

Focus on Virtual MCPs and Alliance Agreements



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In December 2016 NHS England published its multispecialty community provider (MCP) documentation, a suite of documents outlining how it envisages MCPs will work, including the draft contractual documentation for each of the proposed models.

In the MCP framework NHS England outlines 3 types of MCP:

1. The Fully Integrated MCP;
2. The Partially Integrated MCP;
3. The Virtual MCP

These models are stated by NHSE as having the primary aim of removing divides that exist between healthcare providers and creating a new integrated system of care delivery.

Previous [GPC guidance](#) has covered the proposals outlined in the MCP documentation in general, including concerns and alternative courses of action for those considering entering into such an arrangement.

This guidance provides an overview of the 'Virtual MCP' model, with a particular focus upon the template contract upon which a virtual MCP will be based. This is called the **Alliance Agreement**. Further guidance will be issued on the proposed terms for the partially-integrated and fully integrated MCP models.

Overview

A proposal to join a virtual MCP via an Alliance Agreement poses a number of questions for practices, not least of which being what impact signing such an agreement could have for the practice and its current G/PMS contract.

Due to the developmental stage of such organisations at this point in time, and their localised nature, it is difficult to make a certain assessment for all cases. This guidance therefore provides a review of the template Alliance Agreement published by NHS England and seeks to highlight the key issues and concerns that practises should consider when contemplating a Virtual MCP proposal. These include:

- Potential loss of autonomy
- Shifts in workload/services
- Increased liabilities
- Restrictions on leaving the MCP

Of particular note, by signing up to the alliance agreement, and it's stated aims and objectives, practices may have to accept additional obligations beyond those in their core GMS or PMS contract, including becoming obliged to offer extended services for which no additional funding may be available.

It is therefore strongly recommended that practices exercise extreme caution when presented with such proposals and must seek advice from legal professionals and their LMC before proceeding.

What is a Virtual MCP?

The model is being promoted by NHS England as being “virtual”, as the Alliance Agreement is supposed to overlay the existing contracts held by the members of the MCP (which could cover core contracts such as GMS and PMS contracts held by GP practices) in such a way that means that the parties making up the Virtual MCP will agree to work towards certain objectives:-

- the extent of the services to be provided are intended to remain as defined under each providers’ core contract; and
- the actual delivery of those services are intended to remain the responsibility of each individual provider pursuant to the terms of their existing core contracts.

With the above in mind, NHS England has indicated that the primary aim of the Virtual MCP is to encourage providers and commissioners to work in an integrated and collaborative manner that will see providers deliver services in the community.

Who can join a Virtual MCP?

The proposals produced by NHSE are not prescriptive on who can and cannot be a party to a Virtual MCP. Instead, NHSE states that:

‘[i]t is intended that all major providers in the system, including GP practices, would be a party...’
[The multispecialty community provider (MCP) template Alliance Agreement – overview].

There is therefore clearly a possibility for either

- individual GP practices (including super partnerships); or
- GP networks (who have member practices sitting below them)

to join a virtual MCP. We would recommend that individual practices that are considering joining a Virtual MCP should consider establishing a separate legal entity such as an LLP or Ltd company in order to mitigate exposure to risk. Information and advice on undertaking this is available on the [BMA website](#) and from [BMA Law](#).

Whilst this guidance is primarily aimed at situations where individual practices or super partnerships who hold a GMS or PMS contract are looking to enter into the Alliance, there may be some core considerations for GP federations and networks to also consider.

If a GP network is considering the Virtual MCP model, exceptional care will be needed to ensure that they fully understand the interrelationship between the Alliance, the GP network and the member practices that form part of that network itself. In particular they will need to check:

- whether the PMS or GMS contracts held by members of the GP network and the services provided under them would be separate and distinct from the activities of the Alliance and the service contract that their GP network may hold;
- whether the liabilities and obligations of the GP network (or the Alliance more generally) could filter down and impact on any one or more member practice; and
- whether member practices would end up being locked into their GP network as a result of the networks’ involvement in the Alliance or, in the event that there is an ability for member practices to voluntary leave, whether restrictions are needed to protect against a mass exodus (as this could in turn expose the remaining member practices’ to higher risk).

What are the core concerns?

There are some key areas of concern that the Virtual MCP model raises for practices, with a large amount of uncertainty and a lack of clarity contained within the Alliance agreement and the wider virtual MCP proposals. It should be noted that this guidance does not represent an exhaustive list, and practices MUST seek legal advice before entering into such an arrangement. These uncertainties include:

- How will service contracts be amended/ changed to recognise the Alliance Agreement?
- What additional services may a provider be asked to provide if they enter the Alliance?
- What, if any, additional funding will a provider receive to realise integration and to deliver heightened services, and
- Could a provider extract themselves from the Alliance and guarantee that they will have a service contract to return to?

These uncertainties aside, any provider must also be aware of a number of key points when considering a proposed Alliance Agreement:

- As it stands, there is no guarantee that a providers P/GMS will be separated from the activities of the Alliance. The dangers with including core contracts within the Alliance are multiple. At the very least the template Alliance Agreement includes provisions for the inclusion of the Alliance Objectives and Principles (as discussed below) into the service contracts of each respective provider member of the MCP. Whilst any variation to a GMS contract must be agreed with the contractor, practices should be aware of the contracts that are included within the scope of the Alliance Agreement
- Service activity and specifications will be shifted between providers and the utilisation of staff, premises and other resources will change to achieve efficiency. This raises three sub concerns, namely:-
 - at what and whose cost;
 - will this stripping out of infrastructure make a providers involvement irreversible; and
 - **most importantly**, there could be a situation where service is shifted to general practice at a time where there is a significant lack of resources and capacity.
- There is no commitment to any payments for providers working towards the Alliance Objectives and Principles.
- Decisions could be taken by the commissioners unilaterally.
- Exposure to liabilities will potentially increase given the variation to the services that need to be provided.
- There is no right to voluntarily walk away from the Alliance Agreement/MCP.
- There is potential for a considerable loss of autonomy for practices.

Alliance Agreement FAQs

NHSE has developed a template agreement through which Virtual MCPs will be established which is called the Alliance Agreement. This is available [here](#).

The key points to bear in mind when considering whether to sign an Alliance Agreement are outlined below.

General

What is the overarching purpose of the Alliance Agreement?

The Alliance Agreement is intended to be an overarching legally binding agreement which sets out how the contracting parties will work in a collaborative and integrated way.

It does this by establishing so called “**Alliance Objectives**” and “**Alliance Principles**” which all parties to the Alliance are committing to work towards.

Is the Alliance a separate entity (like a company)?

No, albeit the terminology used in the draft agreement (and indeed this guidance note) refers to the “Alliance” – however no separate legal entity is being created by the contracting parties.

Instead the persons and/or bodies that sign up to the Alliance Agreement (which may include GP partnerships) are agreeing to work together under a legally binding contract in a model where their sovereignty is maintained. As such if decisions are to be taken or contracts are to be entered into by the “Alliance” they would need to be made and entered into by all individual contracting parties to the Alliance Agreement.

To the extent that contracts were entered into by some, but not all, members of the Alliance then these contracts would be binding on those members that are signatories only.

Does a provider have to sign the Alliance Agreement in its current form?

No, the current form of agreement is a template that has been developed with the aim of facilitating discussions on the terms that are to ultimately bind the parties.

As a consequence the agreement is negotiable and subject to change. Any provider looking to enter into this sort of agreement **MUST** take legal advice and we would urge them to discuss the proposal with their LMC in order to ensure that they are entirely satisfied with the terms of the agreement, and where necessary seek such amendments as they deem necessary, **before it is signed off**.

This is a crucial point. Any negotiations and changes must occur before the contract is signed off.

What happens to a providers’ core contracts?

The Alliance Agreement suggests that the service contracts (which is a broad definition used in the Agreement which could encompass GMS or PMS contracts) of each participant provider are to be preserved. It will be these contracts that will identify what services are to be provided and how they are to be provided.

In theory this model preserves the autonomy of individual contractors within an MCP framework. The reality, however, may be very different. Indeed, care must be taken as:

- i) **The Alliance Agreement indicates that each service contract shall include specifications incorporating the objectives of the Alliance Agreement but the details of this specification are unknown.**

Given this fact there is the danger that the objectives and principles under the Alliance Agreement will become a contractual term under a providers' core contract. Although such change would require the permission of the practice for GMS a breach of the objectives and principles could theoretically lead a practice to be in breach of their core contract.

- ii) **The terminology of the Alliance Agreement is confusing when it comes to service delivery.**

The underlying principle of the Virtual MCP is that the parties will seek to achieve collaborative and integrated ways of working whilst seemingly preserving the core contracts of those participant providers (i.e. GP practices). The participant providers are to remain responsible for delivery of services under their respective service contracts.

Despite the above, the template agreement uses terminology that is contrary to this overarching aim. Two specific examples include:-

Clause 2.6 – this states that the Agreement sets out how “We” (which covers all parties to the Alliance) will provide the services;

Clause 6.2 & 11.2 – these state that the Alliance may agree to variations to the services to be provided under any service contract.

As such, and despite the fact that the responsibility and liability for providing the services rests with the providers, there is a very real danger that commissioners will turn part provider and input heavily in the way in which services are delivered or enforce the delivery of additional non-GMS work by constituent practices.

- iii) **The Alliance Agreement refers to the fact that activity and service specifications may be shifted between providers' service contracts.**

This shows a clear intention that core contracts may be irreversibly flexed and amended in such a manner that is deemed desirable to realise the Alliance Objectives and Alliance Principles.

- iv) **The Alliance Agreement is developed in such a way as to amend the services that providers are required to provide pursuant to their core contracts and the way in which they are delivered.**

Indeed, the definition of “services” which the providers are required to provide pursuant to their service contracts refers to a schedule which is stated as being subject to local determination. This aside, it is recognised that over the life of the Alliance the actual provision of these services will alter on the “basis of the most effective utilisation of staff, premises and other resources...”.

- v) **The Alliance Agreement refers to the fact that where a provider leaves the Alliance then their service contract is likely to need to be terminated or amended to disentangle them from the Alliance.**

This is discussed in further detail below.

With the above in mind, and given the fact that the Alliance Agreement will contain new **key performance indicators** and a **risk reward mechanism** that providers must work towards, anyone considering a virtual MCP must be under no illusion that there will be at least some degree of variation to their service contracts and/or the ways in which they operate (including their staffing and premises arrangements). These variations could well prove irreversible.

Note: the details of the key performance indicators and risk reward mechanism remain unclear and need to be clearly negotiated. Despite this it is clear from the wider documentation that has been developed on the topic of MCPs that the risk/reward mechanism is to be implemented across all MCPs as a means by which MCP providers, whether virtual or otherwise, will share in any benefits achieved from reducing pressures on acute care and also share the risks if they don't. As to what this will look like, it is difficult to see this being anything other than a financial benefit or a financial penalty and as such exceptional care must be taken to fully understand what you are signing up to and the risks involved.

What is the contract value?

The draft Alliance Agreement does not provide for any payment to be made to providers for entering into this arrangement.

Membership

How long will the agreement last?

The length of the agreement is not specified in the template document and is therefore subject to negotiation.

Can the agreement be extended at the end of the term?

Yes, but any extension can only be triggered by the commissioners and it will require the approval of all parties to the Alliance and it is highly feasible that a re-procurement exercise will be needed

Can a participant voluntarily leave before the end of the term?

No.

Can the Alliance Agreement be brought to an end early?

Yes, but only with the approval of all participants.

In what circumstances can a participant be ejected from the Alliance?

A participant can be excluded from the Alliance where:-

- i) They commit a wilful default
- ii) (in respect of a provider) their service contract is terminated
- iii) They suffer an event of insolvency

Wilful default and events of **insolvency** are both defined terms in the Alliance Agreement and should be considered carefully.

In relation to termination as a result of service contracts being terminated, the provisions within the Alliance Agreement are broadly written and appear to cover situations where

- service contracts are terminated by commissioners due to a breach by the provider;
- service contracts are terminated by commissioners in circumstances where there is no breach (albeit in relation to GMS and PMS contracts we struggle to see how, unless there are changes to service contracts, this could be invoked as there is no ability for commissioners to terminate unilaterally);
- service contracts are terminated by providers due to a breach by the commissioners; or
- service contracts are terminated by providers voluntarily (i.e. they are handed back).

Are there any consequences of being excluded from the Alliance?

Yes. There can be liability implications on any provider who is excluded from the Alliance as a result of either i) a wilful default on their part, ii) an event of insolvency, iii) termination of their service contract due to a breach by the provider, or iv) voluntary termination of their service contract by the provider.

Indeed, and subject to any caps on liability that may be agreed, the provider has to indemnify the commissioners and any other providers against any loss, damage claim or other liability arising as a result of their exclusion or termination from the Alliance.

Liability implications aside, it is possible that a provider may be excluded in circumstances where their service contract remains in situ. In such a situation, the Alliance Agreement indicates that the excluded providers' service contract will likely need to be either terminated or amended in order to disentangle the excluded provider (and their service contract) from the Alliance.

Albeit it is stated that discussions over such amendments are to occur in "good faith" ***we have concerns that there is no right of return in the sense that a provider has no guarantee that they will be allowed to leave the Alliance and revert back to operating under the service contracts they originally held.***

Can new parties join the Alliance?

Yes, with the unanimous consent of the Alliance Leadership Team (see 'Management and Leadership').

Management & Leadership

What are the “Alliance Objectives”?

There are no specific details on what the objectives of the Alliance will be and as such they are entirely subject to careful negotiation.

Objectives should be both realistic and achievable. They should not operate in a way which exposes providers to excessive clinical, financial or administrative pressures. Indeed, there is the very real danger that the Virtual MCP model could be manipulated in such a way whereby

- i) service delivery; and
- ii) key performance indicators (whether on matters such as waiting times or otherwise)

are pushed to providers (in particular general practice) without a definitive commitment to funding. This would result in potentially deepening the current pressures that general practice providers face.

What are the “Alliance Principles”?

The template document refers to an indicative list of the principles that all parties will, as part of being party to the Alliance, commit to. These appear to be negotiable but include:

- Working towards a shared vision of integrated service provision;
- Committing to delivery system outcomes in terms of clinical matters, patient experience and financial matters;
- Committing to common process, protocols and other system inputs;
- Accommodating a risk reward scheme where all parties share in the savings generated in the reduction in acute activity;
- Talking responsibility to make unanimous decisions on a best for service basis.

While this appears to be a list of vague and subjective principles, participant providers should once again be careful that any principles they commit to are realistic and achievable particularly when it comes to implementing systems, protocols or processes. As part of this no principle should expose a provider to financial risk nor adversely impact on a providers overarching clinical obligations to their patients.

As with the Alliance Objectives, they should not operate in a way which exposes the practice to excessive clinical, financial or administrative pressures.

What is the Alliance Leadership Team?

The Alliance Leadership Team, which are accountable to the participants (namely the contractual parties to the Alliance), will have the overarching responsibility for providing i) strategic direction to the Alliance, ii) managing risk and iii) holding the Alliance Management Team to account for the performance of the Alliance against the Alliance Objectives.

In addition to this, the Alliance Agreement is to provide a set of defined responsibilities. These are in a draft form at present but include:

- To promote and encourage commitment to the Alliance Objectives;
- To formulate, agree and ensure the implementation of strategies for achieving the Alliance Objectives;

- To agree performance outcomes/ targets for the Alliance.

What is the Alliance Management Team?

The Alliance Management Team, which will be accountable to the Alliance Leadership Team, will (as the name suggests) have responsibility to manage the alliance, manage its performance and implement agreed plans and strategies to realise Alliance Objectives.

How will meetings of the Alliance Teams work?

Meetings of the two teams will be governed by the following general rules:-

- They are to be held at regular intervals;
- They will be chaired by the Chair (or in his/her absence the Deputy Chair) as identified under the Alliance Agreement;
- They may, at the Chair's discretion, be conducted by telephone or video conferencing;
- The necessary quorum is 2/3 of the total representatives;
- A representative may nominate a named proxy to attend and vote on their behalf.

The general aim of meetings will be to facilitate to discussions in order to reach a consensus on the matter at hand.

How are decisions made within the Alliance?

Subject to certain "reserved matters" which are discussed below, decisions can only be made with the unanimous consent of all parties to the Alliance via their respective representatives.

Each party will be required to appoint one representative to sit on an **Alliance Leadership Team** and one representative to sit on an **Alliance Management Team**.

Such representatives will have written delegated authority (the form of which is unclear and should be checked) to make decisions in respect of and express views on matters concerning the Alliance.

So does that mean a participant cannot be forced into a decision?

Leaving aside "reserved matters" which are discussed below, the indication is that they couldn't be forced into a decision.

However, the Alliance Agreement refers to the fact that there will be detailed arrangements that will be developed and approved which will cater for situations where one or more participants (whether commissioner or provider) decides not to adopt a decision.

It is unclear what these arrangements will look like. Care should be taken to ensure that these arrangements are not broad enough to erode the principle that decisions require the unanimous approval of all and/or do not enable decisions to be implemented around a dissenting participant.

What are "reserved matters"?

The template Alliance Agreement contains a list of items that a commissioner (and it is stressed that they relate to a commissioner only) can determine unilaterally (i.e. without involving the other provider participants).

These are called reserved matters and specifically include an ability for commissioners to take decisions where there is a change in the scope of the services (which covers those services provided under each providers core contracts) which the commissioners are required to implement by reason of either:

- i) a change in legislation; or
- ii) (more worrying and general) health or social care guidance, direction, standard or requirement which they have a duty to have regard to

This is defined as a “Mandatory Change”. Any decision taken by a commissioner which falls within one of the “reserved matters” must be implemented by the Alliance (and all parties thereto) as if it were a decision they had passed.

Does a provider have any “reserved matters”?

While they are not referred to as “reserved matters” there are two crucial provisions within the Alliance Agreement which protect a participant (whether a commissioner or provider) from implementing decisions against its will.

No participant will be required to take action where to do so would:-

- i) result in them being in breach of legislation or any regulatory obligation; or
- ii) be contrary to their interests.

Care should be taken to understand the scope of these provisions as they seemingly conflict with the ability of commissioners to take unilateral decisions in respect of “reserved matters” referred to above. **Clearly from a provider’s perspective it should be made clear that these two protection provisions override any and every other provision in the Alliance Agreement.**

Other Considerations

What is our liability under the Alliance Agreement?

Before considering what the position is concerning liability it is worth reiterating that ***the responsibility for delivery of services will rest with providers pursuant to the terms of their respective service contracts*** (core contracts etc.).

With the above in mind, and leaving aside certain elements upon which the liabilities can be extended (including where there is a breach of intellectual property and confidentiality provisions), the Alliance Agreement handles liabilities in two ways, namely:-

- where things go wrong with the services then the responsibility and liability will be handled in accordance with each providers' service contract; and
- where responsibilities and liabilities are not covered by the providers' service contract then no party will incur any liability to another party within the Alliance.

Exceptional care is needed here. The liability of providers under their service contracts is uncapped (which, in the event that the provider is a traditional partnership, will be an uncapped personal liability of the partners).

The above must be considered against the backdrop where, pursuant to the terms of the Alliance Agreement, there is a very real suggestion that a providers' service contracts

- will be varied at the outset of the Alliance; and
- may be subject to change at various times during the continuation of the same (be that due to the commissioners forcing through a so called "mandatory change" or provisions are invoked which lead to a shift in the activity and service specifications between the service contracts of providers).

The danger is, therefore, that the already uncapped liabilities will rise as services (which are the responsibility of the providers to provide) flex and extend.

There are three other core issues around liabilities that should be carefully considered. These are:

- Provider participants, as they are responsible for the provision of services (which may extend as mentioned above) and will therefore want control over their means and infrastructure for delivery, will invariably have to front contracts and/or costs in respect of staff, equipment, premises and other elements required to deliver services to be provided by the Alliance.
- If a decision is taken by all participants of the Alliance to enter into an agreement with a third party (whether for the provision of services, acquisition of equipment or otherwise) then it is feasible (depending on the contract terms) that all participants will be jointly and severally liable for the whole of the contract value.
- If, on a more practical level, the Alliance achieves a level of integration that is clearly the hope of NHS England, the demise of one participant (including their failure to deliver in the delivery of their obligations) could directly undermine the interests of the other participants. This could very easily result in participants having no option but to support and/or step in to steady the Alliance as a whole.

The above aside, the Alliance Agreement provides provisions allowing for commissioners to bring a claim for any overpayment or misappropriation. This is unusual given that no sums are payable under the Alliance Agreement.

Is there a requirement to maintain insurance?

Yes. Each provider must ensure that have either a policy of insurance or an arrangement in place for the purpose of providing indemnification to cover the provision of services pursuant to their respective service contracts.

Who is responsible for regulatory compliance?

The providers, as it will be they who provide the services under their respective service contracts.

What are the obligations concerning information sharing between participants?

There are very broad provisions which require:-

- each party to share “all information” that is reasonably required in order to achieve, as it is drafted, the Alliance Outcomes (this as a definition is not defined but it is assumed they are meaning the Alliance Objectives); and
- all providers to provide all financial resourcing, activity or other information as the commissioners may require so it can check that the Alliance Outcomes (again we assume they mean Alliance Objectives) are being satisfied.

Are there procurement and/or competition law issues?

Yes.

The entering into the Alliance Agreement in the first place along with any potential variation to service contracts are highly likely to be events that will trigger a procurement or re-procurement exercise pursuant to the Public Contracts Regulations 2015.

In addition there are very broad provisions requiring all participants to comply with competition laws. The impact that competition laws have on the participants will be very fact specific (depending on variables such as the services to be provided, the size of the Alliance, the area in which it operates etc.) but must be at the forefront of any participants mind. To this regard care should be had towards agreeing and understanding the so called Service Operations Manual that will identify, amongst other things, how competitively sensitive information is to be passed between providers. At the time of providing this guidance no form of such a manual has been prepared.

What happens to staff members?

Providing everything stays the same, then potentially nothing will happen.

However, it is stressed that the Alliance Agreement makes each participant responsible for all costs associated with their staff. This crucially includes the cost of any internal reorganisation or redeployment that may be needed in order for the provider to deliver on their required obligations.

Given that the Alliance Agreement is geared towards shifting services and moulding processes and procedures in order to achieve the Alliance Objectives and Alliance Principles there is a distinct possibility that such internal reorganisations will be necessary. Care should be taken here.

Employers cannot unilaterally change the terms upon which their staff are employed. If redundancies stem from implementing any changes then the costs of this will be borne by the employer.

There is a recognition that should services shift between providers then “affected employees” will be required to shift with it. Care will be needed in handling such a transfer (which will be pursuant to the Transfer of Undertaking (Protection of Employment) Regulations 2006, i.e. TUPE) and in appreciating the resulting increase in staffing costs that the recipient of the relevant staff members will incur.

Are there obligations relating to confidentiality and/or the Freedom of Information Act?

Yes. Both are covered by specific schedules to the Alliance Agreement.

In relation to confidential information, all information disclosed between the participants in connection with the Alliance Agreement is to be classed as confidential and shall not be disclosed. This is subject to the usual exceptions (including where a participant has consented to its disclosure, it is in the public domain already etc.)

In relation to freedom of information, the Alliance Agreement reiterates the fact that participants (or certain participants) will be subject to the FOI Act.

Where they are the parties are to provide such assistance, in clear and specified timescales as provided for under the agreement, as is necessary to enable them to comply with their obligations where a FOI is received.

This is to be expected but it is important to note that given the nature of the Alliance and the parties to the same, communications concerning the Alliance may (subject to any applicable exemptions/ exceptions) be disclosable to third parties under any FOI request.

What happens if there is a dispute?

The Alliance Agreement contains a dispute resolution procedure in Schedule 9. This provides for the dispute to be escalated initially to the Alliance Management Team, then to the Alliance Leadership Team and (to the extent that it remains unresolved) to an independent facilitator.

If the disputes subsists then the procedure will be re-followed. If it still cannot be resolved then the Alliance Leadership Team may either end the Alliance or decide that the dispute will remain unresolved.

Other Options

Are there alternatives to MCPs which can help support and stabilise my practice?

Absolutely. MCPs, whether of a virtual nature or otherwise, are a creation of NHS England and are based on their belief as to how general practice can be stabilised, how working at scale can be achieved and how integrated care can be provided.

MCPs are not, however, the only option. Practice mergers, super partnerships, GP networks and other innovative GP lead models have been successfully developed.

For details on the other potential options that are available please read the variety of guidance we have developed on the issue of working at scale.

This includes:-

- [Collaboration and working at scale](#)
- [MCP proposals](#)
- [GP super-practices, federations and networks](#)
- [Legal structures](#)
- [Practice Mergers](#)

If you are considering entering into a Virtual MCP then we would strongly recommend that you consider all alternative options and take appropriate professional advice particularly legal advice on any contract that is on offer.

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