Network, Federation, Super-partnership or Multi-practice organisation?

A guide to GP provider organisation terminology

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Introduction

As GP practices across the country increasingly come together to work at scale, we are witnessing the development of numerous different approaches and models. These are underpinned by a variety of governance arrangements and legal forms. This variation is giving rise to a plethora of terms which are used sometimes interchangeably. The terms ‘network’ and ‘federation’ are the most commonly used, although they refer to different things and are often used as catch-all terms for a wide range of models.

This short paper seeks to describe the main models that are emerging and to clarify the different terminology used. Drawing on previous research and learning from the Nuffield Trust’s GP learning network of established organisations, it is intended as a high-level guide only and is not advocating any particular approach. It should also be recognised that reality is more complex than the descriptions suggest and many organisations span the boundaries of the different models. See below.

It should also be noted that we have focused solely on the general practice element and have not sought to describe the integrated models that are emerging as a result of the Five Year Forward View (e.g. Multi-specialty Community Providers and Primary and Acute Care Systems).

There will be new models and approaches that are emerging that we are not aware of yet and we would invite users of this network to submit examples and to describe their structure and approach.

Common forms of GP collaborative working

Although there are a range of different organisational forms that GP groups could adopt, there are four principal types that appear to be the most common:

- networks,
- federations
- super-partnerships
- multi-practice organisations.

Below, we seek to define each and clarify the differences between them. We then go on to consider some of the advantages and disadvantages of the different models.

GP networks

A network of practices is an informal arrangement with no formal legal underpinnings or contractual agreements between network members. A network approach might be used as an early form of collaboration where practices want to explore the potential for joint working or it may be used to share intelligence or to share education activities, clinical governance, peer review or to undertake joint time-limited activities such as planning a winter flu campaign. Because networks have no contractual basis, they may be an appropriate vehicle for delivering a specific project but may not be appropriate for taking on extended contracts (e.g. for out-of-hospital services such as diagnostics or audiology) or for delivering significant service change. The only exception would be if a
single practice takes on a contract and creates a service level agreement with other practices that want to participate in delivering the service. However, unlike more formal structures, there is unlikely to be a central organising committee and members are able to leave and join relatively easily.

Although the term ‘network’ is used quite widely as a catch-all term for collaborative groups of practices, there are few ‘pure’ networks in existence in England. Most groupings have some sort of written contract that formalises the arrangement to some extent.

**Figure 1: The structure of a typical network**

Note: No legal underpinnings. Some resource may be pooled for specific time-limited projects but it is more likely to involve partners/staff committing time to work jointly.

**GP federations**

The concept of a GP federation was developed by RCGP in 2008 and has been described as “an association of GP practices that come together to share responsibility for a range of functions, which may include developing, providing or commissioning services, training and education, back office functions, safety and clinical governance”.

Federations of practices are distinct from networks in that there is usually a legal basis to the organisation. Member practices are bound together by a contract or memorandum of understanding, although the legal structure may vary. Practices may be a member of a federation but they generally remain individual businesses with their own GMS or PMS/APMS contract. Many federations have been set up as a limited company and therefore are unable to hold GMS or PMS contracts. However, they can take on contracts to deliver extended services that may be commissioned by a CCG (e.g. community-based contracts such as ultrasound or dermatology).

Our research and survey work suggest that many federations have formed in the past in order to deliver a particular clinical service, commonly out-of-hours contracts or contracts to deliver long-term conditions care and other similar services that are delivered on a locality or CCG basis. Other federations have been more focused on
non-clinical elements and have sought to pool back-office functions, such as HR or IT, removing the need for individual practices to duplicate the same functions on the assumption that this could lead to economies of scale. The extent to which these organisations are rooted in general practice with an explicit aim of transforming care within the sector varies.

Usually, federations are initially funded by individual practices investing into a legal entity (e.g. Ltd company, partnership or CIC), which houses a board and/or executive team who often have the responsibility of managing the main function for which the organisation was established (e.g. bidding for and managing service contracts, or developing and managing back office function(s)). Depending on arrangements and legal structure, practices may receive a share of any profit made through any collective service contracts.

Because, unlike a network, a federation has a contractual underpinning and usually involves investment of some resource, changes in membership require more planning. It is important that expectations, commitment and exit strategy are discussed and agreed with all members on establishment of the federation. According to leaders of existing federations, one of the main advantages of adopting this model is that practices share incentives and risks associated with service delivery or back office efficiencies but GP partners retain their autonomy as practice contract holders.

**Super-partnerships**

Another model that has emerged is the GP super-partnership. A super-partnership is a large-scale single partnership, although it can operate from multiple sites. Super-partnerships form through formal mergers of GP practices. On joining, partners of individual practices become partners in the merged organisation into which their practice is absorbed. An executive board which is accountable to all partners runs the
organisation. Often, partners have a financial stake in the super-partnership and therefore share any profits or losses made, although it is possible to include salaried partners. Super-partnerships usually have a system of representation where partners have a vote on key decisions.

Super-partnerships are typically formed to develop or rationalise back-office functions, create economies of scale, and/or to enable more efficient and effective ways of delivering clinical care for a larger registered population. Our research suggests that, as single organisations, super-partnerships can offer a high degree of coordination between member practices. Existing super-partnerships report that this structure can enable organisations to relatively easily put in place quality standards and data-sharing protocols and can offer career development opportunities for a range of staff. Super-partnerships tend to operate in a single locality or CCG which means that they can develop collaborative with other local providers and commissioners.

Super-partnerships are less common than the federated model. Our survey suggests that only 2 per cent of GP organisations are super-partnerships compared to over 50 per cent that are federations. There is no consensus as to the point at which a large partnership becomes a ‘super-partnership’ but most that do exist tend to cover a minimum of 30,000 patients.

Figure 3: Structure of a typical super-partnership

![Diagram of super-partnership structure]

Each practice is a ‘branch’ of the central partnership. Partners from each practice are represented on the board

**Multi-practice organisations**

The other relatively common model that has emerged in English general practice is the multi-practice organisation (MPO). Although these organisations share some features of both the super-partnership and the federation, they are distinct in that they operate on a regional and national rather than within a single geographic area.

MPOs usually grow by successfully bidding for practice contracts when they come up for renewal (e.g. when partners retire or leave the profession, where there is a shortage of GPs or perhaps when practices are struggling to meet performance targets).
Therefore, unlike super-partnerships, when MPOs take over a new practice, this does not involve a new partner joining the management committee. Instead, the existing owners or partners take on an extra practice contract. As such, these models usually have a relatively small centralised leadership/ownership team and a comparatively high number of salaried clinical and managerial staff. Learning from existing MPOs suggests that, because a small group of individuals owns a large number of practices, there are opportunities to spread learning, share protocols and introduce standardised ways of working. MPOs have the potential to drive quality in primary care and also to diversify income streams by taking on extended contracts, such as elements of out-of-hospital care – similar to federations and super-partnerships.

The key difference between MPOs and other models is that MPOs rely on a large employed workforce instead of partners to deliver their goals. They are often geographically dispersed because they grow by taking over practice contracts irrespective of location. They, therefore, rely on strong local management in line with centrally-generated rules, to ensure smooth day-to-day running of practices and to be accountable to the central body.

Operating over a wide area can pose challenges in terms of keeping oversight of individual practice performance and keeping salaried staff engaged – mostly because it can be difficult for board members to travel between sites. It can also mean that the organisation’s ability to develop relationships with other providers and commissioners is weakened in comparison to an organisation operating within a single health economy. Because they work across multiple CCGs, any extended contracts they take on have to be tailored to the local context and so the services they offer tend to vary from place to place. However, not being wedded to a single geography means that the organisation can take on APMS practices opportunistically as contracts arise, offering greater opportunities to expand and grow than a federated model. In addition, practices within the MPO can join local federations (where terms and conditions do not conflict with the umbrella organisation) which can offer a further source of support and extended contracts.

**Figure 4: Structure of a typical multi-practice organisation**

- **Central management committee/board and support functions.** Partners hold contracts for all practices and run practices, often remotely. Managers in practices do day-to-day management.
- **Practice 1**
- **Practice 2**
- **Practice 3**
- **Practice 4**
- **Practice 5**
Legal forms
There are a range of different options for the legal form for collaborative GP organisations. These can range from Community Interest Companies to Limited Companies to Publicly Limited Companies. It is important that the organisation chooses the most appropriate form to facilitate its aims and priorities. The BMA has drafted a useful paper summarising the different legal options and the pros and cons of each: http://bma.org.uk/support-at-work/gp-practices/gp-networks/basic-legal-structures

The complexity of reality
This short paper has sought to provide very high-level descriptions of the major organisational forms that are emerging and to try to provide some clarity to the terminology being used to describe them. However, it is crucial to emphasise that reality is rather more complex than these descriptions suggest. Many organisations will not identify with any single model. There are organisations that are emerging which incorporate several different organisational forms. For example, we are aware of federations that sit within wider ‘supra-federations’ or include super-partnerships within their membership. Practices within MPOs can also be members of local federations. The New Models as set out in the Five Year Forward View add yet another layer of complexity. Definitions of the Vanguard sites most relevant to general practice are provided below. However, even within these, there is huge variety developing. Some new models are emerging out of existing general practice models such as super-partnerships, whereas some are super-imposing new boundaries on top of existing organisations, forging additional relationships and alliances.

Box 1: Multispecialty community providers (MCPs) and Primary and Acute Care Systems (PACS)

Multispecialty community providers (MCPs)
This approach to care involves a wide range of general practice services, as well as specialist services being delivered outside hospital. They would evolve out of community-based providers or general practices which would be joined together as networks or formal entities. As larger groups of practices, they would have potential to employ specialists and therapists or to bring them on as partners. These organisations could provide a majority of outpatient consultations and ambulatory care and, once sufficiently mature, could take over the running of community hospitals thus expanding their diagnostic and other services. At their most developed, they could take on a delegated budget for provision of services for their registered patients.

Primary and Acute Care Systems (PACS)
The PACS model describes a vertically integrated system which brings together primary and secondary care services. These could either grow out of acute facilities which would own and run their own GP services or they could grow out of established MCPs which could evolve to take over and run local acute providers. At their most mature, this approach could develop into what is known as an Accountable Care Organisation (ACO) in some other countries and involve the single integrated organisation taking accountability for the entire health needs of a registered patient list under a delegated capitated budget, often under a 24/7 basis for acute and urgent needs.
<table>
<thead>
<tr>
<th>Organisation type</th>
<th>Legal status?</th>
<th>Common legal framework</th>
<th>Practices retain own GMS/PMS/APMS contracts?</th>
<th>Can have clinical focus?</th>
<th>Can have back office focus?</th>
<th>Example of advantages</th>
<th>Example of disadvantages</th>
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<tr>
<td><strong>Network</strong></td>
<td>No contractual underpinning although could have some written agreement between practices</td>
<td>None</td>
<td>Yes</td>
<td>Yes but limited re service delivery. May share protocols or pathways but largely voluntary</td>
<td>Unlikely</td>
<td>Practices only come together when specific projects need to be delivered, so can be flexible re ways of working, membership and exit</td>
<td>Loose affiliation means commitment may not be sustained. Unlikely to be an appropriate vehicle for delivering extended services contracts or pooling back office functions</td>
</tr>
<tr>
<td><strong>Federation</strong></td>
<td>Contractual underpinning</td>
<td>CIC; LLP; Ltd Co</td>
<td>Yes, but depends on the legal form. E.g. A Ltd cannot hold GMS or PMS contracts</td>
<td>Yes – both in terms of performance of primary care and in terms of winning extended contracts</td>
<td>Yes</td>
<td>Practices retain their contractual autonomy whilst sharing common goals and outcomes. Can take on and deliver extended service contracts and/or drive change within general practice</td>
<td>Unless a strong vision and stable membership is established, the central body may lack control over member practices and therefore struggle to effect change</td>
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<tr>
<td><strong>Super-partnership</strong></td>
<td>Contractual underpinning</td>
<td>LLP; Ltd</td>
<td>No, usually the contract (typically GMS/PMS) transfer to the super-partnership but there are some instances where individual practices have</td>
<td>Yes – both in terms of performance of primary care and in terms of winning extended contracts</td>
<td>Yes</td>
<td>Single organisation offers potential to embed single culture and implementation of protocols. Potential for economies of scale. Single footprint can offer greater</td>
<td>Merged model may make partners feel like they have lost a degree of autonomy over their own practice. Partnership changes (e.g. leavers) may present complexities. Partnership model (unless a Ltd</td>
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<td>Multi-practice organisation</td>
<td>Contractual underpinning</td>
<td>PLC, Ltd</td>
<td>No. Note that MPOs tend to take on APMS contracts, ex-PCT run practices or practices where there is no replacement partner. A Ltd cannot hold PMS or GMS contracts.</td>
<td>Yes – both in terms of performance of primary care &amp; in terms of winning extended contracts</td>
<td>Yes</td>
<td>Potential to offer economies of scale through centralised back office functions and lean management team. Small management team can also mean organisation can be nimble in its decision-making. Opportunities to expand as not wedded to single geography – has flexibility to take on contracts as they arise. Does not preclude practices from joining local federations</td>
<td>Large number of dispersed practices could present management complexities for small management team. No opportunities for partnership amongst staff. Dispersal across multiple CCGs may reduce influence on local partners. Working across multiple CCGs mean each extended contract must be tailored to the local context</td>
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retained their contract. 

visibility amongst local partners/commissioners 

company is also formed) means that partners share liability
References


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