

A photograph of two men in a clinical setting, overlaid with a blue diamond-patterned grid. The man on the left is wearing a white lab coat and a stethoscope. The man on the right is wearing a suit and glasses, also with a stethoscope. They appear to be in conversation.

The multispecialty community provider (MCP) emerging care model and contract framework

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

July 2016

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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.

Contents

1. Introduction and summary	4
2. Developing and illustrating the MCP care model	7
3. Contract design	20

1. Introduction and summary

This document defines what being a multispecialty community provider (MCP) means by assembling features from the 14 MCP vanguards into a common framework. In turn, the 14 will be adopting or adapting the framework for their diverse local communities, as they progress from their current status as aspirant MCPs towards full maturity.

The care model will evolve as the vanguards continue to learn together about what does and doesn't work. This document is not definitive national policy on how to commission and contract for an MCP; rather it shows where we have got to in the joint national/local work, as we continue to identify and solve the practical issues. From this joint work will come a first draft of an MCP contract by the end of September. To assist with that task, we would welcome feedback and suggestions on this document by 2 September 2016 to england.newcaremodels MCP@nhs.net.

An MCP is about integration. As a patient or a clinician, you would not choose to recreate from scratch the historical partitions between primary, community, mental health and social care and acute services. The boundaries make it harder to provide joined-up care that is preventative, high quality and efficient. The MCP model dissolves the divides. 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.

Across the country, NHS leaders have been developing sustainability and transformation plans (STPs) to implement the *NHS Five Year Forward View*. 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 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.

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. As expert generalists, with their registered lists of patients, general practitioners will always be the cornerstone of any system of accountable care provision.

General practice is experiencing unprecedented workload and workforce challenges. 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. An MCP 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.

An MCP is what it says it is - a *multispecialty, 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 primary care trust (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 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.

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

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-making rights to deploy that budget flexibly, the MCP can reshape the local care delivery system around what really works best for different groups of patients.

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, including for some, integrated personal commissioning (IPC) and personal health budgets; and
- for small numbers of patients with very high needs and costs, it delivers an 'extensive care' service.

An MCP cannot simply be willed into being through a transactional contracting process. Merely rewiring institutional forms, contracts and financial flows changes nothing. 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. The first is the 'virtual' MCP, under which individual providers and commissioning contracts are bound together by an 'alliance' agreement. The second is the 'partially integrated' MCP contract, the scope of which excludes primary medical services, supported by contractual arrangements between the MCP and the GPs to achieve operational integration. The third is the 'fully integrated' MCP contract model with a single whole-population budget across all primary medical and community based services. These versions illustrate the spectrum of what is possible. All three are voluntary options. Working with six MCP aspirant systems, 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. It is too early to say; national and local thinking will continue to evolve.

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: (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.

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 practice to leave the security of its general medical services (GMS) contract in perpetuity. 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.

2. Developing and illustrating the MCP care model

Developing an MCP

The process of establishing a successful MCP involves doing 10 things well. Initial conception through to full maturity and effectiveness may take several years.

10 essential jobs in creating an MCP

- 1** Build **collaborative leadership** around a shared local vision based on a new clinical model. Engage the local community and engage local GP practices individually as well as through federations and clinical commissioning groups (CCGs).
- 2** Create a dedicated '**engine room**' to drive and manage the local transformation programme, with adequate dedicated resources and capabilities. This is not just a programme management office and it needs your best people.
- 3** Establish a transparent **governance structure** so that everyone knows how decisions are made, and to ensure collective responsibility.
- 4** **Understand the different needs of your diverse population**, and segment into different population groups, to design your new care model.
- 5** Develop and maintain a clear and explicit description (a '**logic model**') that explains how the proposed transformations in care are intended to lead to the outcomes that the MCP wants to achieve. Logic models provide a simple visual means of showing complex chains of reasoning. Care models and logic models of the 14 MCP vanguards are available on request from england.newcaremodelsmcp@nhs.net.
- 6** Establish the financial case (a '**value proposition**') for developing the MCP. Commit to a clear return on investment, so that there is a compelling and credible proposition for service change. This includes setting out how the MCP will help moderate demand, and increase provider efficiency. It has to fit with the local sustainability and transformation plans (STPs).
- 7** **Design and document each of the specific component parts of the care redesign**. This includes clinical and business processes and protocols, team design and job roles. Do these work with and for patients, carers and clinicians? For the most complex services, develop a clear understanding of the different costs, the expected throughputs, and the methods for selecting patients for proactive care.
- 8** Systematically **plan, schedule and manage the implementation of the changes** in line with the emerging design specifications, and the value proposition timetable. Achieve effective clinical and patient participation.
- 9** **Learn and adapt quickly**. Inevitably some changes won't work as intended. Generate timely monitoring and evaluation loops covering (a) initial implementation of change, broken down change-by-change, team-by-team; (b) the ongoing management of the services; and (c) the quantified impact on outputs and outcomes. Identify successes and rapidly address the inevitable teething problems that will occur, and failures in design or execution. Scrap the interventions that don't work.
- 10** **Commission and contract** for the new model, so that organisational forms and financial flows are supporting your goals rather than get in the way.

Many MCP vanguards 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 approximately 800,000 people. Key to that expansion was the funding and development of clinical leaders and locality managers for each of these localities.

There are many aspirant 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.

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 the 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;
- alignment of clinical and financial drivers with appropriate shared risks and rewards.

Further details can be found at www.napc.co.uk/rapid-test-sites

To accelerate progress and support double running costs, a national new care models funding stream will contribute to support additional future MCPs and PACSs. In 2017/18 we expect to expand national support from coverage of about eight per cent 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, PACSs 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 2017/18, 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.

An MCP or a PACS?

Multispecialty community providers (MCPs) and integrated primary and acute care systems (PACSs) are both population-based new care models that aim to improve the physical, mental and social health and wellbeing of their local population. Both are based around the general practice registered list, and apply a new model of enhanced primary and community care. They encourage diverse communities to look after themselves by supporting self-care and connecting people to community assets and resources. They support staff to work in different ways, with a focus on team-based care, and harness digital technology to achieve their goals. Both MCPs and PACSs are provider models that will ultimately need to be commissioned using new contractual mechanisms and funded using a whole population budget.

However, MCPs and PACS will differ in scope and may differ in scale. On scope, both models include primary, community, mental health and social care services. A PACS also provides most or all local hospital services. 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. Both models have the potential to transform where and how traditional hospital services are provided. The PACS model offers the prospect of achieving this transformation across all hospital services.

The other difference may be one of scale. The natural unit of both the MCP and the PACS model is the neighbourhood population of 30,000 to 50,000. At a minimum an MCP will need a population of 100,000, but could be much larger. At a minimum, a PACS will provide care for all the population served by its acute trust, generally at least 250,000.

Local commissioners may initially aim to commission a PACS but instead commission an MCP. This could happen where, for example, it turns out that there is insufficient desire amongst general practice to fully integrate with the local hospital. Or the local acute trust may be happy to be able to 'dock' with a newly established MCP, without wanting to run it; and instead focus more of its energies on wider acute and specialist collaboration.

What is the MCP care model?

Every MCP will be subtly different, growing from and reflecting the context of its own community. But behind the differences, all MCPs are seeking to achieve the same objectives, and by applying the same core methods. They will increasingly form a common, identifiable model as they implement this framework. They are critical delivery vehicles for achieving the *NHS Five Year Forward View* and making a reality of STPs.

The success of an MCP depends 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. The opportunity for an MCP is across all three. 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. It harnesses 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. And it empowers and engages 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 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.

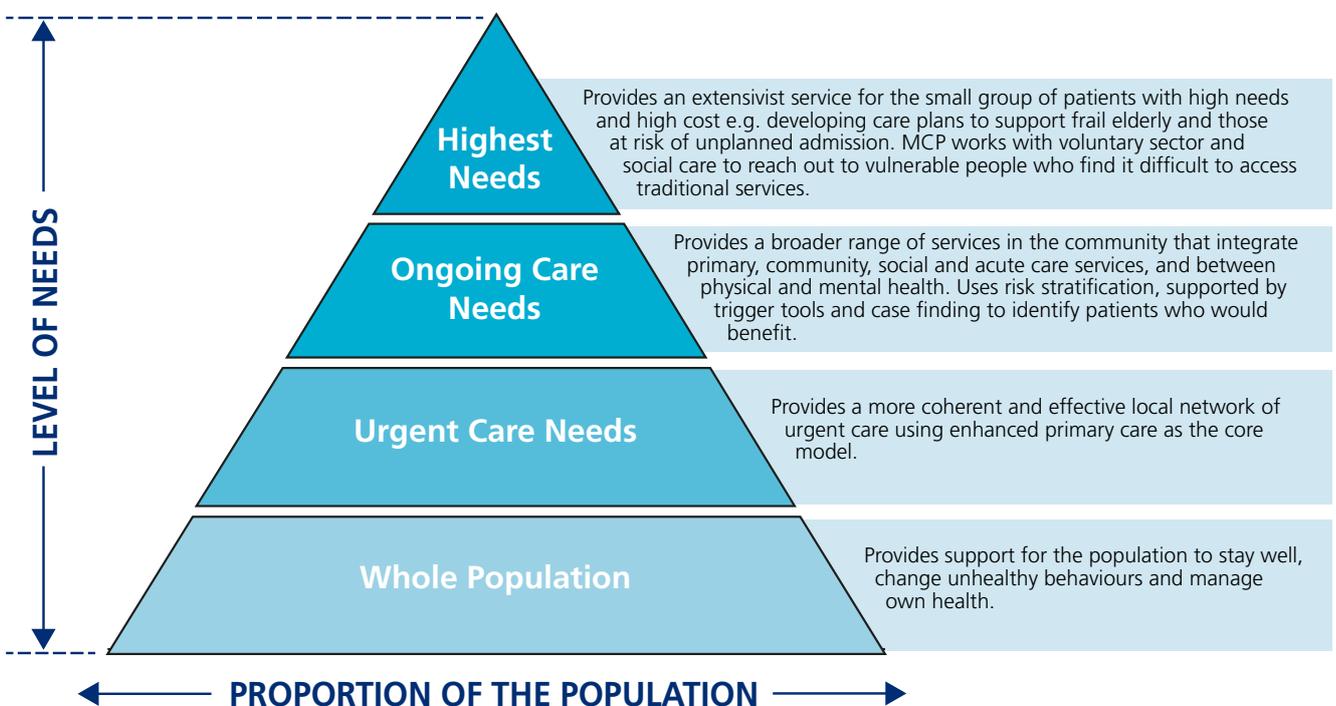
But before it builds its new care model, the MCP first needs a deep understanding of its population. To segment its population and manage care accordingly, it requires joined-up care records across primary, community and social care and acute services, real-time data, business intelligence systems and access to significant analytical capability. It maps differential needs, activity and spend. It uses analytical models to predict the health interventions that will be required by sub-populations and individual patients; it identifies where it can make quality and efficiency improvements to tackle unwarranted variation, and through holding a whole-population provider budget, it can far better align resources to needs.

The MCP model:

- takes account of the joint strategic needs assessment;
- creates integrated datasets, drawn from interoperable health and care records. It aims to cover episodes and outcomes from primary, community, acute, mental health and social care services. As a first step, a number of MCP proposals are extending the use of the existing GP record into other community services;

- uses actuarial approaches to model the risk profile of their patient populations and estimate potential cost efficiencies of specific interventions (e.g. Principia Partners in Health (Southern Nottinghamshire), Better Local Care (Southern Hampshire));
- is reliant on using high quality business intelligence systems, with data that is as real time as possible. Without these, an MCP is 'flying blind'. Core aspects of 'commissioning support' such as business intelligence will increasingly become 'population health management support', and all MCPs and PACSs will be making use of these services as key customers;
- adopts or adapts the NHS Rightcare method, which supports commissioners to understand and tackle unwarranted variation in the health outcomes and costs of their population (www.rightcare.nhs.uk);
- stratifies risk and segments the population, using the four levels of the MCP care model;
- takes care to understand specific sub-groups of its population with the greatest needs, such as within particular housing estates, care homes, remote rural neighbourhoods, toddlers, people who are homeless or in the lowest quintile of deprivation; and
- uses and joins up data safely, including by conducting a privacy impact assessment to ensure that it uses data in line with the Data Protection Act 1998. It applies the tools developed with the integrated care pioneer programme by the Information Governance Alliance (<http://systems.hscic.gov.uk/infogov/iga/resources>).

Figure 1: The four levels of the MCP care model



Reducing future demand

Prevention is a 'must do' for every MCP. It is not just a job for local government and CCGs. All the vanguards have developed promising examples - whether it's through engaging pupils to run a mile a day (Better Care Together (Morecambe Bay Health Community) PACS, after the Falkirk primary school model); making every acute contact count; engaging with the fire service to help with preventing ill health; or undertaking deep analysis of tackling inequalities (Tower Hamlets Together MCP, West Cheshire Way MCP, My Life a Full Life PACS (Isle of Wight)). The NHS Confederation and partners publication [New Care Models and Prevention](#) describes the work of All Together Better Sunderland and West Wakefield Health and Wellbeing Ltd. As Sir Michael Marmot, Director of the Institute of Health Equity, says "It is great to see prevention being put into practice in community, mental health, acute, ambulance and care homes settings".

The MCP vanguards are all aiming to apply systematically the six principles for effective local engagement:

A defining feature of an MCP is that it nurtures social capital and community resilience. In All Together Better Sunderland MCP vanguard over 18,000 volunteers have been engaged as community health champions and they have in turn reached over 104,000 others. All the MCP vanguards are developing or are now operating large-scale social prescribing schemes, some tailored to particular patient groups. Better Local Care (Southern Hampshire) MCP vanguard, for example, has developed social prescribing pathways that are focused on people with signs of low-level mental distress or mild cognitive impairment. Increasingly vanguards are looking beyond integration with social care and public health, to how they can work with schools, housing associations, job centres and youth justice and probation services.

Figure 2: The six principles of engagement



Accessible and responsive urgent care

Out-of-hospital services are a vital part of the urgent and emergency care system. But for patients and staff they rarely feel as coherent and streamlined as they should be. Developing an MCP or PACS is one way of helping to address this. Accountable care models ought to make it much easier to simplify the interactions between GP in-hours, GP extended access services, minor injury units, walk-in centres, community pharmacies, 111, GP out-of-hours, and A&E. The MCP can also provide the basis for sharing data and care plans, and allowing the direct booking of appointments within a collaborative governance arrangement. By April 2017 nearly all the MCP vanguards will be operating as part of a local system where the following eight commissioning standards are met:

1. patients can make a single call to get an appointment out-of-hours (OOHs);
2. data can be sent between providers;
3. the capacity for NHS 111 and OOHs is jointly planned;
4. the summary care record is available in the clinical hub and elsewhere;
5. care plans and patient notes are shared between providers;
6. the system can make appointments to in-hours general practice;
7. there is joint governance across local urgent and emergency care providers;
8. there is a clinical hub containing (physically or virtually) GPs and other health care professionals.

West Wakefield Health and Wellbeing Ltd MCP vanguard provides a good example of enhanced signposting. The vanguard has increased the number of patients signposted by care navigators by forty per cent over three months. A care navigation framework (directory of services) is embedded across practices and receptionists use this to signpost patients to cost effective and appropriate services to meet their needs in a timely manner. The vanguard recently recruited 41 additional care navigators making the total trained 114. This initiative is releasing GP time.

MCPs will be well placed to deliver improvements in access to general practice as described in the *General Practice Forward View*. As additional investment comes on stream, any national requirements around access will be included within the MCP contract, and applied as additional investment comes on stream. The MCP vanguards will all be offering patients the choice of electronic appointments and prescriptions, and greater support for self-care, for example, through the use of health apps and telecare.

Increasingly MCP vanguards provide alternatives to face-to-face appointments, including video calls, email and telephone consultations; and are also redefining professional roles. For example Modality MCP vanguard (Birmingham and Sandwell) recognised the high-level of smartphone use in its population. It developed an app that allows people to book appointments, send messages to clinicians, and receive real-time feedback. The participating practices are increasingly using Skype and the telephone for consultations, with 90 per cent of such consultations obviating the need for a surgery visit. These initiatives have been associated with a 72 per cent fall in 'did not attends' and were introduced as a response to a 10 per cent rise in activity. Average remote consultation times have fallen to under five minutes, and 70 percent of patients say the new system has improved access.

The majority of MCP vanguards will deliver enhanced urgent care services, through clinical hubs with patients immediately accessing GPs, nurse prescribers, pharmacists and dentists through 111 or a single point of access. Integrated access means that the vanguard is able to appropriately divert a proportion of potential urgent and emergency care patients away from secondary care but ensure the patient has access to the right point in the system. Principia Partners in Health (Southern Nottinghamshire) MCP vanguard is a good example. Here, GP practices now have a fully interoperable clinical record system. For patients accessing care urgently via other routes, whether through an out-of-hours GP, walk-in centre or emergency department or via emergency ambulance, each point of care has access to view the ten key fields from the GP record, therefore providing the clinician with information to support management plans or avoid admission. The East Midlands Ambulance Service control centre has access to view records which assists ambulance crews when in a patient's home via call-back to control for additional information. This can frequently reduce the need to convey patients to hospital. The system interoperability is being extended and by October 2016, all hospitals within the area will be able to see GP records, including emergency and elective care, and GPs will have access to the care records of their patients while in hospital.

The benefits of working at scale are for clinicians as well as patients. Better Local Care (Southern Hampshire) MCP vanguard has created a 'same-day access service', which pools together the urgent workload for the participating GP practices into a single service that is operated from a central location and is resourced by the practices. In the six weeks from opening in December 2015, the service handled 5,500 patients - almost two thirds of whom had their needs met over the telephone.

At Encompass (Whitstable, Faversham and Canterbury) MCP vanguard, initially based out of Whitstable, paramedics are now attached to general practices to act as the first responder to urgent patient calls. Urgent calls are received by the practice and if a home visit is required, the paramedic attends and assesses the patient. The paramedic has access both to the full patient record and to the duty GP for advice. The early indications from the aspirant MCP's evaluation of the initiative show a 15 per cent reduction in conveyancing. They have also demonstrated their patient's confidence in the service as the paramedic can respond more quickly to a request for support than a surgery-based GP. Dudley MCP vanguard is now seeking to implement this model.

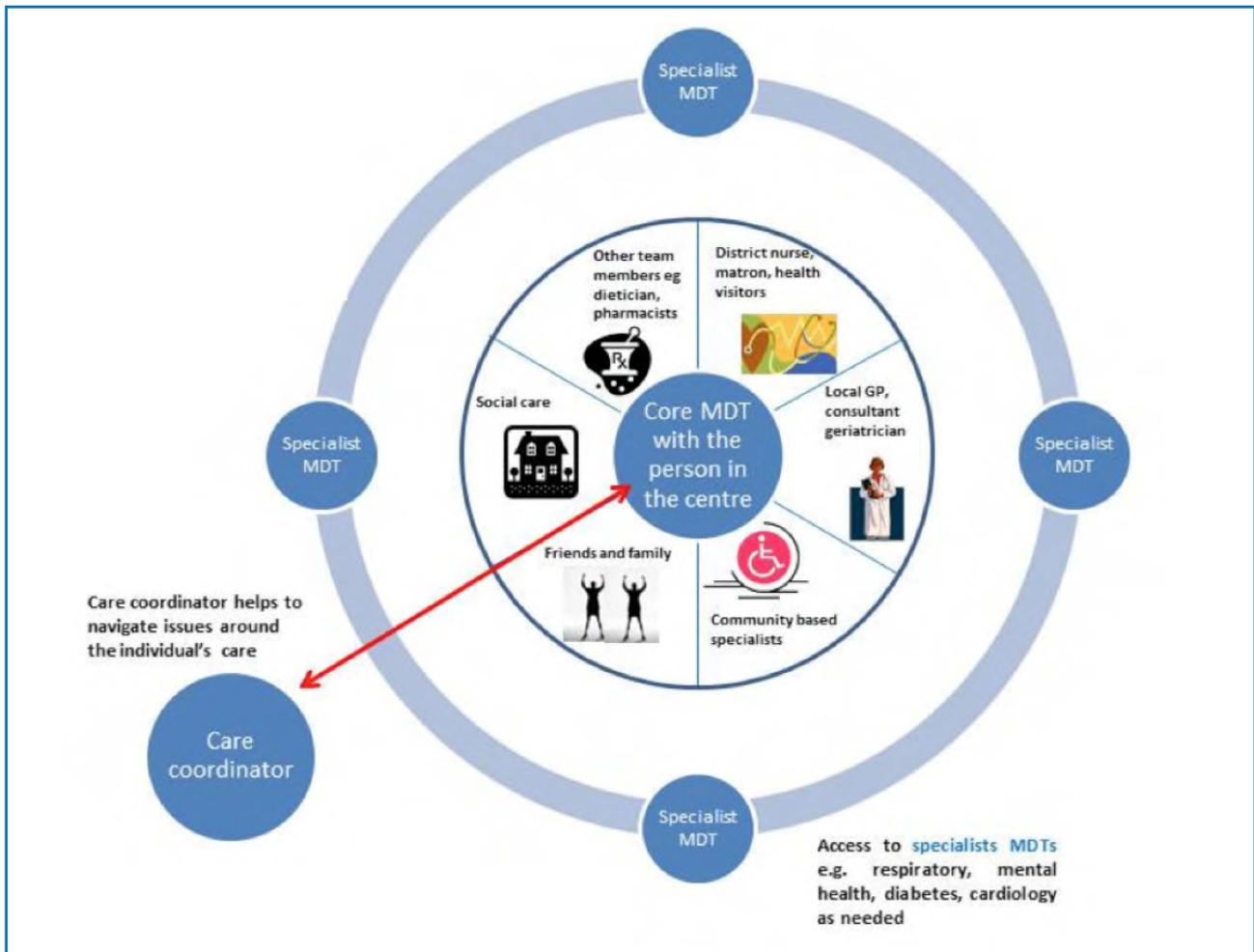
The MCP's community-based facilities can also provide a wide range of diagnostic tests, which support the delivery of both urgent and routine care. As a result, fewer patients are required to attend hospital. Some clinical monitoring regimes have moved in their entirety from hospital to a community setting under the supervision of the GP, with appropriate software support and with rapid direct access to specialist advice where required. For example Lakeside Healthcare (Northamptonshire) MCP vanguard has introduced an expanded range of diagnostics in its locality hub, including blood tests, blood gases, urine analysis, pregnancy test, X-ray, ultrasound, bladder scan and ECG. The hub also has an observation unit, which allows clinicians to observe the patients for up to 12 hours between 8am and 8pm. By combining these observations over time with the laboratory diagnostics and imaging, a more complete treatment plan can be developed and implemented, which often obviates the need for a hospital admission.

Integrated primary and community based care for people with ongoing needs

The heart of the MCP model is integrated primary and community-based care. The current MCP vanguards have registered populations of between approximately 100,000 and 800,000. MCPs are organised into localities or hubs based on one or more GP practices with a combined registered population of approximately 30,000-50,000 patients.

MCPs are aiming to increase both the breadth of primary care services delivered (e.g. by following standardised protocols and integrating primary, community, mental health, social and urgent care) and the depth of intervention delivered within the primary care setting (e.g. by increasingly providing services that traditionally have been delivered within outpatient settings). A core component of each hub within an MCP is the integrated community multidisciplinary team (MDT). In turn, MDTs are supported by colleagues from other sectors and by care co-ordinators who provide dedicated support to patients and their carers who have multiple interactions with different care settings. The GP ensures continuity of responsibility for the patients on their list. The core MDT not only provides support to patients at high predicted risk of unplanned hospitalisation but also ensures that responsive care is offered to all individuals who need it. The MDT also provides inreach into hospitals to ensure timely discharge of patients.

Figure 3: Integrated community multidisciplinary team (MDT)



The wider infrastructure of the MCP can help provide more consistent care across the hubs. Dudley MCP vanguard has developed a standardised long term conditions framework. This framework describes how care will be provided for the 34 percent of local people who have a long-term condition. GPs and practice staff are supported to deliver the framework through a series of standardised tools in the EMIS clinical system - tools such as comprehensive health checks for patients presenting with a new co-morbidity, and tools that help the clinician consider the patient's needs as a whole rather than overly focusing on an individual long term condition. An initial evaluation of the scheme found that 54 percent of participating practices thought that the changes had improved the patient consultation. An ongoing evaluation will measure the impact of the service on other aspects of patient care.

In an MCP, community services are ultimately fully integrated with primary care and work with both specialists (such as community-facing consultants, specialist nurses and consultant therapists) and generalists (such as district nurses, physiotherapists, occupational therapists). The elements include:

- core community care – focuses on the maintenance of health including: falls prevention; administration of medication; monitoring for deterioration. Many patients in this group will be supported by the extensivist model;
- rehabilitation and reablement – focuses on recovery after a period of ill health and supports independent living for as long as possible;
- specialist care – focuses on a specific aspect of a patient’s condition in the community. For example, in Encompass (Whitstable, Faversham and Canterbury) MCP vanguard, work is ongoing to train community and practice nurses together on wound care.

All Together Better Sunderland MCP vanguard, for example, has developed a recovery-at-home service with a single point of access to crisis support and intermediate care and reablement services, with the ability to respond quickly in a multiagency fashion that supports all of the individual needs of the patient. The ‘recovery at home’ service brings together a wide range of health and social care professionals, as well as other local support organisations to make sure that when people need short term, intensive care at home they have a service that is wrapped around them.

Enhanced health in care homes will become a core part of all MCPs and PACSs, learning from the six care home vanguards. An example vanguard is Principia Partners in Health (Southern Nottinghamshire). Early outcomes within the MCP vanguard have shown:

- ambulance responses to care homes are 55 per 100 care home beds per years, compared with the South Nottinghamshire average of 108;
- hospital conveyances are 29 in the area compared to 64;
- there were no community acquired pressure sores in older people resident in care homes in the last two quarters of 2015/16;
- initial indication of the financial impact of reducing the risk of falls and hip fractures with a nurse led community approach suggests predicted cost savings of around £73,000 for year one, representing a return on investment of 52 percent.

Another way of joining up health and social care provision is through integrated personal commissioning (IPC - www.england.nhs.uk/commissioning/ipc). No matter how good its' patient engagement, no single provider or commissioner will ever be able to fully understand and tailor services to the unrevealed preferences of some of its most vulnerable patients or those with the highest needs. And so we will support all MCPs to adopt the IPC model fully, and provide personal health budgets to a small but growing proportion of its population, e.g. those with complex long-term conditions, wheelchair users and people with significant learning difficulties and/or mental health needs. By 2020 MCPs will be contributing towards the national ambition that 100,000 people will be benefiting from personal health budgets. The influence of personal health budgets' collective decision-making is likely to help improve the quality of mainstream care; and where people opt for more personalised care, the total cost of care to public services tends to fall. Above all, the MCP means catalysing and supporting patients to be able to become more active in managing their own care. All MCP vanguards will be supported to improve levels of patient activation and self care and this may bring the additional benefit of helping to ease pressures on general practice.

The MCP and PACS model offers the opportunity to rethink existing elective care pathways. Again, this will become an integral part of the model. Stockport Together MCP vanguard's consultant connect service allows GPs to easily get expert advice from hospital consultants about a patient who has visited their surgery or during a home visit. The service is available seven days a week, 24 hours a day. The service means GPs can get advice immediately and prevents the need for patients to be referred for an outpatient appointment. Since being launched, the service has cut hospital referrals by 70 percent for patients needing haematology or endocrinology services. Stockport Together MCP vanguard is now working through a 100 day change programme to further redesign elective care pathways. In Tower Hamlets Together, the MCP vanguard has established an e-referral service for patients with renal problems. The system has drastically cut the number of people having to attend an outpatient appointment. 50 percent of referrals are now being dealt with without the need to visit hospital, with advice being given in an average of five days – compared to 64 days for patients attending hospital.

The General Practice Forward View provides examples of practices in vanguards delivering elective care on-site. Several MCP vanguards have minor surgery or ambulatory care suites, some with laminar flow facilities as well as short-stay observation units. The cataracts service that now forms part of Encompass (Whitstable, Faversham and Canterbury) MCP vanguard, for example, has recently delivered its thousandth cataract operation. For patients, these facilities mean that diagnosis, treatment, recovery and follow-up care can all take place closer to home. The MCP model supports GP specialisation as well as creating new options for clinicians currently based in hospitals.

Implementing the 'extensivist' model

The fourth distinct level of the care model is for the small group of patients who incur the very highest NHS costs. A range of extensivist models are operating within different vanguard areas. As part of its evaluation, the new care models programme will be describing which work best. The extensivist model of care is associated with fewer unplanned admissions, shorter lengths of stay, and fewer unplanned readmissions.

The Fylde Coast Local Health Economy MCP vanguard's 'extensive care service' is a fundamentally different way of delivering care for 500 or so patients who have the highest needs and who are most at risk of unplanned hospital admission. The service is oriented around the needs of the individual patient, and is able to address all aspects of such patients' care: medical, social, psychological, functional and pharmaceutical. It brings together the full range of assets in the local community and focuses on early intervention and proactive prevention. With the patient's consent, clinical responsibility passes from their GP to the extensive care service, which is led by an 'extensivist' (a consultant geriatrician or GP) and supported by a multidisciplinary team. This team coordinates both disease-specific care (e.g. heart failure) and generic care (e.g. end of life care). Members of the team deliver some care themselves, but they are also supported by specialist services.

A detailed clinical blueprint for the service was developed by a multidisciplinary team of local clinical leaders and the service is underpinned by a shared records system that operates across primary care, community services and secondary care. This service mostly caters for people who are aged 60 or over and have two or more long-term conditions, such as cardiovascular and respiratory problems, or diabetes and dementia. Each patient is allocated a dedicated 'wellbeing support worker' who helps them to identify a set of wider non-clinical wellbeing goals, and then supports the patient to achieve them. A preliminary evaluation suggests that compared with a control group, people receiving the extensivist service attended A&E less frequently and made less use of non-elective and outpatient hospital services. There has also been a drop in non-elective and outpatient activity in the extensivist group of patients.

3. Contract design

By far the most critical task in developing an MCP is to get going on care redesign. But to be sustainable and fulfil their potential, all MCPs ultimately need to be commissioned rather than continue to rely on goodwill, so that money flows, contracts and organisational structures all actively help rather than hinder staff to do the right thing. An MCP may start off as an informal coalition, but sooner or later it has to be established on a sound legal footing under contract. A common theme from all of the vanguards is that they wanted national help in working out the best approach.

General practice at scale

General practice at scale is a natural first step towards an MCP, for example via super-practices or GP federations. Working in groups of at least 30,000 patients enables general practice to:

- be commissioned to take on new services and funding set out in the General Practice Forward View. These could include the provision of additional access, co-funding for the introduction of pharmacists within general practice, or infrastructure investment;
- consolidate existing local enhanced services, subject to local commissioner agreement; or
- go further and consolidate all essential, additional and enhanced services, (e.g. under the super-practice model), as a way of building resilience, enabling staff development and opportunities, creating new capabilities, (e.g. to manage infrastructure), and realising economies (e.g. in administration). Some super-practices may develop into other geographies, for example where they can help support struggling practices.

These services can all be commissioned under existing forms of contract. Stronger super-practices or federations could then seek to further develop into credible bidders for wider MCP contracts, whether alone or in partnership with others.

The three emerging versions of MCP contracting

Going beyond primary care at scale, we see three broad versions of MCP contracting emerging: for the virtual MCP, the partially-integrated MCP, and the fully integrated MCP.

Version 1 is for the virtual MCP, under which providers of services within the scope of the MCP care model and their commissioners would enter into 'alliance arrangements', which would overlay but not replace traditional commissioning contracts. This agreement could establish a shared vision and a commitment to managing resources together, as well as clear governance and gain/risk sharing arrangements, together with an agreement about how services will be delivered operationally. Alliance arrangements will be easier to establish if GPs have already come together to operate at scale for certain services. This type of arrangement is a pragmatic step forward and is the least disruptive. It adds an extra layer to an already complicated set of contractual arrangements, rather than simplifying these. It is also the weakest form of MCP in terms of its rights to create and manage integrated provision, and its ability to deploy resources flexibly.

Version 2 is for the partially-integrated MCP. A step beyond an alliance approach would be for commissioners to re-procure, under a single contract, all services that would be in the scope of a fully-fledged MCP except for primary medical services. The resulting contract could include some aspects of local enhanced primary care services. By agreement, it could also add QOF and directed enhanced services (DESS). The contract holder would be required to integrate these services directly with primary medical services delivered under GMS and personal medical services (PMS). The entity that was awarded the contract could be a new organisation (perhaps a joint venture vehicle) or an existing organisation taking a lead role across the system. That entity may, of course, sub-contract elements of the services to existing or new providers.

Version 3 is for the fully integrated MCP. Here the MCP holds a single whole population budget for the full range of primary medical and community based services. It best reflects the logic of the new care model. The MCP has the greatest freedom to redesign care and workforce roles. It can more easily redraw the line between what the CCG does, and what the MCP does. Getting there is complicated, more radical and furthest away from the status quo.

These three versions serve to illustrate a spectrum of what is possible. All three are voluntary options. Developing a new care model is an organic process, and a single national contracting solution will not work everywhere. Local areas will need to work through the trade-offs between: (i) the degree of formal integration they want to achieve; (ii) their appetite for change; and (iii) the pace at which they wish and are able to proceed. Some areas may choose to stick with an alliance 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: the different models have not yet been fully developed or implemented.

Six systems are working with NHS England to shape and develop the detail of the draft MCP contract that will be published in September. These are based around the following areas: Dudley, Birmingham and Sandwell, Canterbury and Coastal, Hampshire, Wakefield, and Greater Manchester. The September draft contract will be based on the fully integrated version - in order that they, and the wider NHS, can see and understand what it looks like but will also demonstrate how the partially-integrated version would work. The six have been defining and drawing from the national work, as they begin to decide which version or variant works best for them. The new care models programme is providing intensive support to each, so that they can learn as a group, create common approaches wherever that makes sense, and develop solutions that are tailored to work in their own communities.

Features of the fully integrated contract

The fully integrated MCP contract is for delivery of services that are currently commissioned through both primary medical services contracts (whether GMS, PMS or APMS) and NHS standard contracts. It is a new type of hybrid contract. It sets the terms upon which the MCP will be paid and how it will be held to account by its commissioner to achieve specified outcomes and standards across the defined range of services, including what happens when things go wrong or when there is a breach of the contract's terms. In developing the contract our aim is threefold: to increase flexibility for the provider; to focus better on outcomes; and to simplify.

The MCP contract will be of longer duration than those that are typically offered to NHS providers at present. We are working on the basis that it could have a 10 to 15 year term, including an initial early break-point (e.g. after the first two or three years of the contract term). This is to provide stability and support ongoing investment in care redesign. In the period before the break-point, there would be scope to learn and adjust through an agreed mechanism. At the time of the break-point, if the break 'right' is not exercised, then there may be the ability to vary the contract, e.g. to add a wider range of services. The contract will also allow for some ongoing adaptation, e.g. additional practices joining.

An important role for commissioners will be to describe the full scope of services to be delivered by the MCP, and to finalise a service specification that details the design features, outputs and outcomes of the MCP. The specification will consist of mandated national requirements, core elements of the MCP care model, and local service requirements and standards. The balance between ambition for improvement and deliverability will emerge through our intensive design work with the six local systems.

Dudley - service scope

Dudley Clinical Commissioning Group has developed a prospectus for the procurement and commissioning of an MCP. The prospectus outlines the local service requirements, including the range of services to be provided and the service outcomes, organisational requirements and relationships with the local system. The service delivery model has been shaped by three broad-based outcomes that were identified through local public consultation, namely improved access, continuity of care, and coordination of care. The CCG envisages a 10-year contract awarded to a single entity that will include:

- community-based physical health services for adults and children;
- some existing outpatient services for adults and children;
- an urgent care centre and primary care out-of-hours service;
- primary care services provided under existing GMS/PMS/APMS contracts
- all mental health services;
- all learning disability services;
- intermediate care services and services provided for people assessed as having NHS Continuing Healthcare needs;
- end-of-life services;
- voluntary and community sector services.

The mandatory requirements will include relevant legislation, NHS Constitution commitments and objectives set in the Government's Mandate to NHS England. As a probable single provider, it will be particularly important for MCPs to support and safeguard the patient choice agenda. We will work with the six sites to explore the options to protect and improve patients' right to choose their GP practice and provider of secondary care services that migrate into the MCP.

The MCP contract sum

A fully-integrated MCP will receive a single budget – the 'contract sum'. The sum will cover the whole population budget and the MCP performance payment, and will be adjusted to reflect the risk and gain share agreement with the local acute provider(s). Merging separate existing funding streams into a single payment made to the MCP should allow for more flexible allocation of resource, directed towards the areas in which the funds will have the greatest impact on population health care.

The whole-population budget will cover the full scope of services to be provided to its population. An MCP's population is defined as the patients registered with participating GPs plus an estimate for its share of people living in the MCP locality who are not registered with a GP.

The initial value of this whole-population budget will be calculated on the basis of the current commissioner spend. For services where commissioner spend is uncertain, an approximation will be made of the share of the contract value associated with the MCP population. The intention is for whole-population budgets to be multi-year, adjusted broadly in line with changes in CCG allocations, and to achieve reasonable improvements in provider efficiency.

The gain and risk sharing mechanism complements the MCP's whole population budget. Its purpose is to ensure that the payment system does not inhibit the path to transformational, system-wide change. NHS England is working intensively with MCP vanguards to develop a method with practical examples of its implementation. This work will determine the prerequisites to gain/risk share arrangements, including trust between the relevant parties, transparency, and a robust governance structure. It will inform alliance contracting models. We will then test the concept of gain and risk sharing using metrics and targets owned by the vanguards and expressed in the logic models that they have developed. By basing these measures on the logic models, we should ensure that the scope of the gain and risk sharing agreements is focused on agreed local priorities where there is collective agreement on systemic impact. An example would be an aim to reduce avoidable activity in secondary care (hospital admissions). The intensive work will model the metrics, consider the impact of volatility and efficiency targets, and determine the method for measuring progress against the specified target.

CCGs will need to ensure that their contracts with acute providers are revised at the same time to take account of: (i) any transfer of services to the MCP (e.g. any outpatient or diagnostic services, or services for frail older people, which are currently provided in acute settings); and (ii) the risk/gain share arrangements. Provisions in both MCP and acute contracts will define the business information requirements and the standards for clinical communications between the two sets of organisations, not least to facilitate new risk/gain share arrangements through sharing the required information.

Through the MCP performance payment, the contract will also reflect the aim of the MCP in improving population health, quality, and outcomes. The main rationale is to enable a focus on specific quality improvements. International capitation systems generally include quality incentives, as does general practice in England.

The MCP performance payment will effectively supersede the existing commissioning for quality and innovation (CQUIN) and quality and outcomes framework (QOF) schemes for providers that become part of the MCP. It would be easier to bring about this change under the fully integrated MCP model. Based on discussions with MCP vanguards, our provisional intention is that the performance payment could constitute around 10 per cent of the total value of the MCP contract. The intention is for the performance payment to be stretching but achievable - to get the right balance between supporting improvement, and a high level of earnability. We know that current performance payments form part of the core cost base of the provider; they are certainly not just marginal.

We intend the new scheme to be simpler and easier to operate than QOF, but that doesn't mean the goals for the local population will be less ambitious. In line with its wider service scope, it will include a focus on population health, drawing on some of the prevention metrics in the new CCG improvement and assessment framework. The scheme is likely to include national and local priorities where mainstream financial flows may be insufficient to incentivise concerted, rapid action. The scheme will reward a blend of implementing care redesign, and process and outcome goals. Many of the metrics will typically appear over a two or three-year period, to support focused and concerted improvement efforts, before being retired. Through being more dynamic than QOF, the scheme can be kept shorter and simpler and more up-to-date.

We will develop the draft performance payment arrangements through intensive joint work with our six systems. The principles set out in this document are the starting hypotheses. Arrangements will also be refined during the first two years of operation, in light of experience. Nationally, NHS England will fund an evaluation of the scheme in order to learn and make improvements for wider deployment or at the initial break point for the first adopters.

Options for organisational form

In developing a bid to deliver an MCP, prospective providers will need to agree an organisational form and decide how it will relate to GP practices and other staff groups. In all cases, an MCP will need to be a formal legal entity, or group of entities acting together to form the MCP, that is capable of bearing financial risk, and which has clear governance and accountability arrangements in place for both clinical quality and finance. The robustness of this organisational form will be assessed as part of the contract-awarding process. We are working with NHS Improvement and the Care Quality Commission (CQC) to agree the approach to the ongoing oversight of MCPs. It is quite likely that many existing organisations that deliver parts of the proposed MCP service scope will be unable in isolation to be credible holders of a fully integrated MCP contract, and they will need instead to forge new partnerships.

The precise form of legal entity will be for local determination. With the vanguards, we will develop examples of organisational forms in local systems, to avoid other local systems needing to initiate duplicative work. Options include:

- a limited company or limited liability partnership (LLP). These could be a GP super-practice or a federation bringing a much broader range of services into the general practice model. They could also be newly formed as a (joint venture) vehicle for the purposes of delivering the MCP contract. Parties to a joint venture may be shareholders or members and would need clear decision-making rights over the running of the MCP and its budgets. A joint venture company would need to be sufficiently robust to hold a contract as a single legal entity with the

commissioner;

- a community interest company (CIC) – a particular type of company, bringing parties together as a social enterprise, using its assets and profits to improve the care of the population;
- an NHS trust or foundation trust (FT) , building on its existing assets and workforce. Given that MCPs will be responsible for out of hospital services, the natural application of this option would be with existing community trusts or FTs.

The work with the vanguards and experience from the GP access fund has already highlighted a number of issues related to organisational form:

- Pensions. Where the MCP is a lead provider, engaging GPs and others under sub-contracting arrangements, there was a concern that income derived under those arrangements would not be pensionable for the purposes of the NHS pension scheme. We have agreed with the Department of Health to amend regulations to allow GMS/PMS contractors to pension subcontracted income subject to certain conditions, and are working with them to review the need for further changes;
- Clinical negligence. The Department of Health and NHS England are working with the NHS Litigation Authority to provide information to potential MCP providers on their options of securing cover. We will work with the medical defence organisations and the commercial insurance industry where required to ensure clarity around the MCP model of care;
- VAT. NHS England and the Department of Health are in discussion with Her Majesty's Revenue and Customs (HMRC) about the VAT rules that will apply to MCP arrangements, with a shared desire to maintain NHS providers' existing ability to reclaim VAT on contracted out services;
- Regulation. The CQC is committed to supporting the new care models, and will explore the right approach to registration in each case. Depending on the organisational form and accountability arrangements, this could include a single CQC registration for an MCP. Prospective MCPs will be subject to the fundamental, legal principles governing CQC registration, as are all health and adult social care services. Prospective MCPs are encouraged to make early contact with CQC¹ about issues concerning organisational forms and registration and to get in touch with a locally-based CQC contact to explore their specific needs. This will also allow CQC to learn and adapt its approach.

The MCP's relationship with its GPs

General practice must be at the heart of the MCP model. The fully integrated version includes all primary medical services within the contract. Indeed, general practice (working through networks and federations of practices) is a key driving force in developing the MCP model.

¹ Questions can be directed to: enquiries-newmodelsofcare@cqc.org.uk

The MCP model opens up the prospect of a wider set of options for how GPs and other clinicians could relate to the NHS. Depending on the organisational form of an MCP, these professionals could be any one or more of: (i) partners in an LLP or shareholders in a CIC or other limited company; (ii) subcontractors or independent contractors operating under a clinical chambers model, where the MCP manages the service infrastructure; (iii) employees; or (iv) employed within a staff mutual organisation. This provides the opportunities for GPs and others to relate to an MCP in a way that works for them.

The new MCP contract is between commissioner(s) and the MCP as a provider, rather than with individual GPs or GP practices. There would be local flexibility for the MCP to agree remuneration and new ways of working to support the integration of services. GP participation in an MCP arrangement also has implications for their current contractual arrangements. One option is that GPs participating in an MCP leave their current contractual arrangements permanently. They might contribute their existing GP partnership, for a share of the MCP partnership or equity, as may happen now in a super-partnership.

Discussions with the MCP vanguards have shown that, for now, many GPs partnerships wish to retain the option of returning to their GMS or PMS arrangements in future, not least because of the perpetuity of these contracts. We are discussing with the Department of Health an amendment to the relevant primary care legislation to create such an option. This amendment could provide a mechanism for GPs who are enthusiastic about the model to move with greater confidence to a new MCP. An amendment to regulations would create a formal provision by which commissioners could agree with GPs/practices to 'suspend' a GMS or PMS contract for a defined period of time that aligns to the MCP contract term and which allows for a return to a GMS or PMS contract at a defined future point. In the interim, the suspension would allow the MCP contract to provide for the provision of primary medical services to the relevant patient list, and GPs could take a full part in the MCP arrangement in all of the ways described above. The terms on which GPs did so would be a matter for local discussion in line with the new care model. We shall be working with the MCP vanguards and GP representatives to establish how the details of any return to GMS or PMS would work.

One option to consider in some of the partial integration models is to manage primary medical care contracts differently at a local level, helping to implement the MCP care model but without all aspects of primary care services being provided for in any new contract. Possibilities include additional integration agreements overlaying GMS/PMS or sub-contracting arrangements, which could break down boundaries and commit GPs to new ways of working (e.g. by working at scale, redesigning the workforce, and developing operational protocols). By agreement, these arrangements could also add QOF and LESs. In all of these arrangements, the governance and accountabilities must be sufficiently strong to deliver the MCP care model effectively.

Given the choices for GPs about the nature of their relationship with an emerging or fully-fledged MCP, there is no single new 'contract' for individual GPs wanting to take part in an MCP arrangement. For example, many GPs will take leadership roles in MCP organisations with the associated decision-making rights, moving decisively away from current contracting arrangements, or suspending them. Others will wish to become employed. This will always be a local, and personal, decision.

The MCP's registered list of patients will comprise the registered lists of those practices taking part in the MCP arrangement.

Procuring an MCP

The commissioning bodies that could be party to an MCP contract are one or more of: a CCG or multiple CCGs; NHS England (in respect of those services that it directly commissions); and the local authority (if social care or public health, including health visiting services, are provided by the MCP). As with the award of any other NHS commissioning contract, commissioners must comply with procurement regulations – both the NHS Procurement, Patient Choice and Competition Regulations 2013 and the Public Contract Regulations 2015. Under the latter, which came into effect for clinical services from April 2016, all proposed healthcare contracts with a lifetime value of over 750,000 Euros (currently about £630,000) must be advertised, unless one of the (very limited) exemptions applies. However, under the 'light touch regime', commissioners have the flexibility to design their procurement process and selection criteria for contracting healthcare services to suit local circumstances, as long as the process is consistent with the principles of transparency and equal treatment.

Commissioners will need to complete a number of steps to ensure that they conduct a process that complies with procurement law and with other legal obligations:

- Consult. It is the responsibility of commissioners to ensure that they have fulfilled their legal duties to consult, where appropriate, on proposed changes to local services, ensuring that they engage with patients and with the public if they are not already doing so;
- Decide on scope. Commissioners should determine the scope of the services and the service model to procure;
- Develop the service specification and budget;
- Advertise the opportunity through a prior information notice (PIN) in the Official Journal of the European Union (OJEU);
- Develop a selection process, using agreed selection criteria and an open process to ensure that there is a level playing field for all providers, if more than one response is received. This process should be agreed in advance of receiving any responses to the advert;
- Publish a contract award notice once a provider has been selected, again in the OJEU.

Under the regulations, it is clear that a partially or fully integrated MCP cannot be commissioned without at least issuing a prior information note (PIN). The PIN and subsequent process would likely:

- set out the broad scope of services and invite options for integrating them;
- make clear that the CCG is open to options that involve partnering between different organisations (including incumbent providers and potential new providers);
- encourage prospective bidders to engage with GPs and vice-versa. All prospective providers would be asked to demonstrate that they could command the support of the local GPs (who hold the patient lists). This does not mean that GPs have preferred provider status for the MCP contract. At the same time, under no outcome would they lose their right to continue to provide primary medical services against their will;
- make clear that the CCG is open to ideas about the exact constitution of the provider entity that would deliver the integrated care model;
- set a clear expectation that the new provider could manage financial risk, had the capabilities it required, and had an emerging mobilisation plan including, for example, initial sub-contracting arrangements with, say, acute/community partners; and
- provide the opportunity for engagement, ensuring that a 'level playing field' is achieved as far as is reasonably possible (e.g. by ensuring relevant information is shared with all bidders).

However, issuing a PIN does not necessarily mean that there will be a competitive procurement involving multiple bidders. In some local areas, the response to the PIN will result in the commissioners engaging in dialogue with a single bidder. But where the process proceeds beyond initial advertisement to an open contest, there will be the potential for a range of outcomes. One option open to commissioners, on the back of encouraging bidders to engage with a number of prospective partners, may be to reserve the right to designate particular parties as nominated subcontractors to the MCP organisation for specific elements of the contract scope, regardless of which bidder is successful. This arrangement might be desirable to ensure value for money, system sustainability, or better outcomes. However it is likely to be preferable for bids to represent clearly expressed partnerships.

During our intensive work with MCP vanguards over the next six months, we will seek to co-develop examples of procurement documentation, such as PINs and selection criteria, which we will publish to assist local organisations in working through the procurement process.

The commissioner

Commissioners have a range of roles:

- developing the service model, scope and specification, developing the payment and risk/gain share arrangements, managing the procurement process; and agreeing the local contract;
- once the MCP is up and running, acting as payor and overseeing the MCP's delivery against the contract;
- continuing to commission services from other providers and align other contracts with the MCP contract where appropriate (e.g. to manage utilisation risk across different parts of the local system).

New models of accountable care provision will move the boundary between what is commissioning and what is provision. We are working with a number of MCP vanguards to establish which activities must always remain with the CCG (or other commissioners), and which activities an MCP would perform under contract.

CCGs also need to address potential conflicts of interest: some of the people driving the development of MCPs may currently work in CCGs but in future may wish to take up a role in the new provider organisation. That is entirely understandable and legitimate. In some places, it may not be possible for a CCG to commission the MCP without experiencing significant conflicts of interest. We would expect CCGs to take appropriate steps to address this situation, for example by working with NHS England, and with neighbouring CCGs and local authorities to ensure that a fair and transparent commissioning process is undertaken. What is appropriate will depend on the specific circumstances but as a principle, we would expect existing CCG staff who expect to migrate to a prospective MCP to divest themselves of any involvement in CCG business related to the procurement of the MCP. We are working with MCP vanguards and with legal advisors to establish protocols for managing conflicts of interest in commissioning new care models, and will publish additional guidance in the summer of 2016.

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

www.england.nhs.uk/vanguards