Proposal to form a Suffolk Super-Partnership

Draft for Discussion

Introduction

In December 2015 the Federation published 'Options for Suffolk Primary Care Development' which analysed the relentless pressures facing practices and the strategic responses that are available to members. Options identified include:

1. Wait and see (e.g. for the 2017 voluntary contract).
2. Do nothing.
3. Networks/clustering of groups of practices.
4. Federations.
5. Mergers.
6. Salaried model.
7. Vertical integration with hospitals running primary care.
8. Super-partnership.

In January 2016 the Federation organised a follow-up meeting for those interested in the super-partnership option. This resulted in a request for more detail and for a proposal to be be developed setting out how a super-partnership might work. This paper sets out a detailed 'strawman' proposal to form a super-partnership in Suffolk, based on the feedback from this meeting and meetings with individual practices.

The Federation will organise discussion meetings once members have had a chance to digest its contents and subsequently a lead will be taken by those practices with an interest.

Key messages

- According to the BMA and RCGP, change is inevitable – a super-partnership allows you to maintain control over the future of your practice.
    - You fully control entry to and exit from the super-partnership:
        - Easy exit back to your original PMS/GMS contract (deleted full-stop)
        - You will be able to take advantage of the 2017 voluntary contract (deleted full-stop)
        - Series of checkpoints (on entry and at the end of Year 2) when you can choose whether to move forward and with whom.
        - Ultimately, if a practice or partner consistently fails to meet the partnership's standards, they could be required to leave – meaning you will not be part of a 'failing' organisation.
    - Five year implementation timetable with a road map of how it will be achieved. All of this work will need to happen even if practices choose to merge with neighbours or form a locality network – but is more easily managed at a super-partnership level.
    - Early participants will determine the final shape.
    - We can implement the proposal in 6-9 months – minimising uncertainty.
    - Establishment costs are minimised – we estimate £1.50 per patient for a partnership with a list of 100,000.
- Better for patients – ensuring practices are resilient and sustainable, with improved access and services.

- Better for GPs because this will result in:
    - Continued clinical autonomy and independence – putting patients' needs first.
      Choice:
        - Where to work – existing practice or other roles in the locality or wider afield.
        - Career and development opportunities.
        - Work more/earn more; work less/earn less.
    - A true partnership:
        - Clinically led.
        - Positive culture of teamwork, support, training and personal development. Developing future GP leaders and the next generation.
        - Speaking and acting with 'one voice', having real clout within the NHS and enabling primary care to grow its share of NHS spending once again.
        - Commencing with separate individual practice accounts but moving, in Year 3, to standardised partner workload and a single profit pool – with some exceptions e.g. dispensing.
        - Supportive management.
        - Making partnership attractive for most GPs by lowering buy-in costs and enabling individuals to choose whether to invest in property.
        - 'Joint and several liability' – but with risk shared across a much larger partnership.
- Better for practice staff:
    - More career opportunities and personal development.
    - Security – motivated by refining back office for growth, not cost cutting.

Proposal to form a Suffolk Super-Partnership - Executive Summary

- There are a range of strategic options available to practices in response to the "crisis in GP" – this paper is for those interested in the super-partnership option. Super-partnership is motivated by maintaining GP control over the future and facilitating the growth, once again, of primary care.

- A super-partnership would create a single new 'joint and several' partnership. However, each individual PMS/GMS contract would be retained to avoid any changes to rent reimbursement, NHS Pension or dispensing. It would also allow practices to leave the super-partnership and return to their GMS/PMS contract or participate in the 2017 Voluntary Contract. There would be minimal initial entry criteria, but the partnership would be free to raise the criteria and cost for practices joining later.

- The partnership would be clinically led and structured around 10 localities, each of approximately 60,000 patients, with six practices in each. Each locality would have an elected Board GP director and the partnership would have three managing GP partners. The Board would also include PMs, executives and an LMC observer could be invited. Ultimately, if a practice or partner consistently fails to meet the partnership's standards, they could be asked to leave. The governance arrangements would be set out in the partnership agreement.

- The super-partnership would have a Five Year Development Programme, reviewed annually by the partnership:
    - Some things would remain unchanged e.g. GP partners will always have full control over where they work, the network of practices would remain, and practices would have autonomy over their 'look and feel' and who works in them.
    - On formation, all non-clinical staff would TUPE to the super-partnership. There would be a gradual move to avoid duplication e.g. single set of HR policies and CQC registrations. Surplus administration staff would be redeployed into areas of growth e.g. research.
    - In Year 1 & 2 practices would retain autonomy for clinical services and each practice would have separate accounts. During this time the partnership would work up proposals for:
        - A new model of partnership with partners 1) having defined workloads and limits to uncontrolled workload; 2) separating property ownership from partnership. Property would be placed in a separate vehicle with new partners choosing whether to invest.
        - A single profit pool and how this will be shared. Individual practices would need to achieve minimum levels of sustainable profitability to participate in this, and dispensing is likely to remain linked to individual practices.
        - Potentially merging GMS/PMS contracts.

      At the end of Year 2 the partnership would vote on the proposals and individual practices would choose whether to proceed and with whom.
    - In Year 2 there would be a phased introduction of new approaches to LTC management and 'on-the-day' provision. Years 3 to 5 would include developing services to address home visits/care homes, on-the-day and using technology to improve self-management.

- One-off implementation costs for practices forming the super-partnership will be £1.50 per patient (assuming 100,000 patients). There may be some financial support from NHSE and cost savings, but these cannot be relied on in the first two years. Implementation will take 6-9 months.

- The Federation represents all members and is facilitating discussion regarding options going forward. It is up to practices interested in forming a super-partnership to form a Shadow Board and decide what relationship it wants to have with the Federation. It is likely that the Federation will continue to run non-GMS/PMS contracts, but some back office services might be shared.

- There will be a meeting in May for practices interested in forming a super-partnership.

Section 1 Challenges and Opportunities – Why a Suffolk Super-Partnership?

Over the last few years:

- 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 now manage 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 and primary care's share of NHS spending has now reached a new low of 7.2% of the NHS budget.
- 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 RCGP now refers to a "crisis in GP" and you have told us:

- 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 means 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. Luckily we still have some time in Suffolk before the crisis fully affects us.

Why a super-partnership?

There are six reasons why the super-partnership option is worth considering:

1. **GP control**
   The BMA, RCGP and other GP representative bodies, along with NHS England, all agree that change is inevitable in primary care. Super-partnership is the strongest option to ensure GPs remain in control and fully shape the final outcome.

2. **Strengthen primary care in today's world**
   You will be able to speak with one powerful voice. By virtue of holding a list, CCGs and other NHS organisations will be obliged to take notice of you. A super-partnership can collaborate with other similarly sized organisation on an equal basis – or compete with them if necessary.

3. **Better patient services**
   Scale means a super-partnership has the internal financial and managerial resources to introduce new initiatives that help to meet patients' expectations of rapid access, high quality and continuing personal care from their own GP and practice team.

4. **Staff recruitment and retention**

Partners and staff can reap benefits from being part of a larger partnership:

- Improved work/life balance, particularly for partners, through introducing 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 undertaken by managers and GPs with management expertise and training.
- Opportunity to develop new portfolio career opportunities as part of a diverse partnership.
- Individual GPs belong to a larger partnership which is more organisationally and financially stable.
- Easier to arrange sickness and holiday cover through a bank pool of GPs.
- A more attractive workplace for all staff through investment in training and development.

5. Management and governance

A super-partnership has:

- Managing GP partners and a Board with 'headroom' to consider new approaches.
- A large enough organisation to employ a wider range of staff, for example pharmacists, consultants, physicians associates etc, provide them with appropriate training and support, and sufficient of them to facilitate holiday cover.
- A support team of senior managers to lead implementation e.g. specialist IT, patient communications and HR, which is relevant if non-traditional practice staff are introduced.
- Scale, so implementation costs are shared across a large list size and are therefore more affordable. The 'wheel is not reinvented' each time a change is introduced.
- The ability to pilot and refine changes, before they are rolled-out – with the risk being taken at the super-partnership rather than the surgery level.
- The ability to hold a contract of sufficient value to become a powerful force in the local health economy with the potential to access new funding streams.

6. Financial

A super-partnership has greater financial resilience and less partner risk because of its scale.

A Suffolk super-partnership is positioned for primary care growth as the era of hospitals taking an ever-rising share of the NHS budget goes into reverse. A super-partnership is able to attract these significant new revenue streams and, by streamlining administration and back office systems, is able to deliver them using existing resources.

Motivations for practice interest in super-partnership

The discussions held so far suggest there are a variety of different individual practice motivations for those potentially interested in super-partnership:

- For some, it is the potential opportunities that 'working at scale' can bring, such as: taking advantage of the need to shrink our hospitals; increasing income from research; improving patient care (for example by reducing variation across practices); or making Suffolk more attractive for salaried GPs – who are now the majority of our workforce.

- Others are motivated by a desire to more clearly define partner workload and limit exposure to uncontrolled work – in the knowledge that this is likely to require a sacrifice in income.
- Maintaining/increasing current income is a motivation for other practices.
- Some practices have defensive motivations, for example preparing for when/if PMS disappears.
- Others want help with succession planning/property.

What are the trade-offs needed to develop a Suffolk super-partnership?

If a Suffolk super-partnership is to be formed, it will require a compromise between different motivations. The key issues are:

- **Initially large v initially small** – a larger super-partnership has more 'clout' and potential for future development but requires lower entry criteria. A smaller initial grouping will be able to move faster but the partnership may never achieve the scale intended.
- **What changes and what stays the same?** – the main issue is how much autonomy individual practices within the larger partnership have over clinical ways of working, decision making, administration, finance etc:
    - If practices retain a high degree of clinical and financial autonomy (i.e. keep these the same as they are now) this inevitably means a super-partnership, like the Federation, can only marginally impact these areas.
    - If the super-partnership is too centralised it will be unattractive to work in and lose the benefits of partnership.
- **Partner income** - if partners want a more structured working environment, less stress but to retain their existing ways of working, we believe there is an associated cost which cannot be funded from efficiency savings alone.
- **Timing** – a super-partnership requires a journey of at least five years, which means not all issues, particularly property, can be dealt with in the first year or so.
- **The role of the Fed?** – which has an objective to support and develop Suffolk primary care, represents all member practices but also has much of the infrastructure that a super-partnership will need to replicate.

These trade-offs are an essential component of the shape of any super-partnership that might emerge.

Section 2 A Suffolk Super-Partnership – Detailed Proposal

Principles

1. A true partnership.
2. Patient focused, including retaining the highest standards of continuity of care.
3. Clinically led.
4. Inclusive – including a positive relationship with practices not joining.
5. Suffolk-wide scope but with a locality structure to retain a local feel.
6. Commitment to evolutionary change set out in a Five Year Development Programme.
7. Moving towards a single profit pool – with exceptions e.g. dispensing.
8. Positioned to expand primary care – not cost cutting or managing decline.
9. Transparent and accountable - including an elected Board and managing partners (with recall).
10. An exit route for practices wanting to permanently withdraw.

Legal structure and ownership

- Create a single new 'joint and several' partnership (e.g. called Suffolk General Practice – 'SGP') consisting of every partner from each practice wishing to join.
- The initial practices would determine any joining criteria – these are likely to include:
    - Sign-up to the partnership and Partnership Agreement and the details contained in this document.
    - Commitment to training for all staff.
    - Adequate clinical staffing or a plan to achieve this.
    - Minimum QoF achievement – as a marker of quality.
    - Meeting current PMS/GMS contract requirements and CQC Good or Outstanding rating.

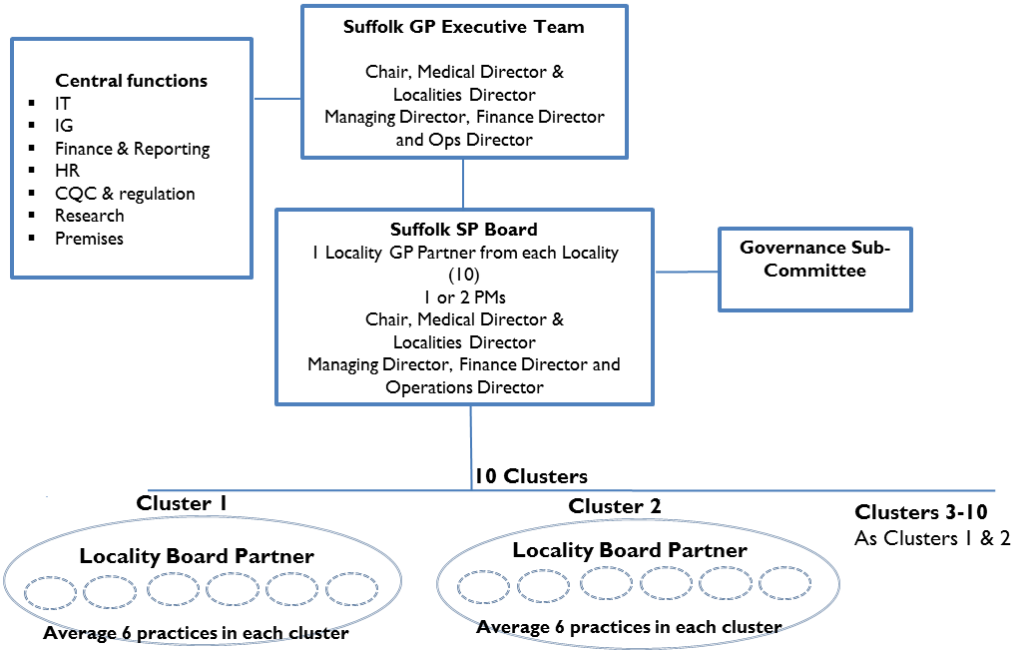
  The partnership would develop Action Plans for practices wanting to join but not meeting the criteria, or for those joining with low levels of profitability.
- Each individual PMS and GMS contract would be retained separately. The mechanism to do this would be by each partner in the super-partnership becoming a signature on each individual PMS and GMS contract (so if initially 20 practices join, each partner would become a signature on a further 19 contracts). This means NHS Pensions, rent reimbursement and dispensing rights will continue as now, and simplifies NHSE approval.
- The Five Year Development Programme, in Year 3 onwards, would develop options for:
    - Potentially merging individual PMS/GMS contracts. This would only be done with full agreement of partners, no loss of dispensing, rent reimbursement etc and NHSE approval. Merging of contracts is not essential but may become desirable.
    - Implementing a new type of ownership model, capable of attracting salaried GPs who do not intend to become partners. The model discussed at the Holiday Inn meetings was:
        - Aim for most/all GPs to become partners – with a low cost of 'buying-in' (say around £10k for non-dispensing) and no requirement to purchase individual property but the option of purchasing an interest in a property vehicle containing a portfolio of premises (see Property section below).
        - A clear definition of expected partner workload and a mechanism to limit exposure to uncontrolled workload.
        - An appraisal system which removes those partners who do not meet the requirements of the partnership.

This would require approval from the full partnership and is discussed in more detail later in this document.

Governance

A proposed governance structure is set-out below for a super-partnership in which, over time, the vast majority of practices have become members. In the early stages, for example if only say 10 practices joined, the structure would not have locality groups and the Executive team would be smaller and more part-time.

Suffolk Super-partnership – Proposed governance structure



The governance structure is described below:

- Full partnership:
  - Super-partnership Agreement setting out how decisions are made etc.
  - Vote of full partnership – resolutions would be proposed and partners would have 30 days to vote, with those not voting being deemed to consent (this is the typical approach used in larger partnerships). Full partnership vote on:
    - Appointment of new partners, expulsion of partners and entry of new practices.
    - Election and recall of Locality Board representative and Managing Partners – vote only held if elections contested.
    - Various reserved matters e.g. changing the Partnership Agreement, merging PMS/GMS contracts, varying profit share arrangements etc.
  - Quarterly meetings for all partners – video-conferencing and capability for 'watch-later'.

- Localities:

- Each practice would be part of a locality of around six neighbouring practices - approximately 50-80,000 patients and reflecting existing groupings and local geography.
- The locality role is to shape how services work locally to reflect the needs of different populations and also enable neighbouring practices to work together.
- Each locality would have an elected GP Board Partner (unpaid in at least Year 1). Nominated from GPs within the locality (i.e. including current salaried GPs) but chosen by full partnership electorate (same system the Fed uses for elections, which retains the partnership ethos).
- Localities would decide local meeting arrangements.

- Board:
  - Consists of 10 elected Locality GP Partners, 1 or 2 elected PMs and 6 Executives (plus potentially an LMC observer).
  - Meets monthly for 2 hours – agenda and minutes published.
  - Delegated authority for all matters which are not reserved for the full partnership.
  - Decision-making body for the partnership – (deleted comma, replaced with en-dash) sets Five Year Development Programme and strategy, plus monitors implementation, scrutinises the work of the Executive team etc.
  - Governance Sub-committee of the Board:
    - Contains a mix of Locality GP Partners and Executive – chaired by a Locality GP Partner.
    - Meets monthly and holds responsibility for all governance of the partnership.
    - Locality GP Partners appraise Executive team.

- Executive Partners and Managers:
  - 3 GPs – Executive Chair, Medical Director and Localities Director.
    - Initially 1 day per week each, rising to 2 days per week each.
    - 3 year terms with a maximum of 2 terms (i.e. 6 years).
    - Medical Director becomes Caldicott Guardian for the whole partnership.
    - To stand for election a candidate must be a practising GP, pass a competency assessment supervised by the Governing Body and not be on either CCG Governing Body or Clinical Exec. Election then by full partnership – each partner with one vote.
    - Recall system – either a majority of Locality GP Partners or (say) 33% of full partnership request a fresh election.
  - Managing Director, Finance Director and Ops Director.
    - Single SIRO and CQC Registered Manager for whole partnership.

The Five Year Development Programme

The super-partnership Five Year Development Programme, reviewed annually by the partnership, would set out a programme of how the organisation would evolve and change, include working practices. The outline of the programme is in Section 3 and detailed below:

What always stays the same?

- GP partners will always have full control over where they work. Partners can choose whether to take advantage of opportunities outside their practice which will generally be within a Locality of six neighbouring practices, although some will require more travel e.g. Locality Board Partners or Executive Team.

- Practices will always have autonomy for:

    - The look and feel of each practice, which will stay individual and reflect the local population and partners/staff.
    - Final selection of individuals who permanently work in a practice. Typically HR will advertise roles and prepare a qualified shortlist with practices then interviewing and selecting their preferred candidate (note this process will not start immediately).
    - Managing delegated practice budgets covering local non-routine maintenance, training not organised by the partnership, attending conferences etc. We would need to finalise what is on this list.
    - Patient Participation Groups – unless all practices choose to have this function managed by the central team.

Years 1 & 2

- For Years 1 and 2 individual practices will retain autonomy for~~.~~:

    - How it delivers clinical services, the culture and ways of working of the practice and how workload, holidays, study leave etc are managed. GPs would continue to work in their present locations unless they chose a role which was locality- or partnership-wide.
    - Clinical staff – GPs, NPs, nurses and HCAs. However, during Year 2 we would expect decisions on, for example replacing a member of staff, to be taken in the context of the wider locality e.g. advertising vacancies internally first, redeploying staff within localities etc.
    - Finances – individual practices would continue to have separate profit and loss and bank accounts within the overarching super-partnership accounts. All income, including seniority, private work, dispensing etc would be allocated to the individual practice (or individuals) who would continue to determine drawings etc. However, over the course of Year 1 the finance functions of individual practices would be brought together.
    - Property including maintenance, dispensing and pharmacies.
    - Whether to leave the super-partnership.
    - Changing contract e.g. PMS to GMS or the 2017 contract (as this will coincide with the super-partnership's founding).

- During Year 1 the super-partnership will take responsibility for:

    - All non-clinical staff (i.e. administrators, receptionists, PMs etc) would TUPE to the super-partnership (i.e. they retain their existing terms and conditions, and have various TUPE rights). In reality most staff would continue as they were and in the same location. However, when individuals resigned or left the partnership, we would review how their work was delivered and this might require change (subject to consultation and TUPE rights).
    - Collection and internal publication of activity and outcome data. A range of data would be automatically extracted including that relating to safety, clinical outcomes and activity.
    - Standardising HR e.g. using a single set of HR policies. This would require consultation with staff and be subject to their TUPE rights.
    - Standardise templates, starting with any new initiatives.

- Contract management including relationship with NHSE and CCGs, reporting and data. This would enable the super-partnership to speak with a single voice.
- Care Quality Commission registration and regulation. There would be one Registered Manager and one set of policies and procedures.
- Information governance – there would be one Caldicott Guardian and SIRO, and a single set of policies.
- IT – support, templates etc. By the end of Year 1 there would be a single set of templates partnership-wide.
- Governance processes e.g. complaints, serious incidents etc – the processes to manage these would be organised centrally but investigations would happen within practices.
- Organising partnership-wide new services e.g. 7-day working (if this is contractually required) or some of the other services possibly commissioned from the CCGs.
- Working with practices and national best practice, identify options for how LTC management could be improved and likely impact on clinical outcomes and costs.

- During Year 2 it is currently envisaged, but subject to discussion by partners, that the super-partnership would develop options around:

  - Ownership – all subject to full partnership agreement:
    - Develop plans for the new model of partnership including:
      - Defined workload for partners.
      - How profits are shared if a single profit pool is introduced.
      - Separating property ownership from partnership – this is detailed in the section below.
      - Potentially merging GMS/PMS contracts, providing there was no threat to PMS, dispensing, NHS Pension, rent reimbursement etc.
    - Before moving to a single profit pool we need agreement on:
      - The criteria practices need to meet in order to become part of the single profit pool i.e. a minimum level of sustainable profitability.
      - Treatment of dispensing and private income.
      - Action plans for practices that have been unable to meet the minimum level of profitability.
      - Other entry criteria for quality.
  - Clinical services
    - Introduce an internal locum system i.e. offering additional shifts to GPs within the partnership.
    - On a phased basis, introduce new approaches to the way LTCs are managed with the aim of improving outcomes, reducing variation and costs. The precise model of how this would work will be developed within the partnership.
    - Review on the day provision in Ipswich, Haverhill and other areas under severe workload pressure. Examine a phased introduction of a 'Minors Team' covering a locality and consisting of a GP, practice nurses, NPs and HVs who would be able to deal with most on-the-day minor illness.

  - Administration
    - Bring together the finance function (but with each practice continuing to have a separate bank account and profit and loss).

- IT – migrate to a single clinical system. Clearly this is contentious and needs debate.

Year 3 onwards

- The Years 3 -5 Development Programme would include:
    - The introduction of the new model of partnership for practices meeting the entry criteria.
    - Developing services to address home visits/care homes, minor on-the-day illness and using technology to improve self-management and so reduce demand for appointments.

Patient communications

- The key messages for patients would emphasise that they will experience minimal change, for example continuing to see 'their GP in their practice'. After the decision to form a super-partnership there would be a programme of patient communications and consultation to refine this proposal via Health Watch, PPGs and public meetings. Most of this work would be organised centrally using standard communication media that can be localised by individual practices.
- The super-partnership team would attend PPG meetings and publish a website and patient Q&A leaflet.
- Press communications and social media would be managed by the central team.
- By Year 3, if it was the will of the partnership, there would be an expectation that patients could book appointments in any practice, whilst at the same time retaining a 'home' practice for continuity

Property

- Immediately post the formation of the super-partnership property ownership, financing, maintenance etc would remain unchanged.
- The Development Programme would undertake the following:
    - **Year 1** – examine the opportunities to refinance the portfolio at a lower interest rate as the portfolio will be more attractive, particularly to large investors. This may not be feasible because underlying ownership will remain unchanged and some mortgages may have early redemption penalties, although there are reliefs available.
    - **Year 2** – examine if/how property could be placed in a separate 'practice property' vehicle with existing owners having a share in the portfolio, rather than in individual buildings. This would reduce financing costs, lower the risk associated with owning an individual property (particularly the need to find a successor to purchase a retiring partner's share) and make it more attractive to new partners. Key challenges, which we are advised are all manageable, include:
        - Valuation.
        - Tax implications e.g. potential loss of Entrepreneurs' Relief and other reliefs.

Finance

- Prior to the formation of the super-partnership the following would need to be agreed for Years 1 and 2:

    - Whether partner defence costs were paid by the partnership or individually.
    - Whether drawings were paid gross or net. BDO advise that superannuation should be calculated and paid by the practice but that otherwise partners should be responsible for their tax.
    - What percentage of profits would be paid-out as drawings. It is unlikely partners will want individual practices to pay out more than 100% (i.e. increase borrowing) because this would add to the liabilities of the wider partnership. Data would need to be gathered to identify current practice.

  Defence costs being paid by the partnership would allow alternatives to be explored e.g. whether the super-partnership could self-insure ('captive insurer') smaller claims and reinsurance be purchased for the remainder.

- Years 1 & 2 – individual practice accounts retained:

    - Income charged to the practice profit and loss account remains as now e.g. all income (including seniority, private work, dispensing, rent reimbursement etc).
    - Costs treated as follows:
        - Clinician costs (GPs, NPs, nurses and HCAs), premises, dispensing etc – all charged directly to the individual practice as now.
        - Administration costs:
            - In Year 1 all admin staff would be employed by the super-partnership but in reality would continue largely working in the same role in their practice. Hence their costs would continue to be charged to individual practice P&Ls – as now.
            - From Year 2 admin costs would be aggregated across the super-partnership and then apportioned to individual practices using a formula (e.g. list size). This means that savings in administration staff costs would be shared across the partnership.
            - Partnership overheads – allocated on a standard accounting formula.

- Year 3 onwards – single profit pool

    - During Years 1 & 2 we would model how each practice operates, its clinical staff mix, how workload was managed and current definitions of a 'session'. The modelling would allow:
        - A standard session and FTE partner workload to be defined.
        - An assessment of the impact of sharing profits using these standard definitions of workload on practice and individual partner profits.
    - There are likely to be various difficulties:
        - Dispensing. Options would need to be evaluated including partners in dispensing practices continuing to receive a larger share of profits (probably the most likely), non-dispensing practices 'buying out' dispensing practices or dispensing profits transferring to the super-partnership as partners retire – which would raise the incentive issue. A contingency plan would also need to be agreed if dispensing rights were limited/lost as a result of national contractual changes.

- Practices which, for structural reasons, had materially higher or lower levels of profitability (i.e. not because partners chose to have high or low partner ratios).

Implementation costs and funding support

We estimate the Year 1 one-off implementation costs would be approximately £250,000, or £150,000 if the Federation provided programme management support. Assuming 10 practices participate initially, the one-off cost would be £1.50 per patient:

- Legal costs – Hempsons proposal – £35,000 ex VAT.
- Accountancy costs – BDO proposal – £65,000 ex VAT.
- Programme management – could either be provided by the Federation or, if purchased externally, would cost a further £80-100,000 (ex VAT).
- 2 GP managing partners – 1 day per week – £50,000 – paid from savings in Year 1 on accountancy, recruitment advertising and CQC fees.
- Super-partnership Board – assume unpaid in Year 1.

We believe the £1.50 per patient would be covered by savings and additional revenue but these should not be assumed until Year 2. These costs, along with the value of unpaid time from initial participants, would be recovered from practices joining the super-partnership later.

There are three additional potential sources of resources to support Year 1:

1. **CCGs** – we do not believe the Suffolk CCGs are likely to provide any funding. There may be opportunities from the work of the two Integrated Care Organisations which are seeking to shift work out of the acutes. However, this cannot be relied on.
2. **NHS England** – has a fund, whose name changes regularly (currently called Primary Care Transformation Fund), to which we could apply. This will not cover professional fees but may fund back-office infrastructure and programme management.
3. **The Federation** – depending on its role.

In Year 1 we would assume minimal cost savings beyond accountancy fees, recruitment advertising and CQC fees which should cover the costs of the GP managing partners.

Role of the Federation

The Federation represents all members and our objectives are to ‘strengthen, support and develop primary care’– hence our role facilitating discussions around super-partnerships.

Practices forming the super-partnership would need to decide what relationship they want to have with the Federation:

1. One option would be for the super-partnership to develop independently.
2. Another option, particularly in the early period, would be for the super-partnership to utilise the Fed’s existing back-office infrastructure to avoid having to replicate it. If the second option was preferred, the Federation Board would need to consult with members to ensure this was acceptable.

Looking forward it is likely that members will want to retain a separate Federation in order for it to undertake non-GMS/PMS contracts which may have different risks compared with core general

practice. However, there are also likely to be potential cost saving synergies from sharing back office services.

Benefits of joining the super-partnership at formation

- Be part of a limited group of practices determining the shape of the partnership and how it develops. Later joiners would sign up to an agreed 'model'.
- Initial joining criteria would be minimal. Criteria for later joiners would be determined by partners in the super-partnership and are likely to be more onerous.
- Practices joining later are likely to have to pay more than £1.50 per patient to cover the unpaid work of the pioneers.

Timeline

- March & April:
  - Federation Board agree potential role of the Fed and consult with members.
  - Continue open meetings with practices examining strategic options for primary care.
  - Consult with NHSE

- May – open meeting for practices interested in forming a super-partnership.

- June – Steering Group refines the proposal and forms a shadow board.

- July – launch meeting.

Section 3 – Suffolk Super-partnership initial proposal of a Five Year Development Programme – subject to approval by partners

Workstream	Year 1	Year 2	Year 3	Year 4	Year 5
Patient comms	▪ PPGs and patient comms remain organised by practices ▪ Super-partnership manages issues relating to its formation, Health Watch and press, and produces media that can be localised	▪ Single website with individual practice sub-sites	▪ Patients able to book appointments in any practice		
Legal structure & ownership	▪ Single partnership formed with Partners' Agreement ▪ All partners become signatories on each PMS/GMS contract	▪ Develop and agree plans for expected partner workload ▪ Proposal for most GPs to become partners with low buy-in and excluding property ownership ▪ Agree proposal for single profit pool i.e. which practices participate and how profits are distributed	▪ Implement new model of partnership ▪ Single profit pool (with some exceptions) ▪ Potentially merge GMS/PMS contracts		
Governance	▪ Localities formed and GP Partner elected for each ▪ Board and Executive Partners elected and operational. Sub-committee of Board responsible for governance ▪ Single partnership-wide system of clinical governance e.g. complaints, SUIs ▪ Information governance managed by super-partnership e.g. training, ICO registration ▪ Monthly summary of each practice's performance using a suite of relevant clinical indicators				

Workstream	Year 1	Year 2	Year 3	Year 4	Year 5
Clinical 'ways of working'	▪ Practice culture and ways of working remain 'as is' ▪ Collect practice activity and outcome data. Model current activity and capacity ▪ Plan introduction of new approach to LTC management based on best practice ▪ Plan how Physios, Emergency Care Practitioners, Link Workers, HVs etc can be introduced including examples of where they already work effectively ▪ Review on-the-day provision in Ipswich (Minors Team)	▪ Introduce LTC approach on a phased basis ▪ Introduce Minors Team in Ipswich (e.g. starting with afternoon provision) ▪ Introduce model using Physios, Link Workers & HVs ▪ Develop proposals to standardise a 'session' ▪ Plan introduction of Domiciliary Teams for care homes, home visits etc ▪ Review options for standardising triage/pre-appointment	▪ Introduce Domiciliary Teams ▪ Expand Minors Team across super-partnership ▪ Introduce triage/pre-appointment system	▪	▪
Training	▪ Standard super-partnership induction programme for IG, IT, governance etc ▪ Negotiate with HEEE for a delegated budget for training.	▪ Implement a partnership wide training proposal covering GPs, nurses, NCAs, PMs, administrators etc ▪ IT training			
Contracts & regulation	▪ Single CQC registration and associated policies & procedures ▪ Exec Partners commence contract meetings with CCGs and NHSE ▪ Board decides super-partnership approaches to LES/DES ▪ Prepare business case to expand research ▪ Agree with CCGs scope of work being shifted from acutes and timing				

Workstream	Year 1	Year 2	Year 3	Year 4	Year 5
HR	▪ Commence quarterly staff/partner attitude survey ▪ Undertake TUPE process for admin staff including consultation ▪ Standardised HR policies and procedures (incl. induction) for admin staff (within TUPE regs) ▪ Single payroll & HR system ▪ Vacancies advertised internally	▪ Commence consultation for organisational structure ▪ Introduce internal locum system	▪ Standardised HR policies and procedures for partners		
New workstreams	▪ Develop clinical research offer for pharma	▪	▪		
Administration	▪ Admin staff TUPE to super-partnership. Staff continue working as now. ▪ Agree where admin tasks e.g. reporting occur (practice, locality or centre) ▪ Agree super-partnership organisational structure	▪ Phased implementation of new admin model			
Property	▪ Property including maintenance, dispensing and pharmacies remains 'as is' ▪ Review if property can be refinanced at better rates but ownership stays as now	▪ Develop 5 year plan for property needs ▪ Develop a plan to place property in a Prop. Co. ▪ Plan how maintenance etc takes place	▪ Implement Prop Co. plan ▪ New partners have a choice of buying into Prop Co if they wish	▪ Prop Co holds property ▪ Routine maintenance organised centrally	

Workstream	Year 1	Year 2	Year 3	Year 4	Year 5
Finance	▪ Build super-partnership financial model ▪ Practices continue to have separate profit & loss accounts but with a super-partnership-wide summary ▪ Finance functions brought together. Evaluate options for a single financial system ▪ Agree single chart of accounts ▪ Tender for single firm of auditors & financial advisers from end of Year 1	▪ Introduce new accounting system ▪ Work up detailed finance function operational model including controls etc ▪ Identify debt financing for loans to new partners ▪ Prepare proposal to share profits	▪ Move to new profit share arrangements		
IT	▪ Agree if all practices should move to S1 ▪ Single set of S1 templates for all new work ▪ Local S1 support introduced ▪ Review how other super-partnerships are using technology (esp. Modality)				