

GP Partnership Review

Case studies: Business Models

15 January 2019

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Introduction

While revitalising the partnership model is the focus for the GP Partnership Review, it is clear that one way of operating does not suit all practices. Throughout the review we have had the opportunity to work with several practices that have been using alternative business models and different ways of working to suit their practice's needs.

To foster the spirit of shared learning, this document has been created to showcase those models. Thank you to all those who have contributed to these case studies.

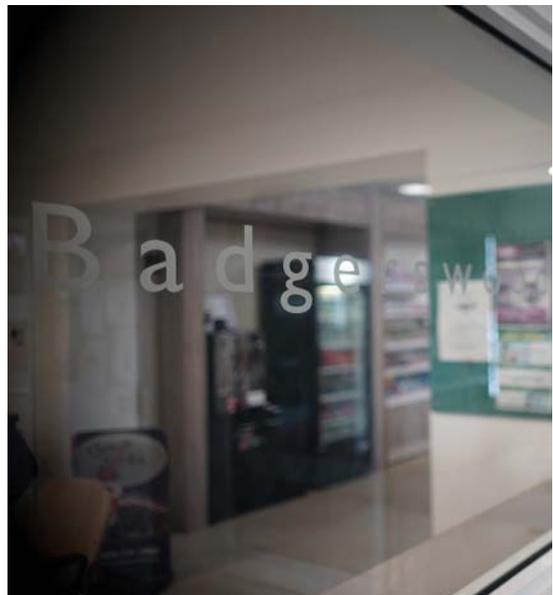
Corporate model with different components

1. Badgerswood Surgery – North Hampshire

- Partners: 4
- List size: 13,000
- Other staff: community midwives, community nurses, community psychiatric nurses, physician associate

Description of your current business model:

Badgerswood Surgery is a semi-rural practice operating under a GMS contract out of two locations with adjoining Headley and Chase Pharmacies at each. Staff are able to work across both surgeries and often do allowing us to cover posts such as when someone is off. What distinguishes us are collaboration and diversification. We work with hospitals, councils, academia, the third and private sectors, bringing additional services and resources to our patients. These partnerships also enable knowledge transfer and help us take a system view rather than thinking in silos.

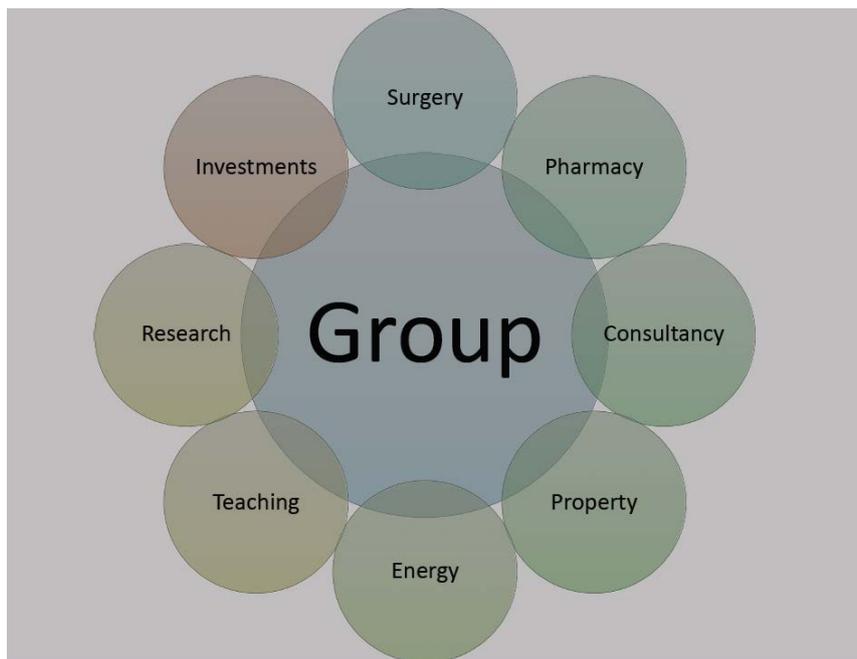


Our patient list has grown at half to one per cent a month and our turnover even faster. We have diversified into a corporate structure with multiple entities working in synergy. We are one of the surgeries that now have a physician associate and will probably be hiring more when our patient numbers grow. We use the pharmacies to do some traditionally surgery work e.g. measure blood pressure, give flu jabs, etc. so the thinking is more 'integrated NHS'. Community staff have direct read-only electronic access to our records and are very much encouraged to come in to the practice.

In terms of investment of staff there needs to be the belief and trust up front - inevitably this pays dividends long term. This could be courses, sending the nurse to observe a hospital clinic, getting more qualifications and most importantly, just spending time explaining and going through a topic or 'how to'. We keep saying to everyone that they must always be and feel safe. It's not just the knowledge, it's also the culture so staff feel they are supported, valued and in turn they develop a much more 'can do' attitude, which then in turn helps everyone.

Why did you choose this type of business model and how did you implement it?

Our external environment is changing at an ever-increasing pace. We needed a model that increases our capability and capacity, yet retains enough flexibility to meet that challenge. It was really a series of steps rather than a single grand change. We used to have a top-heavy structure with more GP's than other staff. In time, our nurses, pharmacists, physician associate and other support staff took on more of the load from the doctors. We have invested in our staff and made sure they were safe and supported. This in turn led to greater efficiency and job satisfaction for everyone.



Challenges to implementing your business model:

We soon realised that doing the day job well is not enough. We had to do more. Managing growth requires investment, which in turn means forgoing a short-term gain for a more strategic goal. We needed new skills, staff, contacts and partners we could work with. Thankfully, as we became known for excellent clinical standards, innovation and a 'can do' attitude, we attracted like-minded individuals who wanted to work with us. Believe in your people and they will in turn create belief in the organisation.

Benefits of your business model (including how it remedied existing challenges):

Workload - we addressed workload challenges by having the right mix of staff, embracing technology and with a patient focussed culture that takes a long-term view.

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Workforce – we believe being successful is entirely in keeping with doing the best for our patients and this certainly helps with recruiting the best staff. We invest heavily in training and development which in turn pays dividends in efficiency and satisfaction.

Risk – mitigated by continual growth, diversification and innovation.

If you would like to learn more about Badgerswood Group please contact: Practice Manager Sue Hazeldine, Badgerswood Surgery, Mill Lane, Headley GU35 8LH Tel:01428 713511

Primary Care Home

2. Beacon Medical Group – Devon

- Partners: 24 including one non-clinical
- List size: 43,000
- Other staff: dermatology and musculoskeletal services

Description of your current business model:

Being a Primary Care Home is a hallmark that would be suitable for a number of different partnerships that have good working relationships, but it does set a clear intent to think about the community served, as a single capitated budget with a unified team (not necessarily all working for one employer), providing services which are prioritised through good use of data.



We are a GP practice supporting 43,000 patients on one single PMS contract across six sites. We also have enhanced services that have some additional standalone contracts with the CCG, to provide services including our MSK service. There was some initial funding linked to being a Primary Care Home (small pot to support project management) but this is no longer available.

We have approximately 145 staff and 24 partners (including a non-clinical partner). As one of the first Primary Care Homes we have good working relationships with the local acute, community and mental health services, as well as community pharmacy, the voluntary sector and patient groups, and have several joint projects under our belt. We have also been able to expand our offer to provide secondary care within the community – for example, holding contracts to provide dermatology and musculoskeletal services.

Why did you choose this type of business model and how did you implement it?

Beacon was formed of a merger of three practices in 2014. All three practices were performing well and were training practices. They found that their boundaries were congruent and they had a similar value set. A merger was chosen over a federated model as a way of exerting economies of scale and making and implementing decisions more quickly. To support the merger, the group purchased freelance support from an external

consultant and then employed a new Chief Operating Officer. The first year was then spent preparing a strategy for the group and carrying out a series of reorganisations to align roles to a new staffing structure.

Challenges to implementing your business model:

The changes did depend on creating a trusted board of 4 partners to implement changes and make quick decisions. Many teams had not been through change in the past and this process was challenging for some staff and patients.

Benefits of your business model (including how it remedied existing challenges):

- Ability to offer additional services to patients
- Creating groups of skilled non-clinical staff enabled greater resilience and investment in skills and process improvement
- GP partners had more time to focus on being GPs
- Additional headspace allowed us to build relationships with other providers and commissioners, to bid for new projects and new monies and change our working model.

If you would like to learn more about Beacon Medical Group's model please contact them via their website www.beaconmedicalgroup.nhs.uk, twitter @beaconmedgroup or via email at beaconmedicalgroup@nhs.net

3. Larwood Health Partnership – North Nottinghamshire

- Partners: 16
- List size: 32,800
- Other staff: named secretaries, mentors, paramedics, pharmacists, advanced nurse practitioners

Description of your current business model:

The Larwood Health Partnership has 16 partners and five salaried GPs. They cover a patient population of 32,800 across five sites in North Nottinghamshire, one main site and four branches. They work closely with community and voluntary sectors and social care as part of a Primary Care Home model with an in-house community hub. The community hub is an area of the practice dedicated to third sector organisations that benefit the partnership's patients. They include Bassetlaw Community Voluntary Service (umbrella voluntary organisation), Citizens Advice, Bassetlaw Action Centre (Keep Well Sessions, transport), Aurora (a cancer charity offering support and screening promotion) and IAPT services. The partnership books these appointments and meets and greets patients.



Patients can contact the practice by phone or online. Admin queries are answered quickly by staff. Any clinical contacts are undertaken by a GP or Nurse Practitioner and patients are usually phoned back within an hour and given phone advice, or offered a face to face (60%) appointment that day and usually that session. The practice pre-books, for example, appointments for diabetes, baby checks, the gynae clinic and minor operations, and has extended hour surgeries available for patients to book into. Patients can also request a reply using an online system if they would prefer.

The partnership has an extended team, with most urgent visits being done by three paramedics. This allows GPs to focus on complex visits and nursing homes/palliative care. There are also three pharmacists who lead on prescribing quality and efficiency.

The partnership has a strong working relationship with community nurses, who are co-located and have developed an effective primary care home team, reducing bureaucracy, improving care and improving staff wellbeing and job satisfaction.

GPs have named secretaries and mentors. Excellent managers, with defined roles, mean clinicians can really focus on patients and services. There are two main managers (business and practice managers) as well as a HR manager, estates manager,

appointments manager and training manager. Each site has a site manager as well. The partnership believes in effective management to enable the practice to succeed, as well as allowing the doctors to focus on medicine.

The main managers and three partners form a management team which meets weekly and oversees operational business, with partners meeting monthly. Clinical meetings are held every two weeks. The practice train at every level and is an Advanced Training Practice.

Why did you choose this type of business model and how did you implement it?

The practice members are strong advocates of the partnership model. They believe this enables sustainability for the practice and continuity for the practice. Innovation is key in general practice, and they are able to make changes rapidly and with a sense of self-determination. If there is a problem they look for solutions and have a strong team for delivery.

Challenges to implementing your business model:

- Annual changes to commissioning priorities mean they have to regularly adapt.
- Recruitment can be difficult but they have been successful in building a strong team of clinicians and administrative staff.

Benefits of your business model (including how it remedied existing challenges):

We have a reduced GP turnover, and our democratic model with excellent managerial support means we can implement changes and GPs and nurses can focus on being clinicians. We have a strong team of paramedics, pharmacists, GPs, nurses, advanced nurse practitioners. We have the autonomy to change, to work in partnership with other providers and to develop their services as needed. Training is provided for every role which is helpful with recruitment and increases job satisfaction. Two Outstanding CQC ratings reflects the commitment to the practice across the whole team.

If you would like to learn more about the Larwood Health Partnership's model please contact: Dr Steve Kell, Partner, Larwood Health Partnership, Stephenkell@nhs.net

GP Lead Partnership (as part of a Federation)

4. Church Lane Surgery, Boroughbridge, North Yorkshire

- Partners: 7
- List size: 10,500
- Other staff: pharmacist

Description of your current business model:

Church Lane Surgery is a seven partner semi-rural, part dispensing practice with two sites. We have a patient list size of 10,500 and are a part of a CCG wide GP Federation providing extended hours.

In addition to the seven partners we have three salaried GPs. We have informal working relationships with a neighbouring practice and jointly employ a pharmacist.



Church Lane Surgery is a training practice for GP registrars, practice nurse students and the occasional medical student. The practice also provides personal palliative care from GPs in the evenings and weekends.

Why did you choose this type of business model and how did you implement it?

Church Lane Surgery has always run the partnership independent contractor model with the building owned in partnership share. The practice use the predominant partner model to share workload and governance and they currently own their building.

Challenges to implementing your business model:

The practice is currently exploring sale and lease back options of the building because of the likely instance new partners will need to buy in. There are concerns of 'last partner standing' on future leases. The increased workload is leading to decreasing profits for partners which is not sustainable.

Benefits of your business model (including how it remedied existing challenges):

The practice has a strong community focus with high patient satisfaction and low staff turnover. We have an ownership of service resulting in very low sickness absence in partners and high continuity of care.

If you would like to learn more about Church Lane Surgery's model please contact: Dr John Crompton, Partner, Church Lane Surgery, john.crompton@nhs.net

Employee Ownership Trust

5. Granta Medical Practices – Cambridgeshire

- Partners: 12 currently, moving to an employee owned model
- List size: 44,000
- Other staff: advanced nurse practitioners, health care assistants, emergency care practitioners, clinical pharmacists, dispensers and a social navigator

Description of your current business model:

LoGranta Medical Practices (Granta) formed through the merger of four local general practices under a GMS contract around a shared vision.



The practice covers one geographic area of South Cambridgeshire with a single patient list of 44,000. Our members can access any one of our five sites and are served by a multidisciplinary clinical team including GPs, nurses, advanced nurse practitioners, health care assistants, emergency care practitioners, clinical pharmacists, dispensers and a social navigator.

A skilled administrative and management team allows our clinicians to focus on clinical care. Granta has built a close working relationship with Addenbrooke's, our local hospital, including access to its electronic health record. Working with the hospital and our CCG, the practice is improving and expanding the range of services that can be provided in the community.

In recognition of primary care as a team-based approach Granta is moving from a traditional GP partnership model to an Employee Ownership Trust. All staff will become co-owners of a limited liability company and all will share in its success. The shares of this company will not be tradable but held on trust for all staff. Through this model, the growth of Granta's commercial value will be owned by the community it serves. There will be a Board to make business decisions that will be accountable to a staff committee. In terms of clinical liability, this risk has been mitigated through insurance while the business liability sits with the CCG.

This model maintains the cost consciousness of for-profit organizations while preventing the short-termism of personal wealth creation through tradeable share-holding. It ensures

a good balance between productivity and efficiency on one side and sustainability and improving value-creation for our practice members on the other.

Why did you choose this type of business model and how did you implement it?

An employee ownership model is particularly well aligned with the changing landscape of out of hospital care, which is no longer doctor-focused but requires a multidisciplinary team approach. While the skill set of GPs remains vital and central to primary care, it is no longer sufficient for complete care. The team, rather than the individual GP, is increasingly the nexus of care delivery.

The entire team shares in the ownership of the practice, which breaks hierarchies and encourages personal commitment and loyalty. This makes such an organisation a particularly attractive place to work for clinicians with a strong commitment to delivering the best team-based care for their patients.

We believe primary care needs to transform to meet the needs of the population and help the NHS deliver better care at lower cost. This transformation of function needs to be underpinned by a structure that works for the next half-century but which does not lose the cost-consciousness and productivity focus that the independent contractor status has delivered over the last half century.

Challenges to implementing your business model:

Some of the challenges that Granta has faced during the process are that it hasn't been done before, therefore it's been a learning process through procedural issues, application to transfer and giving assurances to patients through this change. The practice wants to ensure that shares can't be sold or traded in the future and has received limited funding in exploring this venture.

Benefits of your business model (including how it remedied existing challenges):

The way Granta has approached the challenges has not been prescriptive. Other networks may copy only parts of Granta and adjust others to their local contexts. However, there are some common principles that emerge from our experience and that have some general validity for practices that want to create a strong organisation that is ready and focused on providing an increasing scope of services for its members through a practice team. Granta fully acknowledges that our aspiration will remain limited in scope if we only focus on the development of our own practice. We can achieve much more if we make our experience available to our local health economy and the wider NHS and engage in bootstrapping a whole-system transformation of primary care.

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We believe that a transformed primary care system can reduce emergency bed days by 25% and reduce routine outpatient visits to hospitals by 70%. That's the offer that an invigorated GP practice environment can make to its local system.

If you would like to learn more about Granta's model please contact: Gerard Newnham, Strategy Director, Granta Medical Practices, gerard.newnham@nhs.net

Super Partnership

6. Modality – Birmingham

- Partners: 115
- List size: 400,000
- Other staff: multidisciplinary primary care teams, home visiting service teams, paramedics

Description of your current business model

Modality is a single partnership delivering primary care and out of hospital / community services. The list size is over 400,000 patients across 8 regions and more than 40 sites. We have 115 Partners and 1,100 staff and our governance structure consists of national and divisional boards that oversee the business, with support provided by a central team that performs the function of Finance, Payroll, HR, Communications, Business Development, etc. We hold a combination of GMS, PMS and APMS contracts. We are one business and all contracts are ultimately held by the partnership.

We are at various stages of harmonising our care delivery models and protocols across the country. We are moving towards multi-disciplinary primary care teams and in different areas, the use of a home visiting service team resourced with paramedics has worked well. We are also implementing virtual consultations across the country to provide more choice to patients.



Why did you choose this type of business model and how did you implement it?

Coming together of like-minded partners created opportunities for economies of scope and scale. Our aim is to preserve the best of General Practice and ensure Primary Care steps up to play a leading role in shaping and delivering a sustainable health system. We have made meaningful progress by transforming how we support our workforce, seeding growth and diversification, and always placing patient and population health at the centre of everything we do.

Challenges to implementing your business model:

Some of the challenges include: personal unlimited liability exposure, Parity (financial & workload), change readiness, talent management and capital investments.

Benefits of your business model (including how it remedied existing challenges):

We have taken steps to mitigate personal unlimited liability exposure by way of setting up alternate limited liability vehicles to take on other service contracts, however it is still a work in progress.

Other benefits include: local autonomy with national scale advantages, scale brings more resilience and opportunities for administrative savings, income growth and diversification, and a platform to enable change at pace.

If you would like to learn more about Modality's model please contact: Vincent Sai, CEO, vincent.sai@nhs.net

7. Our Health Partnership (OHP) – Birmingham

- Partners: 190, including 3 practice manager partners
- List size: 400,000
- Other staff: over 1,200 including partnership services team, rolling out skill mix across networks. For example, OHP employed pharmacists

Description of your current business model:

OHP is a single legal partnership, in which each practice is run by the partners based there. GMS contracts are retained, and each practice runs as a highly autonomous profit centre. OHP is a single employer, registered as a CQC provider and governed by an elected Board of partners.

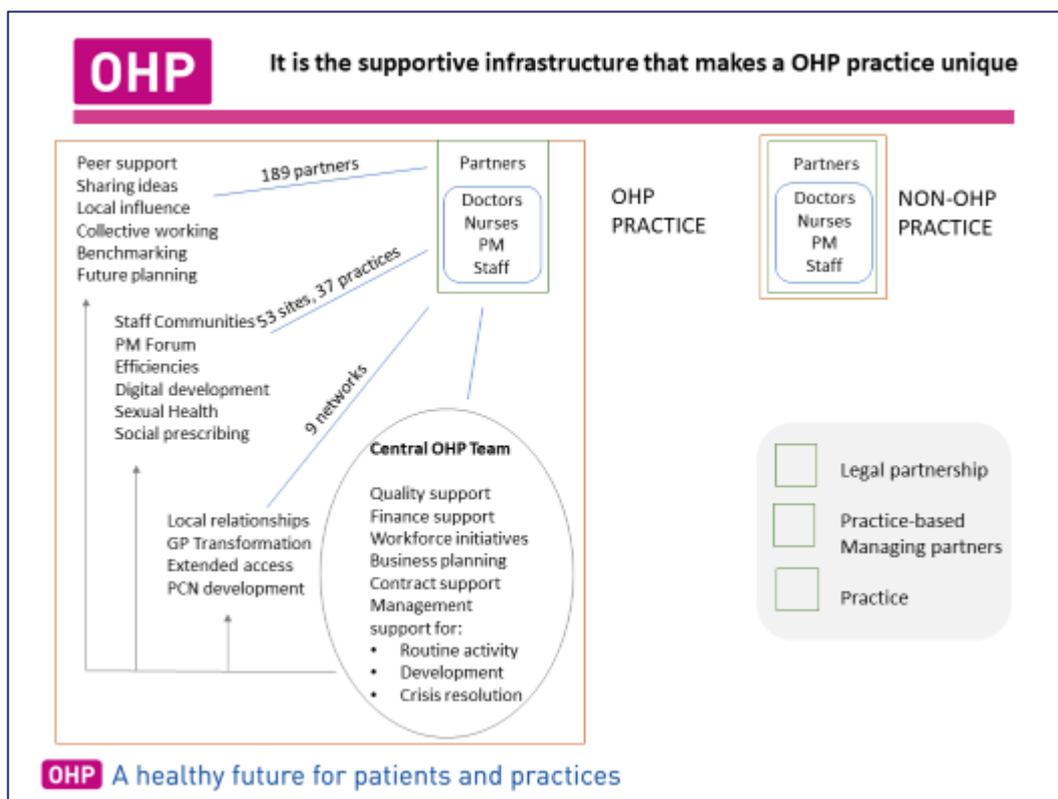
The Partnership Deed details the powers of the Board, and describes which risks are managed centrally and which accountabilities remain with

practices in line with their autonomy. A central team provides partnership services including accounts management and quality support and monitoring. Clinical services redesign is approached in a network fashion.



OHP operates in two regions (Birmingham and Shropshire), organised into eleven networks, and has 35 practices over 45 sites, with 190 full equity partners serving c400,000 patients. We have a range of advanced role staff working within our surgeries. Up to now these have been based on individual practice preference but we are currently

developing skill mix e.g. OHP-employed pharmacists, and we expect to use this approach increasingly in the future, using our developing Network footprint.



Whilst not exhaustive, examples are:

At Practice level, OHP site Hall Green Health serving 25,000 patients has embraced skill mix by providing multidisciplinary care with a team of pharmacists and paramedics complementing the usual GP workforce. A more traditional approach is seen at OHP Harlequin surgery, serving 12,000 patients. At the time of the merger, the practice had one partner. Help and support was provided by the central team, and the practice has since returned to a full complement of partners and salaried GPs. OHP is able to support both ways of finding workforce solutions, allowing for true local tailoring of workforce needs to the patient population.

At network level, 6 OHP sites in Sutton Coldfield have undergone a full contractual merger, within OHP, to form Sutton Coldfield Group Practice serving 52,000 patients. This provides workforce resilience, efficiency, and a team approach across sites. Within the partnership but in other networks, staff are shared across sites and collaborate to form quality improvement teams.

At wider partnership scale, OHP provides both staff development and communities for salaried doctors, practice managers, and soon nurses and other staff. OHP has an internal bank of over 100 GPs working on a sessional basis, and has just rolled out a staff bank for nurses and administrators, both of which give resilience and consistency for patients and

practices. It acts as a central employer for salaried doctors wanting flexible or portfolio working, where part of the week is in practice, and part pursuing a clinical or managerial interest. OHP acts as a central employer for NHS England's international recruitment programme, and is becoming a footprint for NHSE's GP retention scheme. After the recent change in government stance on Tier 2 visas, OHP has become a tier 2 visa sponsor and already retained a UK trained GP with 10 years' service at Kingsbury Road Medical Centre and now plans to expand this. Whilst not exclusive to working at larger scale, these workforce solutions are achieved far more easily, and with far less risk in a very large partnership.

OHP has the aspiration to be the GP employer of choice.

GP at scale and system influence

When OHP formed three years ago, the board agreed that involvement in system working was a major strategic objective, alongside the provision of support to member practices. This was driven by a belief that the 'GP provider' voice should be heard as the local health system transformed; many GPs felt they had useful experience and expertise to offer, and wished to help shape the developments and define the role of general practice within the new provider landscape. It was acknowledged that, historically, the sector had been difficult to work with, due to a lack of individuals who could legitimately speak for others in the way that a Trust CEO can do. The creation of OHP changed that.

The rapid emergence, and the scale and unique governance of OHP meant that it took some partner organisations within the Birmingham and Solihull (BSol) Health economy a little while to incorporate OHP into their working arrangements, particularly the commissioners who had historically communicated directly with individual practices. Over time, OHP has become an active player in the local health system in several ways and has more recently started to replicate these approaches in Shropshire.

The OHP Executive has formed a direct relationship with the CCG, and meets regularly in a 'Board to Board' format. Similar relationships have been formed at senior level with local acute, mental health and community trusts, to foster greater understanding and explore areas for constructive collaboration. Regionally, OHP's Executive team has good relationships with the NHS England local team, and regional team within the medical directorate and primary care teams.

Initially, GP providers were not part of the BSol STP process. OHP formed an Alliance of the 8 large GP providers in the STP region, and approached the system board to request involvement. This was granted, and has now evolved much further so that four of the providers, including OHP, are now core members of the STP on the same basis as the NHS Trusts and signatories to the same Memorandum of Understanding. As a result, the GP workstream has been identified, strengthened, and re-focused towards the development of general practice and its role in the transformed health system. OHP's

Chair is BSol STP Clinical Lead, the only GP provider that performs this role nationally, and this allows general practice to lead rather than respond to system planning.

Nationally OHP has had the opportunity to brief the NHS England primary care leadership team, and the NHSE executive team, on its approach, and on how OHP sees the evolution of general practice. OHP has also played a part in developing the CQC regulatory approach to large GP providers, whilst going through the process of inspection itself.

Why did you choose this type of business model and how did you implement it?

Our key aim was to create a structure that generates the benefits of large scale, whilst preserving local practice autonomy. The profit centre model ensures that partners in each practice can make day to day decisions that suit them and their local population, without impacting on the wider partnership. It prevents us from becoming a centrally driven organisation, and helps us preserve the approach of a true partnership. We collaborate with neighbouring non-OHP practices who complete our networks for new clinical services such as Extended Access (additional 100k patients), and are steadily building our network capabilities. Implementation was by Board discussion and wider consensus amongst the partners – the Board meets twice monthly and there is an ‘all partners’ meeting twice a year.

Challenges to implementing your business model:

Initial sign up was large (140 partners) so establishing OHP was complex. Amalgamating over 30 businesses and merging accounts proved time consuming, and there was not, at the time, a CQC approach to large partnerships. Funding was tight, because set up costs have all come via the Partners themselves from the annual subscription. We have grown over the period, including the setting up of a new region in Shropshire. The partnership principle is fundamental to OHP, but we recognise that the need to achieve consensus can slow progress. However, we believe the high engagement levels mitigate this and provide sustainable strength.

Benefits of your business model (including how it remedied existing challenges):

OHP provides access to benefits of scale for practices that are strong, and wish to preserve their local brand and way of serving their local population. The benefits include a collective approach to quality improvement and assurance to CQC, financial efficiencies, mutual support, workforce solutions and, significant influence over local health system planning and decision-making as a peer to trusts at STP Board level. As Primary Care Networks are implemented, we are fully involved and able to shape the development so that general practice can both contribute, and continue to develop.

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If you would like to learn more about Our Health Partnership's model please contact:
info@ourhealthpartnership.com

8. St Austell Healthcare – Cornwall

Partners: 13

List size: 32,000

Other staff: pharmacists, Emergency Care Practitioners, physiotherapists, community psychiatric nurses

Description of your current business model:

The partnership is made up of one practice with 13 partners. The partnership holds a PMS contract and its head office is Wheal Northey Surgery, St Austell, Cornwall. We employ two pharmacists, one of which has become a partner. We also employ Advanced Nurse Practitioners, Minor Illness nurses and Emergency Care Practitioners who work in the urgent care team. These members of staff also undertake home visits. The practice has been actively involved with Social Prescribing, initially employing one person to focus on those patients who are socially isolated and would benefit from physical activity. This has increased to three members of staff and two co-located health promotion staff from Cornwall Council. It is estimated that MSK problems account for about 20% of a GP's workload and mental health accounts for about 30%. The practice therefore recruited two experienced physiotherapists to be the first point of contact for some MSK presentations, and two Community Psychiatric Nurses (CPNs) to help with the mental health workload. We also have specialised admin teams like a prescriptions management team, a coding team and a document processing team.



Why did you choose this type of business model and how did you implement it?

St Austell is one of the largest towns in Cornwall with a population of about 20,000. There were four practices based within two miles of each other, serving a population of about 32,000, with a significantly deprived population. In 2014 the largest practice with a registered population of 10,000 patients returned its GMS contract following financial difficulties. The remaining three practices were very concerned about the impact of this action on their practices. The practices decided to meet the challenge by joining forces and taking over the practice under an APMS contract, initially for a year. Having worked together for a couple of months the three practices decided that we had a lot in common and would be stronger by merging rather than remaining as individual practices.

Following the merger in May 2015, the practices redesigned their services, initially by mapping what our existing workforce were doing. We then separated acute care from routine care, opening an urgent care hub in one of the buildings in August 2015.

Benefits of your business model (including how it remedied existing challenges):

The Kings Fund estimates that 25% of health is determined by healthcare systems, with the rest being determined by lifestyle choices and environmental factors. Working with the voluntary sector, the Social Prescriber manages internal referrals either via a telephone call, and signposts the individual to a service, or arranges a face to face appointment. The Social Prescriber provides links for patients to physical activity-based opportunities, whilst providing motivational interviewing and support. The service has now developed, and the local Voluntary Services have funded some additional people to work within it. The practice has found that this has reduced the demand on appointments, especially from some high intensity users. The physiotherapist posts have been funded initially and it is hoped that they will save money within the system and that, therefore, their funding might be considered. We believe that the MSK practitioners and CPNs based in the practice will help with the practice workload, but will also help the system with reduced referrals and reduced spend on medication.

The specialised admin teams have reduced the administrative workload for GPs; we estimate the prescribing team have given 45 minutes back to GPs per workday. Instead of reading 30-40 letters a day, GPs now read about five due to the document processing team. As a result, staff morale has increased across the whole practice. The practice feels sustainable now; there is no longer that feeling that if one partner leaves the practice will collapse.

Challenges to implementing your business model:

1. There was a CQC inspection on the fourth practice prior to its collapse, with a follow-up visit shortly after it was taken over under the APMS contract by the other three practices. The report was critical but CQC were supportive, as a plan was in place to improve services and provide a high quality, safe service for patients.

2. Engraining the culture of multi-disciplinary team working into the practice and with patients was challenging. The patient voice should not be underestimated. Patients need to be kept fully informed of all service development through newsletters, meetings (coffee mornings) and the practice website. The MDT culture is now working well within the practice, with a high degree of integration of teams and ways of working.

3. Continuity of care has been a challenge but we have tweaked the appointments system to help with this. This ensures that patients see the clinician of their choice and follow-ups are undertaken by the same person. At the urgent care hub, staff rotate but are only dealing with urgent on-the-day acute issues.

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If you would like to learn more about St Austell's model please contact: Bridget Sampson, Managing Partner, bridget.sampson@nhs.net

Federation

9. South Doc Services MyHealthcare – Birmingham

- Partners: 50 core members and 12 associate members
- List size: 360,000
- Other staff: dependent on practice population needs

Description of your current business model:

Our Federation promotes independent General Practice and supports the desired autonomy of our practices. We have 50 core members and 12 associate members, covering a total population circa 360,000. Our core members join with a one-off joining investment with no ongoing subscription costs. Our associate members join us for key large-scale programmes. Our federation provides a menu of optional services to our members that they can opt into based on their population's needs. Our mission is to ensure our Birmingham residents receive high quality care in the most appropriate setting for their needs. We are working on raising the quality standards across all practices and have very mature working partnerships with other care providers including our local Acute, Community and Mental Health Foundation Trusts. We are a true membership-led organisation, with our members driving our priorities and focus.

Why did you choose this type of business model and how did you implement it?

The model was developed with our practices via a robust engagement process including large scale workshops. The desire from practices was to remain independent but maximise the benefits of Primary Care 'at scale' working and have an alternative from the super partnership model. We deliver our services from our Primary Care Delivery Networks that are focused on tailoring services for our local neighbourhood communities, to ensure patients and staff truly experience the benefits outlined in the GP Five Year Forward View. We offer a flexible 'pick and mix' menu of services which means practices choose to be part of improvements, increasing likelihood of sustaining these changes.

Challenges to implementing your business model:

Our model reflects a traditional business operational model that relies on the successful winning of contracts to fund our operations built on collaborative working of practices. This challenges us to manage our members resources efficiently and exploit cost savings within the system to fund our work. We believe that this is a more sustainable model for the ongoing success of our Federation. As we were part of the early pioneers for working 'at scale' we have had to develop many of our skills, competencies and systems from scratch. However, we are sharing these locally and nationally with others to ensure the wider NHS

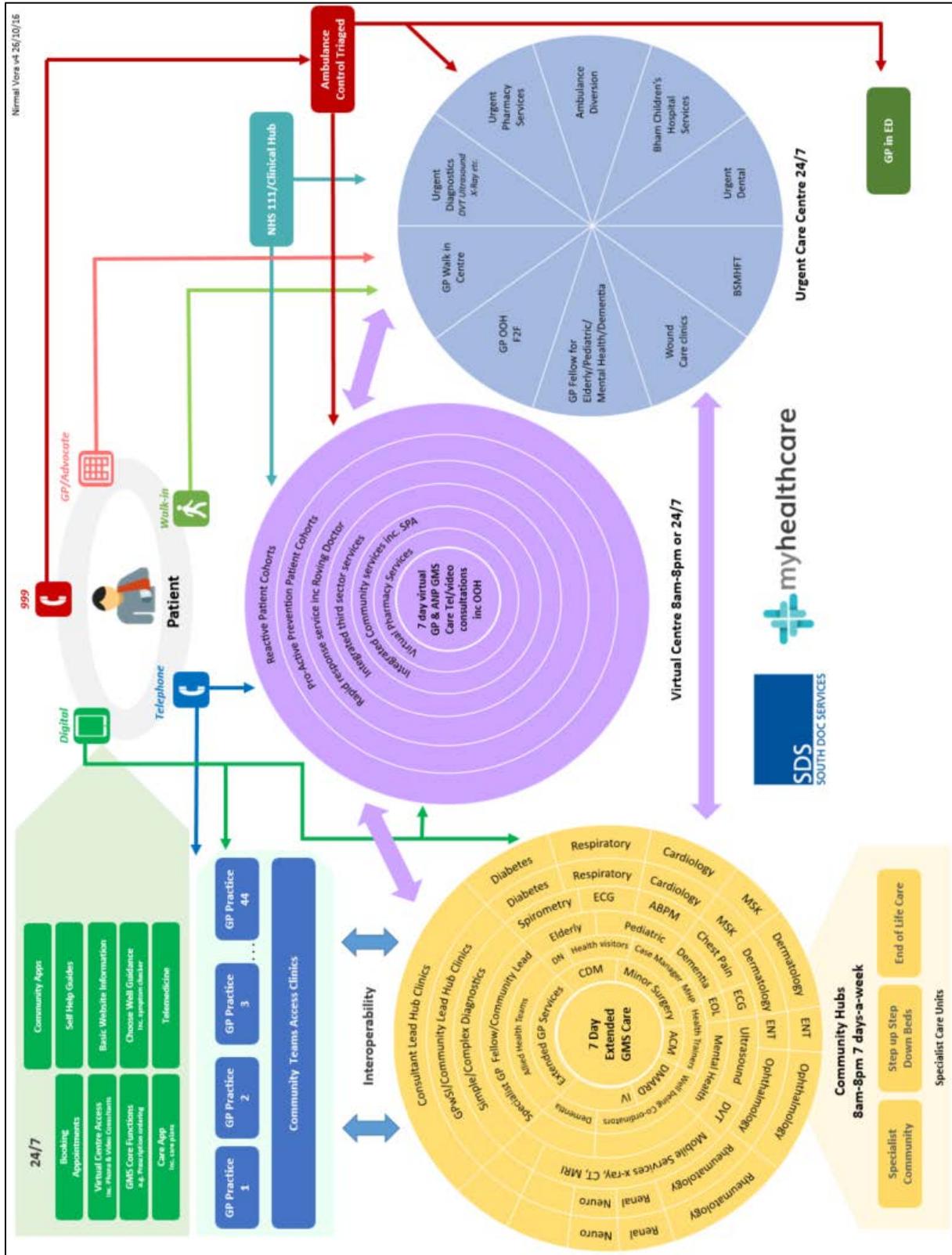
benefits from this learning. For example, we developed a unique Virtual GP and Virtual Pharmacist service, which is developing significant patient and practice benefits.

Benefits of your business model (including how it remedied existing challenges):

Our model is providing opportunities for staff from our practices to be part of our centralised support to increase job enrichment. This also helps more patients and practices benefit from their expertise providing additional resilience to practices. Our approach has driven a huge amount of transformation work resulting in local innovative services such as Virtual Community Clinics in Diabetes, CKD and Frailty, Hub based MSK services, All Age Mental Health Primary Care Services, and centralised repeat prescription services. Our Prescription Ordering Department (POD) and Virtual Services received a CQC outstanding rating in July 2018. A great deal of this improvement work is supported by our close working with the Birmingham & Solihull Training Hub, which is embedded in South Doc Services. The Training Hub leads on Workforce Development including rollout of innovative roles such as physicians associates and Primary Care Pharmacists.

Our work on optimising digital technologies underpins our radical service redesign. For example, our SDS MyHealthcare App uniquely enables patients to book directly into either practice or Hub appointments, order prescriptions direct from the app which are linked to our POD and virtual pharmacist services, provides access to online self-help to empower patients to manage their own conditions etc. We are about to launch a new video consultation service that provides all of our practices with the most up-to-date access channels for patients.

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If you would like to learn more about South Doc Services MyHealthcare’s model please contact: Mani Dhesi, Transformation Director, SDS MyHealthcare, mani.dhesi1@nhs.net

NHS Limited Company

10. Symphony Healthcare Services (SHS) – Somerset

- Partners: N/A - Board Members
- List size: 85,000
- Other staff: dependent on practice

Description of your current business model:

SHS is an NHS Ltd. Company formed on 7 April 2016 by Yeovil District Hospital NHS Foundation Trust (YDH) as an arm's length, wholly owned subsidiary of the Trust, following a direct approach from local practices who had been working collaboratively with the Trust as part of the South Somerset PACS Vanguard (the Symphony Programme), but were struggling and wanted to explore alternatives to handing back their contracts.



The SHS Board has been constituted to ensure that the power within the company remains in General Practice, and to ensure openness and transparency to local practices that have chosen not to integrate into SHS (these practices are represented on the Board).

SHS has grown from three to twelve practices since it was established two and a half years ago. 50% of practices have integrated into SHS for strategic reasons, and the remainder because of operational, workforce, governance or financial difficulties.

SHS currently cares for approximately 85,000 patients. Some functions have been centralised, whilst retaining service control at individual practice level via Clinical Leads and Practice Managers.

Why did you choose this type of business model and how did you implement it?

SHS was established following consultation with all of the practices involved in the Vanguard, the Local Medical Committee (LMC), and commissioners. The aim was to support practices locally and prevent their closure (and consequent impact on other local practices, the hospital's activity, and commissioners); to provide as an alternative model of sustainable NHS General Practice; to preserve GMS and PMS contracts (including allowing former partners the legal right of reversibility under defined circumstances); to

keep these “Contracts in Perpetuity” within the NHS; and to create links and shared incentives with the Acute Trust whilst ensuring that the practices are managed and led by General Practice.

Challenges to implementing your business model:

The cost of integration and central team cannot currently be met via the practice contracts. Turning around struggling practices requires considerable human and financial resources, which is difficult in the current workforce climate.

Benefits of your business model (including how it remedied existing challenges):

The establishment of SHS has been a key part of ensuring that no GP contracts in Somerset have been handed back to commissioners. All GP contracts in Somerset have remained within the NHS, with none moving to time limited APMS Contracts.

The size of SHS and number of practices has facilitated the introduction of a broad multi-disciplinary team into the practices, with the aim of reducing pressure on the GPs. The SHS Employed GP model removes the risks of partnership, whilst incentivising GPs to continue providing the clinical service, continuity and innovation partners historically provided.

Integration into SHS resolves the anxieties and liabilities relating to premises ownership and has allowed a number of the former partners to sell their premises.

SHS has recruited 27 GPs in the past two years. This success partly relates to the opportunities for flexible and remote working afforded by the size of the organisation, and through the ability to create portfolio roles via the links to the Acute Trust. The scale of the organisation has enabled the centralisation of functions (e.g. prescribing and workflow hubs; central CQC compliance process), and accelerated the ability to innovate.

In 2017/18 the SHS practices achieved negative growth for emergency admissions at YDH with a 15.7% growth reduction (Vs anticipated growth). This equates to £1M saving from avoided unplanned admission activity. YDH has also continuously met its National A&E targets for the past 2 years. The estimated cost saving to commissioners in relation to the effects of practice closure (dispersal, re-procurement, and service maintenance) exceeds £1M.

If you would like to know more about Symphony Healthcare Services’s model please contact: Lisa Pyrke, Head of Communications and Engagement, Symphony Healthcare

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Services, Lisa.Pyrke@YDH.NHS.UK or Bryony Finch, Support Officer, Symphony Healthcare Services, Bryony.Finch@YDH.NHS.UK

NHS Trust Vertically Integrated Model

11. Royal Wolverhampton NHS Trust - Midlands

- Partners: N/A multiple practices with partners
- List size: 70,000
- Other staff: primary, secondary and community services

Description of your current business model:

The Royal Wolverhampton NHS Trust (RWT) vertically integrated model allows the redesign of services from initial patient contact through on-going management and end of life care. As a single NHS organisation spanning primary, secondary and community services the scope of responsibility, funding, differing objectives and drivers are removed and clinicians are in a position to manage patients in a completely new way, blurring the lines between primary, secondary care and community services.

The novel sub-contracting approach allows GMS contract holders to retain sovereignty, whilst gaining the economies of scale benefits of a large NHS provider. The GPs are still partners and retain the GMS contract; all partners report into the lead partner GP at the practice who is designated as a Practice Director for the Trust. Each Practice Director has control over day to day running of the practice. Any group decisions for the practices in the network are taken by the Divisional Medical Director, also a GP, and she is supported by a multidisciplinary Divisional Management Team. In addition to this we have two GPs who are members of the Trust Management Committee, the senior leadership and decision-making body of the Trust. The practices operate as autonomous units of the Trust. All staff are protected in this business model and GPs and other practice staff enjoy excellent overall benefits package and NHS indemnity protection. The list size for the VI programme is 70,000, and subject to due diligence process will reach 100,000 shortly.

Why did you choose this type of business model and how did you implement it?

We chose this model as it provides a win-win for GPs and NHS Trusts who are committed to integrated care and working together to find new solutions. It allows the rapid sharing of data, allows investment of resources into primary care with the minimum amount of bureaucracy, and addresses directly the primary and secondary interface which has traditionally impacted negatively on GPs. The implementation plan was based on a shared vision of integrated care delivery and a strong commitment from the Trust to strengthen and promote primary care. Similarly, the commitment from GPs to engage fully in developmental work, such as complex pathway redesign, informatics solutions and embracing the use of technology, are key factors in our success. The relationship aspect cannot be overstated.

Challenges to implementing your business model:

This type of vertical integration model is highly novel and is based upon trust and commitment, and to translate that into the NHS contractual architecture was a challenge as there were no precedents and we had to develop a framework to satisfy the Trust Board, partner GPs, commissioners and system regulators. We succeeded by working together. We strongly believe primary care requires further investment and have invested into our partner practices as it is the right thing to do. We have not received any external financial support.

Benefits of your business model (including how it remedied existing challenges):

Workforce - we expanded the primary care team with other Allied Health Professionals, developed portfolio GP roles, and designed job plans to ensure our GPs had better work life balance. We provided abundant analytical support to look at demand and capacity, and where necessary redesign workflow in line with recommendations of our GP colleagues.

Innovation and Data - our GP colleagues wanted access to hospital and primary care data in real time to enable better decision making and to foster MDT working and care co-ordination and [we created a solution that makes this a reality.](#)

Primary and Secondary Care Interface Issues - Consultants, Hospital managers and GPs developed a Workstream 18 months ago looking at interface issues and this work is still ongoing and making progress.

Indicators - we have improved patient access. reduced A&E attendances (2.3%) and NE admissions (11%) and improved patient satisfaction (2017 and 2018 National GP Survey).

If you would like to learn more about Royal Wolverhampton NHS Trust's model please contact: Sultan Mahmud, Director of Integration, s.mahmud@nhs.net

Primary Care Networks

12. Luton

Description of your current business model:

General Practices in Luton have been working together in networks covering 30,000 to 70,000 patients for four years, with staff from community health services, social care and mental health all aligned around those networks. These networks are now maturing into Primary Care Networks, but importantly the size and coverage are often based more around established relationships rather than just geography.

As the approach matures, a larger number of Luton residents will be actively case managed and supported with varying levels of intensive support. The contract for the community provider will be changed from a block contract to income tied to achieving positive outcomes for the Luton residents who are case managed. The stability and networked approach of primary care is crucial to this new way of working and Luton residents will increasingly see a unified care approach to support their needs, irrespective of the employer of the person seeing them that day. Underpinning all of the above are good relationships, a shared vision and the use of data to intelligently focus the use of scarce health and social care resources in the right way.

All GP practices are actively using the national frailty register that segments registered patients into mild, moderate or severe needs groups. With the community health provider (Cambridgeshire Community Services NHST Trust), this data has been mapped against acute attendances/admissions and community health staff involvement. The resulting information has led to a new model of care for 800 named Luton residents, to support them in a proactive way wherever they live. Community multi-disciplinary/agency teams meet to review patients three times a week (hospital geriatricians, ambulance, community & mental health and social care staff) and daily safety huddles problem-solve live issues to intervene in the most appropriate way. Staff have access to telephone advice directly to a hospital specialist 7 days a week, and the team are using live acute/community health data to underpin good decision making.

Why did you choose this type of business model and how did you implement it?

Our experience shows that the success of a Primary Care Network is based on the willingness to work together to address issues of concern, coupled with a certain pragmatism given that other services will need to wrap around the network. They need to be small enough for the clinical and administrative teams to get to know each other well,

but also cover large enough populations so that they can deliver initiatives, such as recruitment drives or new interventions for patients.

Benefits of your business model

Doing more with little extra resource

Areas of specific focus for the four networks have been where emergency care practitioners or specialist nurses take calls from a number of practices, reducing the need for home visits by GPs and improving response times for patients across the network; targeting the needs of the frail elderly or people with multiple conditions; focusing on the mental health needs of young people or people of working age; and children with very complex health problems (such as a genetic or metabolic disease), as they represent a very high-risk group with complex issues around medication and coordination of medical services.

If you would like to learn more about the Primary Care Network model in Luton please contact Nicky Poulain or Dr Nina Pearson via Lutonccg.communications@nhs.net

Comparing Medical Partnership Structures with other Professions



With a few notable exceptions, primary care partnerships are all very alike. They are typically very flat structures where all partners have an equal say, and profits are shared equally based on sessions worked. There is sometimes a concept of a senior partner, but this is normally just a title conferring status rather than any additional voting rights or profit share.

Because the structure is so flat, there is not usually any career progression available within the partnership. It may take a year or two for a new partner to reach parity, but thereafter any further progression is likely to happen outside the partnership. Opportunities for this might be roles in the LMC, GPC, CCG or perhaps in the community.

The flat structure means that the expectations placed on each partner are also similar. This can be a cause of conflict, since those who want to work in different ways can be seen as 'not pulling their weight' or 'pushy'.

Where structures and profit sharing models are allowed to vary, they can have a very significant influence on culture. We can see this in other professions.

Profit Sharing

Traditionally, law firms employed a 'lock-step' model of remuneration where profit shares increased with seniority. This rewarded loyalty and provided stability, but was sometimes seen as being at the cost of performance. Rewards for outstanding performance accrued to the firm rather than the individual, and disproportionately to the senior partners.

In recent years partner pay has become more merit based with a significant element related to individual and departmental performance. Performance is usually closely associated with business generation, but can also be linked to delivery on internal firm responsibilities and staff feedback. This can lead to very high individual performance and remuneration, but a potential disadvantage with this model is a loss of collegiality and sharing between partners and potentially unwise risk-taking behaviours.

Structures

Legal partnerships typically have a more hierarchical structure. This reflects the historical link to lock-step profit sharing, and also clearer differentiation of roles. It also provides a career path through the partnership and an element of status.

Most firms have an identified Managing Partner and a Senior Partner. The managing partner has ultimate responsibility for running the partnership, and heads up a management board. The senior partner is more of a figurehead role and is responsible for raising the profile of the firm in the industry and with clients. These roles are generally elected from within the partnership.

The management board generally comprises a number of Senior Equity Partners who are either nominated or elected to the board. They would generally be the heads of departments or have responsibility for specific functions in the business.

Junior Equity Partners and Fixed Share Partners would typically be responsible for the day to day legal work including resolving complex legal issues and supervising more junior staff. Typically, their income is kept more stable than that of more senior equity partners by including a significant 'fixed share' element.

Increasingly in law firms there has been a move to recognise those lawyers who do not want to take on the risk and reward profile of partners, but who are still experienced and senior members of the team. Various titles for this role are emerging, the common ones being Managing Associate, Legal Director and Of-Counsel. Typically, the senior lawyers within this group will have team level management requirement, for example heading up sub-divisions within a department, or responsibility for training paralegals or other junior members of the team. They will also undertake more direct fee earning work than partners as they will not have the same business generation responsibilities.

Possible lessons for Primary Care

Some of the pressures on primary care partnerships have direct parallels in the other professions. Most obviously there is a growing demand for more responsibility at a younger age, a reduction in loyalty to a particular firm or practice, a desire for improved work-life balance, and a reluctance to follow the more traditional career paths.

What is clear is that law firms are evolving in a variety of ways to meet these challenges. Indeed, possibly the most interesting development in legal services over the last decade has been the growth of 'virtual firms' with no career structures as such, resourced by senior solicitors who work independently of each other and who are rewarded wholly on the basis of their own billings.

This differentiation is probably the key lesson for GP partnerships. If practices evolve into partnerships of different sizes and provide differing types of service, they will be able to develop more varied cultures. Some will be more hierarchical, and others flatter. Some will be able to reward partners for generating new sources of income for the practice, whilst others may decide that seniority and hence continuity of care should be recognised. By recognising that some partners can have more management related roles whilst others can be more clinically focussed, it also opens up multiple career paths and greater opportunities for work-life balance.

With thanks to:

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January 2019