New business models for general practice

Should the small practice, locally known and trusted, be superseded by super practices based on economies of scale? Caroline Kerby argues for new models that take the best of both worlds

By Caroline Kerby, NHS Alliance General Practice Network Lead, and practice manager in Brent

As the Chinese say “we live in interesting times” and the pessimistic among us could be forgiven for thinking we have the conditions for a perfect storm in primary care.

The economic outlook is bleak with fears that in 2015 we are destined to fall over a financial cliff edge. Primary care is dealing with unprecedented demand quoted by health secretary Jeremy Hunt as 3.7% but with many practices experiencing significantly higher levels. There is a drive to localise urgent care services by extending primary care access for longer hours and at weekends. The majority of QIPP plans are predicated on an expansion of primary care capacity and capability but investment seems to be bogged down by fears of challenges of conflict of interests and anti competitive behaviour.

The vision of Clinical commissioning groups as bottom up local organisations of like-minded clinicians transforming localised services has been overtaken by the centralisation of the need for accountability of public money and regulation. There is a worrying downward pressure of general practice finances encouraging more experienced GPs to consider earlier retirement whilst younger GPs are reflecting on what their future career pathway will look like.

Meanwhile, the lack of investment in to general practice premises and facilities presents a challenge to the ambitious out of hospital strategies and the drive for localised integrated service provision. Many a local premises audit is posing the question: where will patients be treated?

It is well known that most patient safety issues arise at handovers and with an increasing number of access points for urgent and planned care the lack of an integrated IT system magnifies the dangers of fragmentation of services by an array of providers. There are unexplained variations between practices and an increasing performance management regime using data comparisons. There are uncertainties about the future form of the GP contract and enhanced services and whether the levelling of funding will bring about improvements in outcomes.

So much for where we are now. The big question is how do we transform the conditions for a perfect storm into an opportunity for general practice – and the care we provide for patients – to flourish.

Federate or perish?

One question for debate is whether there are new business models that will enable practices to meet these challenges? There have been various reports published on the future of general practice, including the RCGP’s A Plan for Primary Care in the 21st Century (2008), The King’s Fund Report Improving Quality of Care in General Practice and the recent Nuffield report Primary Care in the 21st Century. All three reports suggest the benefits from closer collaboration or federation of general practices.

There are already a number of initiatives to develop networks of care to stimulate primary care provision based on local population needs. A key determinant of success for Clinical Commissioning Groups will be their ability to stimulate local primary care provision and support localised integrated working to sustain patients out of the hospital setting and to improve health outcomes. The focus of the quality premium is to incentivise and reward 48 targets including reductions in emergency admission and improvements in death rates. Few PCTs could claim 100% uptake of current enhanced service provision highlight potential shortfalls in capacity but also the financial viability for practices in setting up services based on low patient...
numbers.

The challenge to general practice is to assess the business environment in which it will be operating and seriously consider the most productive form for it to survive and thrive. To do this it is important to recognise the huge benefits the NHS has gained from the flexibility and agility of the small independent contractor held GMS and PMS contracts.

Is small beautiful?

Patients relate to “their practice” and “their doctor” and there has been a disregard for the value of continuity in clinical care over the past few years in favour of rapid access. No one would argue that for acute care rapid access to care delivered by the appropriately qualified professional is important and desirable. This does not apply to long term condition management where best outcomes are achieved through sustained work by multi disciplinary teams building trust and understanding with patients supporting compliance, behaviour change and the ability to self care.

GPs still command high levels of trust in patients who value the relationship their family shares with their practice and its staff. There are also significant benefits from the agility of the small practice unit to respond quickly, to achieve and to understand the local community. General practice is renowned for being underestimated in its ability to be set a target and achieving above expectations.

The foundation of the Health and Social Care Act was exploiting this detailed local knowledge held by clinical teams with a vested interest in the community in which they worked and utilising this to transform bottom up local provision. The ownership of the practice by its partners has encouraged entrepreneurship ensuring investment into premises, facilities and workforce development. However investment is a double-edged sword and the ability or willingness is limited when shouldered by individuals at varying stages of their career or by the level of business risk associated. Training practices have fulfilled an essential role in educating the next generation of GPs and will need to be able to develop doctors who will be working in more integrated models of extended care.

Keeping the best

Potential new business models will need to be able to retain the uniqueness of practices ensuring positive relationships between clinicians and patients and retaining personnel to ensure continuity of care. They will have to combine the agility of the small business unit with the benefits of the larger organisation in managing business risk and diversification. Examples in the commercial world would include the diversity in the different roles of Tesco Extra hypermarkets to Tesco Express offering local services. The model will have to be attractive in retaining experienced GPs and provide scope for new GPs to shape the future in which their careers will be lived. They will also have to be able to demonstrate their ability to deliver and attract necessary investment.

Across the country there are examples of practices coming together to work in a more cohesive forms that vary from loose associations through to mergers into one new organisation. The shape and governance structure of these new enterprises depends upon the vision and objectives of the practices involved. There are significant benefits for practices in creating the ability to work at scale to provide a more robust level of business sustainability, viability and some real opportunities as the NHS transforms into a predominantly localised integrated service caring for patients either at home or close to their home.

It could be argued that as CCGs struggle to meet the challenge of regulation, accountability and expectation with reduced management funding, it is the local providers working in a cohesive and collaborative manner that will be ideally placed to begin to drive transformation. Therefore the new business models will need to have an agreed way of working that assures transparency, equity and be based in a culture of trust and openness. There are also interesting examples from abroad that can inform the debate. The examination in the Nuffield report of the Independent Practitioner Associations that developed in New Zealand in response to the move by the Labour government in 1984 to privatise state owned enterprises and implement wide ranging market reforms pose benefits that many practices are seeking:

- They provide a durability from political change and are adaptable to shifts in policy;
- They retain the autonomy and independence that is critical to GPs;
- They create a culture to support the development of integrated local services around local population need;
- Provide a robust structure for innovation and to manage business risk and investment;
- They benefit practices through a shared approach to local management infrastructure reducing duplication and expenditure;
- They have the ability to manage local variation in quality between practices; and
• They provide economies of scale supporting business viability.

So how do practices begin to explore the benefits of working closer together as providers and maximise their ability for business development? One starting point may be to map what the group wish to achieve and where the perceived strengths of collaborative work lie. A fundamental question will be what potential threats can we minimise and what opportunities could be maximised by working in a larger scale provider relationship?

New opportunities

We all know the threats, although these may vary in immediacy and scale depending on the area. The opportunities to develop new business and improve profitability in the existing practices need greater focus. It may be worth reviewing what local PMS and PMS+ services have been developed and the potential for these to be extended across the patch. The PMS contracts were based on local need and were locally negotiated they may provide an opportunity for innovation and new ways of working with valuable learning.

Equally a review of current enhanced service uptake may also identify a business opportunity that can be maximised. The CCG QIPP plan should give clear indication of where local capacity and capability could be developed to achieve transfer of care close to home. The issue of competition and conflicts of interest are being worked through but the ability to put forward business cases or to manage inherent costs in tendering will be more realistic at scale. New provider models that address local issues around provision, quality and patient experience will be powerful in transforming primary care in a way that various commissioning initiatives have failed to do. Equally, access to legal advice is also more affordable in a large scale than on an individual practice basis. It may well be that the new structures will be effective at providing management support to their member practices taking responsibility for the ever increasing burdens of regulation and performance management being experienced by practices in delivering at higher quality and lower cost.

Many practices already work closer together than ever before and have therefore begun to build improved communication and sharing through commissioning activities. This forms a sound basis to develop the positive culture that will be essential in a successful move to providing at scale.

General practice is used to be governed under the Partnership Act 1890 but it is worth investigating the potential that the may be offered by a limited liability company or a not for profit model. Most relationships go through a period of getting to know each other and engagement before contemplating marriage. For many a partnership agreement detailing how you will work together and expectations of each other may be the right starting place. It will depend on how ambitious the vision of the group is and the desire to innovate and create robust enterprises for the future.

As with a traditional general practice the relationships are fundamental to success or failure, it will be no different when working in a “super practice” structure. It will take inspired leadership from GP partners but also from practice management to create the new world. There will be a need to balance short-term gain against long-term viability and a shift in mind sets to see a bigger picture of the future.

As PCTs disappear from the NHS stage, CCGs and the NCB will need to find innovative ways to demonstrate their ability to perform and deliver. The increased capacity and capability of general practice working at scale but with its traditional agility and ownership may well prove to be the answer to many a prayer.