**Personal View: When is an MCP not an MCP?**

One of the end products of the Five Year Forward View was the establishment of a new model of care known as a Multi-Specialty Community Provider, or MCP. It was hoped that new organisations would be formed that would revolutionise out-of-hospital care. For example, it is thought that an MCP would consist of GP practices, likely part of an at-scale organisation, community trusts, community mental health trusts and social services. Primary and community care would be delivered through these organisations and include current services but also additional services, such as diagnostics and some outpatient work transferred from hospital trusts. An MCP would, of course have to deal with local trusts as well and perhaps the “promised land”, or the danger zone, depending on your point of view and belief in conspiracy theories is that of Accountable Care Organisations or Systems.

Some would say, “*Well that seems OK in theory, the current system isn’t exactly working well at the moment.*” Others might feel that it is risky and irresponsible to adopt a change of structure for health and social care outside the hospital setting without the evidence that the new system will work, let alone work better than the current situation. In theory, it would be great to provide “joined up” health and social care for our patients, but as always the devil is in the details. From a pragmatic point of view, it seems that integration of care and working at scale is very much to be the direction of travel for primary care. Whilst it is important to maintain a critical eye, one has to do what is best for our practices and hope that our patients benefit.

The first hurdle for general practice to overcome is the formation of a functional at-scale organisation. This has already been achieved by Our Health Partnership. The second hurdle is to then find a way to contractually bind together GPs, community trust, mental health trust and social services. NHS England have proposed draft frameworks for different types of contracts that would enable this. In recent months, the loosest of these has been condemned by the GP Committee of the BMA as being a threat to the very essence of general practice. Briefly, all the proposed MCP contracts would involve that contract superseding the core GMS or PMS contract held by participating GPs. Furthermore, it is envisaged that MCPs would have a pooled, integrated patient list and also be time-limited to 10-15 years. Practices wanting to withdraw from the contract could do so, but they would no longer have any registered patients.

The aim of Our Health Partnership is to preserve, as much as possible, autonomous, locality based general practice, centred around the national GMS contract. Our goal, as far as integrated care with community trusts, mental health trusts and social care, is to develop a framework that enables our member practices, and those that partner with us, to maintain their individual practice lists but at the same time be able to develop an integrated care organisation that our patients would benefit from.

Due to our size and growing influence, we have been able to begin this work with GP Forward View money, and plan to go one step further than simply work with out of hospital partners; we also plan to design and shape how joined-up community services interact with local hospital trusts. The result, we hope, will be an integrated care organisation with general practice firmly at the centre and in control.

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