Suffolk Primary Care – Ideas for Future Development
Discussion Paper and Invitation to Sharing Ideas Workshops

Introduction

Suffolk GP Federation was formed three years ago with the objectives of:

- Supporting the independent contractor model.
- Providing practices with a mechanism to work collaboratively at scale in the delivery of clinical services including those which it was anticipated would transfer out of the hospital setting.
- Providing an insurance against large private sector organisations picking off parts of the GP contract.

Suffolk primary care today

Since 2012 the environment for primary care has evolved:

- The private sector threat to primary care has for now receded. On the other hand, the two acute hospitals in Suffolk have become significantly more powerful. They have recently won the contract for the delivery of community services and are the dominant players in the East and West Integrated Care Organisations.
- The envisaged transfer of clinical services, together with resources, from the acute sector to the community has not happened. Indeed under CCGs, primary care's share of NHS spending has seen an accelerating decline to a new low of 8.4% of NHS budget. Therefore one of the Federation's founding assumptions – that resources would transfer from acute to community services - has been mistaken.
- Within the 'Suffolk health system' primary care is much weaker than the other main players and we have very little influence. For example, hospitals respond to limits in the number of follow-ups they can offer by simply transferring the work to GPs.

The Federation's assumptions about the increasing pressures on the profession made at the time of our founding have proven more accurate, to the point where the RCGP now refers to a "crisis in GP".

- Surgery workload has continued to rise and GP staffing has worsened. This is reducing job satisfaction, creating work/life balance and sustainability issues for many partners and recruitment can be challenging.
- There is rising bureaucracy e.g. CQC.
- GPs have inadequate headroom to innovate.
- There are partner succession issues, especially around estates.

Locally we are already seeing clear signs of sustainability issues for some practices but there is no coherent local or national policy to address this crisis.

Primary care commissioning

CCG's are being encouraged to take full responsibility for primary care commissioning, albeit with no additional funding. Combined with the East and West Integrated Care Organisations this could lead allow local changes to QoF, for example to reduce workload.

There are two national changes which may signify a change in commissioning:

1. NHS England has stated it wants practices 'working at scale' for some time but never commissioned anything to encourage it. They recently announced that there will be a new voluntary contract offered to practices or federations covering at least 30,000 patients and providing 7 day working. This contract may come with new funding.
2. Arvin Madan, a GP from the Hurley Group in London which has a salaried model, has recently been appointed as NHS England Director of Primary Care. Arvin spoke at a Fed Sharing Ideas workshop two years ago and the video of his presentation is available on our website.

What do our representative bodies have to say?

In the absence of national or local initiatives to support general practice and community care, national GP representative organisations are starting to look at other options:

- The BMA comment 'The independent contractor status model needs to evolve. A collaborative care model – which involves larger practices employing bigger teams which can, in turn, work together in networks, as well as with other local health and social care providers' – reflects the core principle of GP-led primary healthcare which doctors and patients wish to see retained.'
- The GPC said in its vision for the future that super-practices could be one of the few ways of ensuring the "core principles" of general practice are retained

The common policy of both organisations suggests unless health policy changes radically, the small business model of GP can sadly no longer survive in today's NHS and GPs have to adapt and work at a larger scale. Around the country some practices are starting to explore alternative models. This paper is intended to stimulate discussion amongst our members, of what these are and their applicability to Suffolk.

What alternatives are there?

- **Federations/Networks** continue to grow in number and vary in size from a few practices to large numbers. Key features include that the practices retain separate partnership deeds and separate clinical governance standards while collaborating on service delivery at scale for LES and contracts won. There are now over 200 Federations in England, many formed in the past 12 months. There are no national or local requirements for CCGs to support, take notice of or contract with Federations even in clinical areas where the expertise of their members is high. In this sense, Federations are currently weak.

- **Networks or clustering** are formed when groups of practices work together, either informally or through a contractual mechanism, to deliver specific services e.g. diagnostics being transferred from hospitals. Clustering has been a strategy pursued by CCGs in London and works when there is little history of practices working together and there is a specific contract to deliver. However, the overheads associated with each cluster are disproportionate and some networks have recently moved to become Federations.

- **Mergers of small groups of practices** are a common way to address the partner workload issue. However, they are time consuming and expensive, and inter personal dynamics and difficulties with taking on premises mean only about half are successful.

- **Salaried models** such as the Hurley Group in London with 80 salaried GPs and four partners. This approach loses the traditional commitment and continuity offered by partners.

- **Vertical integration'** with hospitals delivering primary care e.g. in Northumberland. In Waveney and North Essex the local community services providers are running practices.

- **Super-partnerships** are a relatively new model with two in existence and a number in gestation:
    - **Lakeside** is located in Corby and is expanding next year to include Kettering, Brigstock, Stamford & Oudle. It will be the biggest GP partnership in the country with 62 partners and 100,000 patients but plans to extend to 350,000 patients. The organisation has a well defined clinical model focusing on out of hospital care and in particular one that "caters for the increasingly complex needs of our most vulnerable patients".
      Lakeside also has a provider arm which runs an urgent care centre, short stay community hospital and specialist dermatology, ophthalmology and geriatric services. It is a Multi-Speciality Provider Vanguard site which will manage a capitated health budget for its whole population.
      Lakeside is relevant to Suffolk because it is currently based on a large practice in deprived Corby but is expanding with dispensing practices in market towns which are stable and able to recruit both partners and salaried GPs.
    - **Vitality** in Sandwell and Birmingham has 19 partners, 70,000 patients and 13 sites. It offers 7 day access 8-8, diagnostics and community outpatient services. It is also a Multi-Specialty Provider.
    - **Our Health Partnership** in Birmingham and Sutton Coldfield is due to launch later in 2015 with up to 180 partners. It aims to improve patient services, make working life better at practices, generate efficiency savings and enhance practice resilience.

  By virtue of their holding a list, super-partnerships are currently the strongest form of GP working at scale in terms of influence.

The remainder of this paper focuses on super-partnerships as some GPs believe they are likely to be worth considering for Federation member practices here in Suffolk.

What are Super-partnerships?

- A single partnership is formed by a series of list mergers with all partners joining on the same basis and becoming equity partners in the new organisation. In order to avoid losing dispensing or requiring NHSE approval each individual GMS/PMS contract is retained.
- Serves a very large practice population of at least 100,000 and ideally covering the footprint of the local hospital. While officially a single practice, a super practice operates from a number of different sites.

- The partnership agreement sets-out how the super-partnership is managed. Day to day management is provided by a group of elected partners, supported by managers. A Council with one partner from each practice meets monthly. Key decisions are made by the full partnership.
- As with Federations, the practice may centralise certain clinical functions such clinical governance (e.g. complaints) and administrative functions which reduce duplication including contract reporting, IT, finance, payroll, HR, teaching, training, contracting and CQC.
- All incoming partners make an equal contribution which can be in cash via a loan or property. All assets are then owned by the new super practice.
- All partners hold an equal equity share in proportion to their FTE worked, with proportionate drawings just like a regular practice.
- Super-partnerships aim to retain the distinct identity and autonomy of individual practices and the partners/staff who work in them, but within a larger structure of equity partners.
- The organisation has a single workforce where all staff are employed by the super-partnership and existing staff TUPE across to it. Super partnerships often employ a greater range of other staff than traditional practices.

Some super-partnerships are considering creating organisations in which all staff are partners, like John Lewis, with the intention of addressing the "them and us" culture in primary care.

Super partnerships have existed in other professional services industries for many years. The big law and accountancy firms of today developed from many small town practices which gradually coalesced. Often this was because some partners wanted to be able to focus on the day job but retain the ownership ethos of partnership whilst reaping the benefits of being part of a larger organisation.

Super partnership ethos

The planned Our Health Partnership in Birmingham & Sutton Coldfield with up to 180 partners has a vision and values similar to those of Suffolk GP Federation and our members:

Vision

- *To improve care for our patients*
- *To make life easier, simpler and more profitable for practices*
- *To generate efficiencies and identify business opportunities*

Values

- *To provide high quality holistic care for all our patients*
- *To improve the quality of working life of our partners and staff*
- *To create the environment for a sustainable and high quality workforce*
- *To maintain the identity and autonomy of our practices within a large effective structure*
- *To sustain and build on the partnership model of local General Practice*

Why consider a super-partnership?

We have identified five reasons why super-partnerships are worth considering:

1. **Strengthen primary care in today's world**
   - By virtue of holding a list, CCGs and other NHS organisations are obliged to take notice of a super-partnership.

- A super-partnership can speak with one powerful voice.
- Super-partnership can collaborate with other similarly sized organisation on an equal basis – or compete with them if necessary.

2. Better patient services

- Scale means a super-partnership has the internal financial and managerial resources to introduce new models of care which help meet patients' expectations of rapid access, high quality and continuing personal care from their own GP and practice team. The list below has been gathered from best practice across the country and illustrates the types of initiative which could be implemented locally:
    - The use of technology – in particular an electronic front end to primary care for those wanting to access care in this way.
    - Access to booked and walk-in appointments, including for minor A&E conditions such as lacerations, foreign bodies and sprains.
    - Physios, mental health staff, health visitors, physician assistants, social care and third sector staff seeing patients for initial and follow up appointments, freeing up GP time. Paramedics and community nurses carrying out home visits where the GP cannot add clinical value.
    - New models of LTC care with patients being seen for all their condition in one holistic appointment and with more meaningful involvement in service delivery, governance and, as patients, using the Year of Care model for LTC to improve outcomes.
    - GPs working partly at the surgery and partly in the community leading multi disciplinary teams focussing on frail elderly and care home patients with the aim of caring for them in their place of choice – usually at home.
    - Referrals being channelled through the super practice specialist GP but with rapid access to specialist advice.
    - Improved access to diagnostics.

3. Staff recruitment and retention

- Partners and staff can reap benefits from being part of a larger organisation:
    - Improved work life balance. This is the main motivation for practices joining the Lakeside super-practice.
    - A manageable defined workload. GP partners who want to focus on seeing patients can do so but with a more structured and less open ended day, and with far fewer management responsibilities.
    - Time to treat patients properly.
    - Management done by managers and GPs who like management.
    - Opportunity to work in different areas of the super practice – urgent on the day cases, LTC, as a practice specialist managing intra practice referrals, as a visiting GP or specialising in care home preventive work, on the executive or any other part of the large and diverse organisation.
    - Individual GPs belong to a larger organisation which is more organisationally and financially stable.
    - Portfolio careers and training for new skills can be offered. Within existing practices there are already many GPs with interests or particular clinical specialities but practices find it hard to use them because of the difficulties of backfill which a super partnership could address.

- Easier to arrange sickness and holiday cover through a bank pool of GPs.

- A larger partnership is able to offer a more attractive workplace not just for GPs but for all staff:
  - Investing in training and development for nurses, reception staff and HCAs.
  - Super partnerships generally employ a wider range of staff such as physios, OTs, community nurses, paramedics, nurse practitioners, specialist nurses, mental health workers, third sector workers (CAB for example) health visitors, physician assistant, pharmacists, social care staff and others.
  - Primary care nursing has been regarded as the Cinderella of the nursing profession, but super partnerships are in a position to offer specialist and post graduate training for nursing staff.

4. **Management and governance**
   - Super-practices have much stronger management structures and through common clinical governance policies can ensure greater consistency of standards across the different practice facilities.
   - Facilitating local variation across different sites to reflect the individuality of partners, different patient demographics and priorities.

5. **Financial**
   - The financial objective of the super-partnership is to maintain, or increase, partner drawings whilst improving work/life balance and ensuring sustainability
   - Cost savings from increasing the proportion of time partners can spend on clinical work.
   - Economies of scale from streamlining back office systems and administration, and reducing duplication.
   - Using the strength of a super-partnership. At a simple level this might involve consistently pushing back unpaid work. In the medium term a local QoF could be negotiated. Longer-term, a super-partnership would sit as an equal alongside commissioners and local acutes and would be able to wield substantial influence on clinical services, pressing for the transfer of services and resources which can be used more cost-effectively in the community.
   - Greater financial resilience from being larger and able to attract significant new revenue streams e.g. Corby super-practice also runs an urgent care centre.

   Initial financial modelling suggest time and cost savings of around £18k per partner could be achieved including reduced partner time on administration. Most of this time could be deployed on patient care.

What are the concerns with super-partnerships?

The main concerns are:

- Patient satisfaction.
- Loss of continuity of care.
- Reduced individual influence by partners in a larger organisation.

In the table below we have prepared a comprehensive list of issues and concerns along with responses to them.

Issue/concern	Comment
Many improvements in patient care could be made, but they depend on money?	There are many changes which could be made by the super-partnership without additional funding. These include the staff mix and centralising back office The super-partnership would be in a strong position to negotiate for additional funds from CCG
Will this not reduce continuity of care?	Personal continuing care from a trusted professional is one of the most important features of UK general practice and is highly prized by patients and GPs alike, but is under pressure. The super-partnership approach is intended to support continuity - patients will remain on the list of their existing practice and partners will continue to be based there. There are opportunities for a super-partnership to improve continuity by encouraging booked appointments with the patient's own GP, by visiting GPs retaining a list of frail patients and so on
Patient satisfaction - it is well known that patients prefer smaller practices and many are unsettled at the prospect of being a patient in a super-practice	If the organisations is able to deliver a wider range of services, more problems dealt with in house and easier access, patient satisfaction will rise. The super-partnerships which have ben formed have invested significant time explaining the rationale via PPGs.
Will this increase referrals & ED attendances?	The super partnership will be able to offer simple ED procedures in its walk in facility Referrals will all be channelled through the super-partnership specialist GP Referrals will therefore be reduced
The partnership model seems to have its problems these days e.g. 70% of GPs under the age of 35 have no intention of becoming partners in the near future under existing models	Part of the motivation for forming super-partnerships is to use scale to reduce stress associated with partnership and make it more attractive Other models can be considered, for example a John Lewis type approach where all GPs (or staff) are partners in the core practice. Partners who wished could invest in a property arm
Locums are hard to find and expensive – will this not get worse?	The scale of the organisation will greatly reduce the need for locums at all, and resources can be deployed where needed There will be less competition for locums rates should rise more slowly as individual competition between practices disappears
Salaried staff could feel alienated?	All partnership models have problems engaging salaried docs who feel they are working for a large impersonal organisation set up to benefit the partners Super-partnerships provide more career development opportunities for salaried staff and the organisation itself will offer a far wider range of professional opportunities. There will be a clear pathway to partnership
Is this the start of a transition to an entirely salaried service?	Super-partnerships are genuine partnerships just like existing ones, only larger
Will this just lead to a fragmentation of GPs role e.g. we become glorified triage nurses?	The super-partnership will be clinically led and GP partners will be able to work together to develop the role of doctors and other staff. A super-partnership should be able to more easily innovate and introduce different skill mixes that can support GPs, for example physios, Mental Health Link Workers, pharmacists and Physicians' Associates. However, all of this development will be controlled by GPs.

Issue/concern	Comment
Will decision making be lost to a board consisting of a handful of GPs who are more interested in management than being a GP?	Super-partnerships offer a trade off - fewer day to day responsibilities for partners but improved work/life balance. The organisation is managed by an executive team of GPs who are elected by all the partners and there would be a recall system in the partnership agreement. All GPs on the Executive will have to continue practising a minimum number of clinical sessions as defined in the partnership agreement
Following on from the question above, won't I lose my autonomy?	The important control and flexibility which partners have over their own work will be preserved in the super-partnership model Individual practices will still maintain significant autonomy to run things in a way which works locally Some functions would be organised centrally (e.g. HR and finance) in the same way IT is organised currently In reality the autonomy of the small practice is already shrinking e.g. little influence at a commissioning level some services provided centrally and clinical activity increasingly prescribed
Will a super-partnership work in rural areas?	There is no particular reason why it should not work equally across small/large and rural/urban practices. Patients will have further to travel to services provided across several locations Dispensing practices have significantly higher drawings and this may mean the model is less attractive and difficult to structure
Large organisations have problems of their own?	Large organisations can be hierarchical, bureaucratic, slow and their Boards can be a long way from patients and staff Large organisations can also land a man on the Moon, and the super-partnership would have a very flat structure without layers of managers between the Board and the patients and staff. The organisation will be GP led
Will my income be maintained?	The objective of the super-partnership is to maintain partner income at broadly similar levels and our financial projections support this. The most challenging period is the first year or two when additional costs may be incurred. Typically drawings are equalised over a 2-3 year period.
Staff morale A large organisation inevitably reduces autonomy e.g. a ward sister has little say over hospital policies	Employees value pride in their work and influence over it more than anything else. The super-partnership will offer a high quality clinical service and staff will still have some autonomy over their own individual unit
Will there be redundancies?	Possibly but this is not the rationale for forming a super-practice. There should be more opportunities for administrative staff regarding career development. There will be no compulsory redundancies and the aim will be to achieve change through natural wastage. A significant portion of practice managers are due to retire soon anyway. It is worth noting that many practices are already making staff redundant.
Is this saying the Fed has failed?	Suffolk GP Federation is one of the most successful in the country, but it has not been successful in assisting the CCG to transfer services and resources into the community. In fact, our CCGs have increasingly commissioned from expensive acute hospitals. If this policy changes Suffolk will be well positioned. A super partnership will have a large list and CCGs will have no choice but to listen to what is said

Issue/concern	Comment
	The Federation will continue to exist as now and the super-partnership will be a member practice. If practices stay independent they will continue to be members of the Federation.
Will super-partnerships be taken-over by private corporates? What's to stop partners selling out for their own benefit but to the likely detriment of staff?	No - the whole raison d'être is to create a sustainable but independent model of primary care. The partnership deed could make provision to prevent such a takeover if partners wished
What is the personal risk to me?	As with a traditional partnership, partners remain jointly and severally liable. A larger organisation will mean risks are diversified. An LLP (Limited Liability Partnership) is a possible form but individual drawings have to be publically disclosed
What about property?	There are a whole series of issues including tax and valuation on which professional advice would be needed. The principle is that all property and other assets are pooled but there are options to have a super-partnership and the option of having an investment in a property company

What are the next steps if I want to know more?

If your practice would like to understand more or discuss the super-partnership model the Federation will be holding Sharing Ideas workshops on:

- East - Thursday 26 November 7pm for 7.30pm. Holiday Inn Ipswich, The Havens, Ransomes Europark, Ipswich IP3 9SJ.

- West – Tuesday 1 December 7pm for 7.30pm. Ravenwood Hall Hotel, Rougham, Bury IP30 9JA

If you practice wishes to attend please email attendee names to melissa.tooke@suffolkfed.org.uk. Depending on interest we may need to limit places.

If there is wider interest we will organise further Sharing Ideas on a locality basis so all GPs can be involved in a discussion.