and Sandwell (Modality Partnership), Southern Hampshire, Whitstable and Canterbury (EnCompass), Wakefield and the Greater Manchester devolution area (Stockport MCP and City of Manchester). In addition to developing the full and partially integrated MCP contracts, the team is also:
    - co-producing examples of procurement documentation;
    - testing emerging thinking on governance, accountability and regulation issues;
    - engaging with sites to test emerging options for organisational forms (including workforce / estates implications);
    - testing principles for assessing financial standing and the development of the ongoing financial assurance framework architecture of a new Pay for Performance scheme;
    - developing multi-year payments and risk / gain share mechanisms to ensure incentives for participation and to maximise efficiencies across a local health system, the whole population budget and the new MCP performance payment.

Spread

20. Many MCPs have started small (e.g. based on one or a few 30-50,000 population units), to build momentum and grow – even if the original plan is to scale up quickly. Most have found it is ultimately quicker and smarter to deliver change by going “an inch wide and a mile deep” and then spread, rather than start by going “a mile wide and an inch deep” and seek to add depth. For example, Better Local Care (Southern Hampshire) MCP vanguard was established in three localities with a combined population of 75,000. By March 2016, it had grown to 17 localities covering 800,000 people. Key to that expansion was the funding and development of clinical leaders and locality managers for each of these localities.

21. There are many ‘unofficial’ MCPs around the country outside of the vanguards. They show that national funding is not essential for local systems to get started, though obviously it helps. Spread from the vanguards is beginning to happen through engagement of neighbouring clinicians, and like-minded peer groups from visits, WebEx and social media, and programmes like the Primary Care Home; and vanguards are also learning from people outside of the new care models programme. As a collective the vanguards do not have a monopoly of knowledge. The transfer of learning is two-way.

22. To accelerate progress and support double running costs, a national New Care Models funding stream will contribute to supporting additional future MCPs and PACS. In 2017/18 we expect to expand national support from coverage of about 8% of the country now, to around a quarter. This autumn NHS England and NHS Improvement will be inviting applications for national support for future MCPs, PACS and acute care collaborations, linked to the next phase of sustainability and transformation planning. The most compelling plans for the next MCPs are likely to cover specific communities in 17/18, with wider spread thereafter, rather than all of the CCG or whole STP footprint at the same time. Once we have selected geographies, NHS England's Investment Committee will continue to make investment decisions based on individual plans to deliver value – in particular, a return on investment through a combination of demand moderation and provider efficiency, that are consistent with agreed STP financial assumptions.

Recommendations

23. The Board is invited to:
    - endorse the publication of the MCP framework documents;
    - note the key elements of the model; and
    - support the ongoing work with vanguards and delivery partners to implement the MCP model both among the vanguards and through subsequent spread.

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