Wyre Forest Health Partnership

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Wyre Forest Health Partnership.

How to form a Primary Care Partnership Serving 59 000 patients.

Twelve months ago we were five separate practices based in Worcestershire. We had a long history of working together in fund holding and commissioning. Our belief was that the strongest model for primary care going forward was a merger. This belief was generated by the forces making us want to change.

The Case for Change:

Pressure on General Practice.

- Increasing demand for primary care Appointments.
- Patients with increasingly complex multiple long term conditions.
- Lack of new GP's being trained by the NHS.
- Lack of NHS investment in primary care.
- Increasingly complex contractual demands from NHS statutory bodies.
- CQC.
- Complex UK laws for Human Resources and Health and safety.

Opportunities for Larger Primary Care Providers.

- Offer a model of primary care that breaks up some of the key stresses on GPs.
- Improved efficiency in more specialist managers.
- Investment is now being made into intermediate care.
- Investment is now being made into longer opening hours.
- Clinicians can focus on 1 or 2 lead clinical areas rather then 5-10.

Our Initial Steps:

- Define the case for change and then use this to inform a broad outline vision for the future that all can share.
- Initial "dating" process: share financial information / outline organisational aspiration.
- Engage patient groups from the start.
- Work out the best management structure for our new organisation based on fulfilling our vision.
- Develop a formal project plan.

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The Merger Project Plan

This project ran formally for 12 months. It completed on deadline and had some key interdependent work streams. These must all deliver on the same date. This information is more detailed in Appendix A.

- Patient engagement.
- Partner engagement.
- Legal advice.
- Human resources / staff engagement.
- Financial.
- Contractual (NHS England / CQC / CCG)

Following completion of the project we formed into a New NHS organisation on December 1st 2014. We then set ourselves a four month transition period for our managers to leave their old roles behind and fully take up new responsibilities.

Key Elements of Our New Organisation

We now have 28 partners who delegate functions to a Board and managers via a formal schedule of delegation. The partners meet at least four times a year for partners' meetings; these meetings allow the partners to set the organisational strategy

- The Board meets monthly to oversee strategy and governance. It is constituted with one partner representative from each site, an employed strategic manager and a chairperson.
- Independent patient representative sits on the board. This patient takes feedback from each of the five site based patient groups.
- The Board and in particular the strategic manager are held to account for delivery of the strategy
- The Board delegates day to day running of the organisation to an employed management team. This team covers all sites and has specialist functions (HR / Finance /Patient Services / Quality & Risk/ Nursing lead / Information Technology.)
- Each site has a site manager who fulfils many of the functions seen in a practice manager 30 years ago.

The transition phase has been crucial to allow us to help staff settle into the new organisation. It has also allowed ongoing consultation with patients and stakeholders to introduce our new organisation and gain feedback on our direction of travel.

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Our Strategy for Development:

In January 2015 we had our first all Partnership away day and set a strategy for ongoing development.

Primary Care Functions:

- Share good practice from each site to level up on performance and income.
- Develop a quality and performance framework to allow us to drive up quality and performance and monitor this at Board level.
- Develop a visiting team of doctors and advance practitioner nurses, to look after our housebound patients, working throughout the day thus removing home visits from our site based workload.
- Develop increasing links with pharmacy both internally and community pharmacy to help support our patients.

Integration of Care:

- To develop alongside the NHS five year forward view into a multi disciplinary community provider.
- To work closely with the CCG, Health and Care Trust, social Service and Acute Trust.
- Initially to develop services for our house bound patients, but to use the same systems and relationships to build services for all patients with long term conditions.

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Care
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Integrity

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Appendix A: Detailed Project Plan.

Once we completed this project in December 2014, a truth became apparent to us that each of the work streams was so dependent on others that they all had to complete at the same time on the same day. In this section we give more details about the exact issues facing a merging general practice.

Patient Involvement:

From the early stages of this process all patient participation groups were consulted. We have had regular agenda items on each group meeting since. Other key elements of engagement are:

- Article in local paper to mark formal launch.
- All patients invited to local town hall open meeting to ask questions.
- Advertisement for patient board representative via existing patient participation groups.
- Interview and appointment of successful candidate for patient board representation position.

Partnership Engagement:

One key element of success in this project was having partners who were committed to the success of the project and willing to put in extra work to help progress the merger. The 28 partners were kept engaged throughout the merger process, this was achieved in a variety of ways

- Each site had a lead GP on the steering group.
- Regular evening meetings for all the partners.
- Minutes and agenda of steering group shared to all.

Legal Issues:

The legal issues were split into three main domains and we formally instructed a corporate solicitor to work with us..

1. **The Partnership Agreement**, this was developed over a series of meetings with all 28 partners. This looked at all areas including how we run our new organisation. The main difference with our original agreement was that our new organisation delegates many of the functions of partnership to a Board. This board consists of a chairperson, a patient representative, a site partner from each site, and the strategic manager. Major issues that needed

discussion early were: sabbaticals, holidays, "green sock" clause, maternity leave, outside work commitments and how to make incentives for sites and/or partners to work in certain ways.

2. **Due Diligence:** This process maps out the liabilities and risks that each partnership brings into the new organisation. It means that we now understand where each of the five sites is up to in terms of key risks / HR issues and financial liabilities.
3. **Transfer of Assets:** This is an essential issue in any merger. Without a clear knowledge of which assets are brought into the partnership and which remain outside then we would have spent our first few months arguing about who owned what. Big issues to resolve are buildings / pharmacy and associated business interests.

Human Resources:

Having worked out what we wanted to do with our primary care structure we realised we needed a much more corporate management structure. To achieve this meant a full staff consultation. This was overseen by the steering group and a Human Resources firm.

- Most staff transferred on TUPE.
- Some staff were made at risk of redundancy.
- Five voluntary redundancies.
- 16 new management / senior administrative posts filled, in an internal and external recruitment process.
- Monthly staff meetings for a two way feedback process.
- A new contract of employment for staff. All new staff have been recruited under the new contract. All existing staff have been offered this.
- Monthly newsletter pre merger on HR issues, and more general news post merger.

Financial Issues:

Working with a firm of accountants we had monthly reports that had to look at various issues including

- Harmonising wages payment.
- Understanding and planning for VAT.
- A graduated merger of partnership profit over a 4 year period.
- Coping with financial issues of increasing expenses and static income in each of the five sites.
- Issues relating to transfer of assets and tax liabilities
- Planning for reduction in funding secondary to PMS reviews.

Contractual issues:

The main problems we faced in dealing with statutory bodies were that they had slightly differing opinions on partnership law and also on contracts. It took hundreds of GP and Management hours to get the following issues resolved, to a point where we could merge.

- NHS England kept our five existing contracts. They formally do not recognise a partnership of any kind; only contract holders.
- CQC were interested in us as one partnership not in the individual contracts. This led to some issues of understanding with NHS England that were sorted in the end.
- NHS Pensions struggled to understand us initially but in the end each of our five contracts kept their NHS pensions number and so we had a way forward.

Elements to consider carefully before embarking on a Practice Merger

Issues that arose in the project:

- All the staff found it a real challenge; it is hard for staff to go through a consultation and TUPE process and this affected staff morale for a period of time.
- To change our management structure some of our staff had to be put at risk of redundancy. This is very hard on those staff, but also their friends and colleagues in the practices.
- The NHS bureaucracy made the process more difficult than it might have been. Our Lawyers estimated that we almost had twice the work that we would have done if we were legal or accountancy partnerships merging.
- It was harder than we envisaged and took a toll on the partnerships as we went through the process. This strain continues even after formation. However two months post merger morale is improving and staff are all coming on board the project.
- We were unable to gain funding from the NHS to support the project.
- To gain the efficiencies of scale we felt we needed to serve at least 50 000 patients.

Costs of the project:

Each practice committed £2 per patient and this was used up in a combination of legal fees, accountancy fees, human resources fees and some limited redundancy payments. We also had six clinical sessions a week and roughly one managerial session per site per week to deliver this.

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