Royal College of General Practitioners

Primary Care Federations – *putting patients first*

Feedback from the consultation

November 2008

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Introduction: Primary Care Federations – putting patients first

1. *Primary Care Federation – putting patients first* was launched at the end of June 2008. The publication explores the concept of general practices and primary care teams working together, sharing responsibility for developing high quality, patient focused services for their local communities.

2. It demonstrates in practical terms how GP practices can work together in Primary Care Federations and how the model can be adapted to suit particular geographical circumstances and patient populations, providing real life examples of how GPs and primary health care teams are already making federations work in practice.

3. The document has been widely promoted through the press, College website, bulletins to members and through a wide ranging consultation launched in August.

4. According to RCGP Chair Steve Field:

"*GPs are good at adapting to change and seizing opportunities for improvement. We can achieve more through GP practices working together than by individual practices working in isolation."*

The RCGP Consultation process

1. The RCGP launched a wide-ranging consultation open to all in August 2008. The consultation has been sent to politicians, Medical Royal Colleges at home and abroad, healthcare organisations, Strategic Health Authorities, Primary Care Organisations and patient groups. A full list of recipients can be found at Appendix 1.

2. There was widespread interest in the document and over 40 responses were received to the consultation. Respondents included:

   - The BMA, Royal College of Physicians, Royal College of Surgeons, Royal Pharmaceutical Society of Great Britain, The Royal College of Nursing and other Colleges at home and oversees
   - SHAs, healthcare organisation and charities including the Family Doctor Association, Dispensing Doctors' Association, Society for Academic Primary Care, the Royal National Institute for the Blind (RNIB) and others
   - Patients and patient groups
   - A Conservative Member of Parliament
   - RCGP Scotland, Faculties, the Rural Practice Standing Group and range of College members

3. A full list of individuals, organisations and groups who responded to the consultation is at Appendix 2.

Executive Summary

4. The RCGP is greatly encouraged by the interest that has been generated by the Primary Care Federations model amongst colleagues from a range of healthcare organisations and patient groups in all the countries of the UK, as well as from abroad. There has been a great deal of support and constructive input received on the model as well as some concerns and areas identified where development is needed.

5. A great many individuals and organisations share our belief that Primary Care Federations, involving GPs and healthcare professionals working together in associations, can bring about improvements to services delivered to patients. It has been recognised by colleagues that the model can enable the following benefits:
   - allows services to reflect local need
   - facilitates increased patient input
   - offers the possibility of an increased range of services, including diagnostics
   - encourages the use of resource savings to be reinvested in improved patient services
   - improves the provision of training for healthcare professionals working in the community
   - helps meet the needs of marginalised groups

6. We fully understand that a range of support tools guidance, communications and buy-in to the model from key stakeholders will be required to help GPs and healthcare professionals set up Primary Care Federations. Valuable comments have been received explaining what is needed and, in particular, issues have been raised around commissioning and governance structures. The RCGP is working with colleagues to address these issues and further details about this can be found in the next section.

7. While our model offers many benefits, we realise that it will not always be the chosen solution for all practices, and that it may not be suitable to every area. Different approaches to a Federation will be needed to meet the needs of different localities and populations: there is no one size fits all answer. In implementing the model we must strive to preserve and build upon the strengths of general practice such as the link between surgeries and their communities, the patient-doctor relationship and the holistic approach to care.

8. In developing and promoting the Primary Care Federations model we must work effectively with colleagues from across primary and secondary care, the government, our members and patients to ensure that services are appropriately designed, patient-centred and deliver the highest

possible standards of care. We take on board the constructive comments received from colleagues in other medical specialties and professions on service reconfiguration and share the aim of better integrated working across roles.

9. It is especially pleasing that there are already numerous examples of GPs and healthcare professionals working together to offer improved patient care, and that others are working towards this aim.

Conclusion and Next Steps

10. Initial findings from the consultation were presented at a workshop seminar at the RCGP Annual National Primary Care Conference in Bournemouth at the start of October by the RCGP Honorary Secretary.

11. The report of the consultation has been presented to the Council Executive Committee for their comments and feedback and the College Council. Once the report it has been finalised it will be published on the College website and sent round to all those who responded to the consultation and more widely promoted.

12. Following analysis of the consultation the RCGP will draw up actions to further develop, promote and support the development of Primary Care Federations. This will include working with particular groups to understand how the model can most effectively operate in particular community settings. Ways of promoting the model to stakeholders at all levels will also be explored. A Communication Programme is currently under development.

13. The College continues to welcome the feedback on the Primary Care Federations. Case studies, examples of developing Primary Care Federations and operation in local settings will be encouraged to allow the College to build up a range of evidence on what the barriers and factors for success are. Feedback should be sent to Federations@rcgp.org.uk

14. As part of College's activity to influence the Darzi Review a senior College representative has been identified for each SHA in England to lobby, promote the College's views - including the Primary Care Federations model – and raise relevant concerns. Each Faculty has been asked to nominate a representative to support this work. The Group will coordinate its work through monthly teleconferences and met for the first time at the start of November.

Question 1: Do you support the College's concept of Primary Care Federations?

15. There was broad support for the model from the majority of respondents. Others supported the principle in theory, but voiced concerns and offered suggestions for improvement.

16. It was acknowledged that the College has made a significant contribution to preserving high quality services for patients. The federated model, it has been suggested by the BMA, is an "*effective alternative to single-site polyclinics*" who might not be able to offer the same continuity of care and a "*logical development in light of the gradual changes that some practices have already started to make*." In other words, the Federated model is a natural progression of the establishment of multi-disciplinary teams within general practice.

17. It was suggested that increased local cooperation would be extremely useful to the health of populations. One particular benefit the model could bring, it was argued by Rob Hogan, President of the College of Optometrists, was that the "*exchange of views between groups of professionals working together is good clinical governance, and decreases the sense of professional isolation that can be felt by individuals working on their own*."

18. Other benefits that the model could bring highlighted were:

- Increased local flexibility in service provision
- Increased patient choice
- Economies of scale lead to greater access to services
- Support for better access to diagnostics
- The opportunity for patient and carer groups to be linked into the model

19. Others supported the model in principle, but sought reassurance that the Federated model would not lead to the demise of the smaller practice. The College has been urged to recognise that it is likely that there are areas where practices are of sufficient size and local services are such that there is no need for a practice federation, and that such practices should not be compelled to adopt a Federated model of care as this would be counterproductive. Local needs and local circumstances should always be taken into account.

20. The BMA also suggested that measures should be put in place to ensure that practice federations do not add *"complex, cumbersome and unnecessary bureaucracy to the management of practices and provision of primary care services."* It was suggested by others that there may be conflict between federations, which would require more extensive

management than practices currently do, and the current model of general practice as described by the Dispensing Doctors' Association – *"a small business model, caring for local communities across generations, unfettered by tiers of management."*

21. Others highlighted the need to integrate the model with secondary care, especially if screening and other services which have traditionally taken place in secondary care, take place in a primary care setting. A need to share expertise by maintaining links with secondary care providers would be essential, as would the need to maintain effective systems of governance and high quality care. It was requested that more evidence be provided (e.g. case studies) before unreserved support can be given. Some respondents warned that there may be some overlapping function with the PCT, especially with regards to commissioning. The success of the Federation, it has been argued, is dependent on its ability to commission services.

22. Those who opposed the Federated model were a small minority who perceived that the College was copying the Government in recommending massive reorganisation of Primary Care with little evidence.

23. It was suggested by another respondent, however, that unless the College acts now, less effective models of care will be pushed through by NHS management. And, as stated by the College's Rural Practice Standing Group, the "*concept may allow traditional General Practice to survive in an age when private corporate enterprise is looking to get a hold on Primary Care*."

Question 2: Do you see any difficulties in a federated model of general practice being both a commissioner and provider of services for its local community, and what parallels are there with Practice Based Commissioning in England?

24. Key Points

- The majority opinion emerging to this question was that Primary Care Federations would be able to operate as both commissioners and providers of services
- However, appropriate safeguards should be taken to avoid potential conflicts of interest in this dual role
- Suitable guidance on commissioning is already available
- There are similarities between Primary Care Federations and Practice Based Commissioning
- Only a small minority of respondents felt that these issues were irreconcilable.

One response succinctly summarized this: *"There are potential difficulties with being involved on both sides but with good governance and good management the difficulties should be overcome."*

25. Other difficulties cited include:

- Federation commissioners may opt for internally provided services when those from outside the federation may be better value or quality.
- PCT objections to federations acting as both provider and commissioner.
- Two SHAs had concerns that federations operating in this way could be "anti-competitive" and one of these (NHS South East Coast) also said that development of federations could be challenged by other providers entering the market. The BMA also said that it was important to understand the implications of competition law for Primary Care Federations.

How to deal with potential conflicts of interests

26. The BMA acknowledged the potential conflict but pointed out that "…*this is not unique in primary care, and as such potential conflicts of interest can also exist when PCTs commission and provide care, and when a GP takes on the dual role of practice based commissioner and GP provider.*"

27. The BMA went on to state that "*central to the avoidance of conflicts of interest would be the development of clinical and corporate governance structures to ensure that the processes around commissioning and service provision were sound and robust.*" They also cited Department of Health's

guidance on the commissioning process and BMA's own guidance on probity and standards as useful to achieving this.

28. Several other specific suggestions were made on how good governance and management could overcome this challenge. The most common view was that there should be some separation between the provider and commissioner role within the federation by:

- Separating the provider and commissioning arms of the federation
- Setting up a separate legal entity for the commissioning function
- Ensuring transparency in decision making process
- Robust accountability framework
- Quality assurance processes
- Commissioners from neighbouring PCTs could assess service contract bids from the federation rather than the federation itself
- Appropriate probity safeguards

29. The Royal College of Paediatrics and Child Health echoed the point about separating the provider and commissioner role but noted that commissioning should have strong clinician engagement.

Similarities with Practice Based Commissioning (PBC)

30. In the BMA's view there is a similarity between this model and when a GP takes on the dual role of practice based commissioner and GP provider. Several responses suggested that that the federations could use this experience to effectively commission services.

31. One member noted these similarities but argued a key difference was the "*high calibre management that could develop the collective delivery of certain "back office" functions such as finance and human resources."*

32. The same respondent also stated that PBC clusters and federations could co-exist with the PBC cluster continuing to commission services for the population they served:

"From a finance/commissioning perspective the PBC cluster would commission services from a number of providers. The Federation would sub-contract the actual work done to GP practice members and other organisations for the contracts it won."

Other Points

33. The Royal College of Paediatrics and Child Health suggested that commissioners from a wide geographical area, including consultants,

should work together "…*in order to commission whole pathway networks rather than individual episodes of patient care*".

34. The Princess Royal Trust for Carers said that, *"we don't see a problem with federations being providers and commissioners as long as there was transparency and correct checks and balances."*

Question 3: What kind of additional support and information would aid the development of Primary Care Federations?

Summary

35. A range of support was identified that could aid the development of Primary Care Federations, including:

- Support for the model from PCTs, SHAs and the Government
- Promotion of the model
- Business, legal and financial support
- Information networks, case studies, guidance and toolkits to support delivery
- Building an evidence base to support the model
- Support for commissioning

Support from healthcare organisations and other stakeholders

36. Healthcare organisations cited by respondents as valuable potential supporters include:

- PCTs
- SHAs
- NHS Organisations
- Government / Department of Health
- BMA and Local Medical Council
- Professional bodies such as Medical Royal Colleges
- Patient Groups, charities and interest groups

37. Support from PCTs, in particular, for the model at the local level was seen widely as essential to the development of Primary Care Federations. According to one respondent, "*we tried to set up a federation but were blocked by the PCT. PCTs need to be encouraged to facilitate the development of federations.*"

38. Many respondents stated the Department of Health must encourage this to happen. The BMA view is that "*The support of PCTs would make it more likely that constructive contributions and support would be given to practices considering federation, rather than potential interference if the NHS authorities were against the concept.*"

39. The Royal College of Physicians, along with several other Medical Royal Colleges, urged collaborative working between primary and secondary care and noted the recent joint publication "*Teams without Walls*" was a good resource to support clinical integration.

Learning material on the model: Guidance, toolkits etc.

40. According to the BMA, clear guidance will be needed for practices on a range of subjects, such as:
" …the possible legal frameworks for federation; implications for the employment of staff; service provision; governance models and the financial implications of federation; how economies of scale can be negotiated and achieved; and what corporate structures can take place at a federated level and what can take place at a practice level."

41. A range of other specific suggestions were put forward on types of learning material that could aid development:
    - Off the shelf governance models
    - Templates, case studies and worked examples
    - Support for networks to enable learning experience to be shared
    - Service directories
    - Clear models of financial and legal processes for Primary Care Federations
    - Support for the development of education and training within Primary Care Federations
    - Management/ consultancy support to facilitate practice collaboration

42. A member of a Primary Care Society reported that they had found national learning events run by the National Primary Care Development Team useful and suggested similar events could help emerging Federations learn from more established organisations.

Business, legal and financial support

43. The business, financial and legal aspects of the model (including commissioning) were flagged as areas that could benefit from a range of support to facilitate development.

44. Specific suggestions include:
    - Creation of a management allowance – a federated group allowance
    - Advice on the implications of competition law (this was raised by two SHAs and the BMA)
    - Business and management support
    - Support or signposting to legal frameworks
    - Business information relating to the purchase of diagnostic equipment
    - Managerial training
    - Business and legal support for commissioning
    - PCT support for Primary Care Federation in commissioning
    - Liaison with Practice Based Commissioning Groups.

Development of Evidence

45. At an operational level evidence and information could help the development of individual Primary Care Federations. In particular:
    - Supply of local health information by PCTs to support commissioning decisions
    - Studies of local needs e.g. travel logistics in local areas

46. At a broader level it was suggested that research could be undertaken to demonstrate the overall effectiveness of this model of primary care delivery. For example, the College of Family Physicians of Canada advised that a literature review on the North American healthcare concept of a "medical home" could prove useful.

Other points

47. One respondent suggested that a "Federation Development Division", hosted by the RCGP, should be created to oversee provision of support and facilitate and encourage the development of Primary Care Federations.

48. Other responses highlighted the need to promote the benefits and concept of the model both at a local level with PCTs and Local Medical Councils and at national level with policy makers.

Question 4: Are there any specific changes to policy at a national, regional or local level that could better facilitate the development of Primary Care Federations?

49. As with the previous question, the support of SHAs and PCTs in particular was thought important. The following broad changes were identified:

- The creation of a management allowance to allow the development of enhanced management structures
- Freedom to commission as well as to provide services
- Government to ensure a level playing field in primary care with regards to the entry of private providers
- Ability to allocate PBC budgets at federated levels
- Redefinition of the roles and responsibilities of SHAs and PCTs

50. Several respondents felt the federated model could be delivered under existing arrangements.

National

51. Many identified the need for a shift in thinking away from tight State control towards a partnership between professionals and politicians. It was felt that policy should adapt to local circumstances and that a 'root upwards' approach should replace the micro-management which some respondents perceived to currently exist.

52. It was argued that there should be an explicit recognition in policy making of the need to preserve convenient local access, continuity of care and generalism with a holistic approach in primary care, and that the Department of Health should communicate to PCTs its support for a wide range of local policy options, including Primary Care Federations.

53. It was noted that consensual national support from the Department of Health might not be forthcoming, especially if it runs in competition to PCT provided services or strategic plans. Despite this, many stressed the importance of federations having the freedom to commission as well as to provide services.

54. Others suggested that the BMA needs to provide detailed guidance on how to protect historical practice level investments in the new model. It was suggested that most practices and GPs will be worried about jeopardising their profit share, and that ideally the government would back such legislation to allow such collaborations in order to allow their development.

55. Some identified the need for investment in leadership and improvement in methodologies to enable improvements to be implemented and sustained. Moreover, a management allowance similar to that which existed in Fund-holding to allow Federations to develop the types of management required.

Regional

56. One suggestion was that PCTs should encourage the provision of generalist social care in communities around practices to create a community hub. Others highlighted what they perceived to be a tendency of PCTs to centralise services as a response to poorly performing practices, which was not always desirable.

57. Some had the view that federated practices should not have to satisfy the same stringent criteria as non-federated practices when providing services to a patient who belonged to another practice in the federation.

Local

58. Many responses highlighted the need for more self-government, which would entail the members of the Federation having full authority and control over management of allocated budgets. Clinical ownership and strict management structures were also supported.

59. There was also support for regional hospitals and federations to address their roles together in order to optimise investment for service provision and lower operating costs.

60. The BMA's view is that:

"Local primary care clinicians will be best placed to identify and provide services for their patients, and as such any central policies concerning these models of practice should be light touch and defer to local needs as much as possible."

Question 5 : Are there particular implications for general practices in specific locations such as rural, urban or island based?

Summary

61. There was broad agreement that the specific locality in which primary care is delivered will have implications for the way that Primary Care Federations could deliver care.

62. A number of respondents thought that the flexibility and principles underpinning the development of Primary Care Federations could apply well in both rural and urban settings.

63. Many respondents believe rural areas can use innovative techniques to facilitate development of Primary Care Federations; however, others had the view that the model may not be able to operate in all areas and could be better suited to densely populated areas.

Rural / Island based

64. A mixture of views was put forward here. Most respondents agreed that the particular circumstances would determine the suitability of different models of care and that these could vary between different rural and island based communities.

65. The Rural Practice Standing Group said:
"Overall, feedback from rural practices is positive. The principles of federated practice are excellent. The difficulty is in the execution. For example the smaller federations (on page 11 described as fewer than 10,000 patients) are acknowledged to have little influence. The executive summary suggests that small practices are finding it increasingly difficult to maintain the level of safety required."

66. Some indicated that communication technology could be innovatively used to better facilitate care delivery in remote areas by improving contact with patients and between healthcare professionals in different practices within a Federation. The use of information systems was also identified as key to support service delivery.

67. The College National des Generalistes Enseignants suggested that in remote areas GPs with different interests within a Primary Care Federation could address different clinical priorities.

68. Some responses said that GPs working in remote and rural areas could especially benefit from working in a Primary Care Federation by the ability to access peer support. One response pointed out that if a Primary Care Federation model could deliver enhanced services such as diagnostics within the community this could significantly reduce patient travel times for services which would otherwise be located at a district general hospital.

69. The Royal College of Paediatrics and Child Health view is that in remote areas all services should be better integrated:
"Remote, rural or island based communities probably need to have integrated providers across all functions, integrating hospital, community and primary care"

70. However, others thought the model may not be able to offer the same benefits in rural areas and would be more difficult to establish:
"I am a semi-rural GP and for us once we try and work wider than in our locality the benefits of local services are lost."

Urban

71. Some respondents thought that Primary Care Federations would be better suited to urban settings. There were a number of reasons stated for this:
    - Larger population density
    - Ability to more easily share back-office functions
    - Ability to facilitate face to face meetings
    - Overlapping or geographically close practice populations

72. One respondent had the view that Primary Care Federations in urban areas could help foster a more "unified community".

Question 6: From a health professional or patient perspective do you see any difficulties with this model in meeting the needs of socially excluded people, or can you see how it could improve their care?

Summary

73. A mixture of views was put forward here. A large number of responses said that the federated model could aid the delivery of care to socially excluded groups, while others identified specific difficulties that could arise.

74. Those concerned thought that federations should incorporate policies to safeguard needs of socially excluded groups, and ensure that continuity of care and other core GP values are preserved.

Enhanced delivery through federations

75. Many respondents thought the Primary Care Federations could aid the delivery of care to socially excluded groups. Reasons cited for this included:
    - Creating a critical mass for service delivery can help reduce health inequalities
    - Improved access to practices within the federation
    - Stronger GP-led primary care can enhance delivery

76. The Royal College of Paediatrics and Child Health said of a Primary Care Federation:

    "A larger community-based organisation would enable both specialisation and differentiated services based on needs. Socially excluded, vulnerable and disadvantaged people require focused services as they are less able to access universal services"

77. Several suggestions were put forward as to how federations could improve the ability of general practice to meet the health needs of socially excluded patients:

    - Dedicated Public Health input into each federation to address the needs of those who are socially excluded
    - Federations to incorporate proper policies that would ensure care across the locality for the socially excluded
    - Well publicised rota of walk-in surgeries operating within the federation.

- Support for tailored services e.g. translators, community liaison services
- Using the mechanism of spending PBC savings according to clinical need will be reflected in better care for specific patient groups

Access issues

78. Several respondents cited improved access to primary care that could be enabled by a Primary Care Federation as a benefit to meeting the needs of this group. According to the BMA, "*It is possible that a Primary Care Federation may offer better access to care for those with disordered patterns of consulting as the patient could attend a surgery anywhere within the Federation*."

79. Another respondent thought that federations could offer a number of benefits in this area but cautioned that "…*if services are centralised for efficiency gains the complexity of access may defeat service uptake.*"

Difficulties arising from the model

80. The BMA raised the concern that patients not part of a federated practice could be at a disadvantage where other local practices were part of a federation. They further cautioned that "…*practices with particularly challenging patients may be excluded from the Federation because of the financial risk they will bring*."

81. Another response raised the possible problem that local commissioning decisions could be dominated by practices that were part of the federation at the expense of the commissioning needs of independent practices.

Preserving Key GP Values

82. The importance of preserving key GP values, such as continuity of care, was a point expressed by several respondents throughout this consultation and particularly with reference to socially excluded groups.

83. Both the Dispensing Doctors' Association and the College's Rural Practice Standing Group said that the operation of federations should maintain the community nature of practices and avoid disrupting or fragmenting the continuity of care for patients.

84. The Rural Practice Standing Group said that *"It is paramount that the concept of the family doctor who knows the patients and their needs within the communities served is not lost in the federated model*" and went on to

say that services must operate with safeguards to ensure the needs of the socially and educationally deprived are met.

Other points raised

85. "*Deprived patients don't travel well or communicate easily. The positioning of services and making services locally available is important*" (individual member)

86. There is little financial support from PCTs to support these needs.

Question 7: Do you have any comments on any impact that this model may have on local training in the primary care setting?

87. The predominant view from respondents was that training is an area where federations could realise many benefits. Good links with other medical specialties and training provision for other healthcare professionals was seen as a key benefit of the federated model by many. The Family Doctor Association stated:

    "…the federative model will have a very positive impact on training, not just of young doctors or nurses or professions allied to medicine, but the whole panoply of people involved in the provision of healthcare."

88. The BMA's response identifies the implicit benefit of economies of scale in training: *"Primary Care Federations would strengthen local training by giving greater opportunities across a number of practices for a wider team to provide training. The development of specialist services within the Federation would allow these particular skills to be identified and shared with others."* They also suggested clinical champions could be appointed in specific areas.

89. Good links with other medical specialties and training provision for other healthcare professionals was seen as key by several submissions. One of the benefits of such arrangements would be flexible working across locations and the use of common training facilities to develop mutual understanding of professional roles.

90. One respondent put forward the term "*multi-professional learning organisation*" to describe this enhanced form of training delivery across professions.

91. Some respondents also pointed out that care should be taken to ensure that training standards meet expected quality requirements.

92. The Postgraduate Medical Education and Training Board said that "*Skills such as leadership and cross-organisational team working will be vital to ensure the smooth and effective management of a network of practices, as laid out in the consultation document.*"

93. However, the BMA also urged that the benefits of a designated GP trainer and trainee within a practice setting should be maintained.

Economies of Scale

94. Several respondents believe that such a model would enhance local educational facilities for trainees from various disciplines, and many recognised the potential for federations to improve work place-based learning. Training in a federated structure, it was suggested, would offer many opportunities for whole system learning and would allow teaching resources, including teaching space, to be shared between practices. The federated model would therefore offer a rotation of opportunities for students and trainers, leading to more effective use of time for trainers able to share their expertise across the federation.

95. Other disciplines were urged to follow the lead of General Practice and create successful training in a decentralised structure. One College member felt that it was important that Federations include both training and non-training practices.

96. However, one respondent noted that a potential downside of training in a federated structure might be a loss of ownership and identity resulting from trainees being affiliated to many trainers. The BMA also warned that care should be taken to avoid breaking the link between a designated GP trainer and trainee in one practice setting.

97. It has become apparent from the feedback that skills such as leadership and cross-organisational team working will be vital to ensure the smooth and effective management of a network of practices, as laid out in the consultation document.

Training in a rural context

98. It was suggested that the federation model could be particularly beneficial for the training of students and registrars in rural environments. The College's Rural Practice Standing Group argued that training and education have not previously been targeted at rural doctors, and it would be hoped that the federated model would:
    - encourage training pathways
    - allow organisations to more accurately define rural needs
    - allow backfill to deliver medical cover for educational purposes

Linking with other specialities / professions

99. Many highlighted the huge potential that the Federated model could have for undergraduate and specialty training, the training of other health professionals (including continuing education) and the sharing of Significant Event Audits (SEAs). It was argued that closer linking with secondary care would be key to the success of the federated model with

recognition of specialist training in primary care settings as well as general practice training a priority.

100. The College of Optometrists suggested that it would be helpful if any ‘eye’ training was arranged by or for the Federation, local optometrists and the College. This would help improve each other’s understanding of how health professionals work and the challenges that they face, and would help to improve communication between professional groups for the benefit of patients.

Training standards and requirements

101. It was argued that education and training must be of the appropriate standard to ensure that doctors working within federations have the relevant skills to practise in such an environment. It was suggested that the demands of working within a Federation would necessitate a five year GP training programme.

Question 8: Have you been involved in setting up an association of general practices, and, if so, what barriers did you have to overcome?

Summary

102. A number of obstacles were faced. The level of engagement of PCTs with the process and financial issues was a feature here, as has been echoed in other parts of this consultation. A GP involved in a large practice merger illustrated some of these:

"*Persuading other GPs of the long-term benefits is the biggest barrier. Initial discussion with the PCT was constructive but legal implications may cause difficulty."*

The findings

103. Several respondents cited personal examples of being involved in the setting up of an association of practices. Examples put forward include:

- associations characterised as a federation
- PBC consortia
- Practice mergers
- Other commissioning groups including experience from the time of GP fund holding.

104. Barriers identified include:

- Apathy, reluctance to engage with new ways of working
- Lack of willingness by some to support practices doing less well
- Time commitments to attend meetings with other practices and with PCT
- PCT's approach to the association, including threat of reduction of funding
- Other financial issues: pension entitlements, lack of reimbursement for work undertaken to set up associations of practice
- Limited liability partnerships cannot hold a GMS contract
- Finding premises for new services
- Criticism and issues arising from local practices that are not part of the association
- Change of regulatory or funding frameworks
- Historic rivalry between practices - lack of trust
- Geographical separation

105. The responses indicate that GPs have been working together in associations for many years. One GP said:

“In the 1980s I was part of an association, and now lead two county associations of practices who teach medical students. In both issues of personal finance, personal preference and geographical / team difference were barriers.”

106. As has been stated elsewhere it was thought that the Government, RCGP, Faculties, BMA and LMCs should have a role in breaking down these barriers to better facilitate the development of Primary Care Federations.

107. A number of local circumstances were presented in which associations of GPs were more likely to form. Local clinical leadership in particular was seen as crucial by several respondents:
    - A local clinical leader who can bring other practices together
    - Appointment of high-level practice managers
    - Mutual confidence and trust in the quality of neighbouring practices
    - Time for meetings to allow trust and confidence to develop

Question 9: Can you give an example of your own particular Primary Care Federation model?

108. Several examples were provided at different stages of development. Furthermore, some respondents offered to pilot federations in their locality with the support of the RCGP.

109. The BMA envisaged the following:

"A practice merger to form a large partnership with a corporate ethos: providing core general practice as well as the extended services of a federation; having the size and clout to survive, compete and prosper in the new world of deregulated general practice. Combining all the advantages of traditional independent-contractor led care within a large corporate body."

110. It was suggested by one respondent that practices can be independently minded and might resist joining a federation. One solution might be to encourage the development of PBC groups first as 'prototype' federations. Nevertheless, some respondents were actively involved in federations. Examples included:

- An attempt to set up a group of 20 GPs
- A PBC group working on referral management systems, hospital data validation, pathway development in cooperation with secondary care and supervision of prescribing budgets. Also, a provider arm organisation has been set up which is running a community Pulmonary Rehabilitation Service.
- Two training practices are collaborating as a PLC to try and get Alternative Provider Medical Services (APMS) bid. In this example, the respondent said their partnership was planning to absorb three single-handed practices.

Local drug services

111. A respondent reported they had been working on becoming a social entrepreneur with their local drug services, which are currently provided by the PCT. They suggest that the move to develop long-arm provider units is an opportunity to pilot new models of care with a unique governance model along the lines suggested in the Primary Care Federations consultation document. They suggest an organisation comprising GPs with Special Interests in substance misuse and prison

health, and health and well-being nurses and therapists, working as a social enterprise or with a local federation.

112. Moreover, an organisation such as the RCGP Substance Misuse Unit (SMU) with its educational expertise and linkages could partner and work in conjunction with organisations in the delivery of training and workforce development.

International viewpoint

113. The College of Family Physicians of Canada reported that the model of care as proposed in the Primary Care Federations document “appears to be very similar to other models with which we are much more familiar in North America.” They went on to say that because of Canada’s makeup of provinces and territories, there are a diversity of models developing in their country, and many of them “exhibit the kinds of patient-focused care, governance and management structures, and expanding clinical services that are identified in Primary Care Federations.”

114. The Canadian submission cited examples such as Family Health Teams in the province of Ontario and Primary Care Networks in the province of Alberta. Their response suggested that a review of the literature in North America on the concept of the “*medical home*” could also contribute to the ongoing development of the College’s primary care model.

CASE STUDY ONE: Teaching in a federation

115. One respondent described how four inner city practices in their local area in Birmingham had agreed to work together and become a federation. They said that populations served by each practice were similar with high levels of deprivation, health inequalities and a large number of ethnic groups, and that all of the practices are close geographically due to the high population density within the area. They are in the early stages of planning the most efficient ways in which they can work together.

116. One initial idea was to use the federation to provide group teaching for the GP trainees from the four practices. The practice managers disseminated this idea to trainees and trainers within their individual practices, and most replied expressing an interest in the idea after a couple of e-mails.

117. A lunchtime session was initially held at one of the practices with a learning session on asthma and chronic obstructive pulmonary disease

(COPD). The session was attended by the respiratory lead GP, a salaried GP, the practice nurse specialising in respiratory disease, a medical student and three registrars. Lunch was provided before the formal learning session which offered a chance to network with both members of the multidisciplinary team within the practice and a fellow registrar from a neighbouring surgery.

118. The group went through the practice protocols for asthma and COPD and discussed how these could be updated. They also looked at the templates used on the computer system for asthma and COPD and considered if all the information required was relevant and what extra data may be needed. It was decided that the medical student following these discussions would re-write the practice protocol and update the template in liaison with the respiratory lead.

119. According to the respondent, it was also useful to discuss how their system differed from other practices. They used a single template for asthma and COPD whereas another surgery used separate templates for each, with an option to include all relevant information if the patient had both diseases - this latter option was considered less confusing. They also discussed the eventual need for templates and protocols used by all practices in the federation to be unified.

120. Respiratory clinics are largely nurse led so it was useful to discuss management of these common respiratory disorders to ensure registrars are competent in managing these patients. Also discussed were the recent changes to the availability of some respiratory medications and the implications of this on prescribing practice.

121. The teaching session satisfied RCGP curriculum statements ‘respiratory problems’ and ‘information management and technology’.

CASE STUDY TWO: Market Making – a schematic

122. In order to be successful a group will need providers to come forward with services compatible with its principles. In this featured area there are many small social care providers but limited community based clinical care

123. The costs and complexity of these services needs to fall. This will require a change in organisation of services as well as place. Similarly, the ability to reduce direct admissions, increase early discharge for rehabilitation and replace outpatients with community services will require cooperation from medical organisations. Resources will have to be moved to enable new services for prevention of illness. A contract

that specifies services and allows any willing provider will create the potential for substantial change.

124. This will require:

- Publication of the vision, principles and aims of the group
- Open discussions with providers about the new role requested
- Providers to understand their new role, how they can be successful in the wider NHS and stability for the providers to make changes.
- Interaction, discussion and strategic understanding of the principles of other health and social care commissioners
- Clinical ambassadors to engage with:
    - Patients and patient groups
    - Practices
    - PCT commissioners
    - Trusts
    - Other providers
    - Clinicians
    - Social care purchasers
    - Social care providers
- Advice to providers and constituent practices about the information and format required for contracts
- Membership of the steering and management groups to include the responsibility to accept the principles of the group and promote them as appropriate
- Some clinical ambassadors to negotiate using the principles of the group
- Lists of health and social care partners for practices to contact about local schemes to enable co location of services
- Practices or the consortium holding lists of patients requiring services and organising appointments with providers for regular scheduled chronic disease management.

Question 10: Any other comments

Long term impact:

125. Thought should be given to how the introduction of Federations will impact on the provision of primary care in the long-term.

Prevention of illness and health promotion:

126. Federations should play a key role in **prevention** of illness and **health promotion**.

Care pathways:

127. Federations can improve care pathways.

Access to healthcare:

128. Federations must address the health needs of all, including those who are marginalised.

129. There is an opportunity for Federations to provide a 24 x 7 service by taking over the existing infrastructure, which could save the NHS money and improve patient care without placing more pressure on GPs.

Patient involvement:

130. Patient involvement is critical in the development of Federations.

College guidance on PBC:

131. The College should provide further guidance on how Federations can improve Practice-Based Commission (PBC).

Other:

132. *“To integrate all services that impact on the health and well-being of patients we need to share a model of service delivery between those commissioning, those providing and those regulating services. The NHS Next Stage Review suggests this should be based on pathways and networks, backed by a real commitment and focus on continuous improvement.”* (RCPCH)

133. It would be beneficial to quantify any efficiency gains made from pilot federations as economies of scale have been given as potential benefits.

134. GPs will have to think outside the small business model to succeed.

135. Of note, studies from elsewhere have shown that for many health facilities there is an optimal size required for economies of scale.

136. One potential benefit of Federations could be an enhancement of advice to patients in primary care on matters relating to work and health.

137. It is important to ensure that the financial viability of acute hospital trusts is not undermined as care is moved into community settings.

138. Multiple independent contractors are an inefficient way of providing high quality care in the 21st century, especially where income depends on a highly bureaucratic system of billing for various types of service, with each practice having its own practice manager and having to develop its own governance and quality improvement procedures.

139. Social marketing approaches are equally appropriate for the prevention of secondary complications of long-term conditions as well as the more traditional primary prevention of conditions.

Section 14: OTHER EMERGING TOPICS

A) Small Practices

140. Some respondents, including the College's Rural Practice Standing Group and the Family Doctor Association, felt there was little evidence that small practices were under performing or that they could not deliver the quality of service that could be offered in a larger practice or groups of practices.

141. Other respondents felt the federated model could be a viable solution for small practices as a means of networking and enhancing governance and access to diagnostics. The College of Optometrists said that *"a federation would enable such GPs [small practices] to continue to practise, but without the professional isolation that may have befallen some of them."*

B) Impacts of service reconfiguration

Integrated working

142. Integration with other services and especially secondary care was encouraged by several organisations and individuals, in particular the other Medical Royal Colleges. The College of Optometrists said that it was "*important to ensure that Federations develop and maintain good relationships with other healthcare providers."*

143. The Royal College of Physicians said that the recent joint publication "Teams without Walls" was a good resource to support clinical integration.

Managing Service Reconfiguration

144. It was acknowledged by many that services would be reconfigured and moved from hospitals to the community – caution was urged in this. Close and careful working with secondary care and good governance arrangements was seen as a way to ensure stability in the provision of care and funding streams. The BMA suggested reconfiguration impact assessments, clear reporting of outcomes and financial data as mechanisms for achieving this.

Effective delivery of enhanced services within the community

145. The Royal College of Radiologists welcomed the increased availability of imaging technology and MR in the community and thought that this could be delivered in sites remote from the hospital. They urged that these must be linked to existing local imaging departments *"It is critical that any such development is integrated into the local imaging department"*

146. The Royal College of Surgeons said that federations would need to consider which specialties of surgery can be supported and effectively delivered in the community. They urged:

- Integration into existing surgical services
- Facilities for out-patient appointments
- Adequate training

C) Governance

147. Respondents thought it essential that federations be regulated to ensure a high quality and equitable service. It was suggested that:

"Proper clinical and corporate governance structures must be in place before a federation is able to commission and provide services, to ensure the probity of the clinicians."

Accountability

148. Some respondents sought clarification on what the chain of command would be in a federation. It was questioned whether the federations would be accountable to the Department of Health, their constituent equity partners as independent contractors, or to their patients.

The purchaser provider split

149. It was argued there would be a need to reconcile the issues of governance and conflicts of interest which might arise as a result of an organisation both providing and commissioning services. One respondent warned that what might start as a co-operation might rapidly develop into a hierarchy.

Sharing of records

150. There was concern that if patients were to be able to see any doctor within a federation, this would mean that their records would have to be

shared, and this could potentiality lead to problems relating to patient confidentiality.

Problems of scale

151. While it was recognised that general practices working together is of great benefit, it was hoped that the federated model would be able to avoid the pitfalls of large impersonal management structures and maintain the efficient decision making systems and close working relationships of small practices.

Power structures within the federations

152. Clarity was sought as to whether federations would seek equality of membership from their constituent practices, or whether decision making power would be based on practice size or income. Furthermore, respondents asked whether it was envisaged the decision making process within a federation would be corporate, executive or committee based. One respondent suggested that to offer effective care pathways, federation structures would need to be highly managed.

Profit making incentive

153. Two particularly pertinent issues were raised here. Firstly, what would be the incentive for profit-making practices to join up with, at a potential loss to their income, less-profitable practices?

154. Secondly, it was asked whether money / profit would turn out to be the main driver of health service commissioning in federations, rather than clinical and public health priorities. The College was urged to ensure that 'low incidence groups' i.e. those whose illnesses and conditions are not prevalent in a practice's catchment area, are not ignored in the commissioning process.

155. The BMA highlighted the possibility that federated practices might develop into profitable treatment / minor surgery clinics, and away from primary care surgeries. They suggest that the impact on patients, the traditional holistic horizontal care of the family, the independent contractor model of general practice, and a genuinely local primary care service, must all be understood.

Financial / Contractual issues

156. It has been suggested that the implications of competition law on federated practices will need to be considered, particularly if other local practices are excluded from a federation.

157. In summary, the Royal National Institute for the Blind (RNIB) stated:

"Whatever the setting and whoever the provider, patients' safety and well-being must be prioritised."

D) <u>Back office functions</u>

158. Many respondents recognised the need for high calibre management within federations and supported the idea of the collective delivery of back office functions. It was said that the executive management of federations would require higher and different skills than are to be found in many practices, and that this could potentially reduce the administrative workload on practice partners.

159. It was argued that there would be benefits in sharing HR and management staff, including efficiency and financial gains. Nevertheless, the BMA highlighted the potential for these gains to lead to fewer and larger practices leaving patients with a less convenient service.

160. Feedback also suggested the possibility of an overlapping function with the PCT, and that the relationship with PCTs is not addressed in the document. One respondent asked whether the federations would duplicate the functions of existing PCTs. If, for example, federations have a robust management structure, it was said that there would not be a great need for PCT organisations in their current shape and that some revision of roles would be necessary.

APPENDIX ONE: List of recipients

The consultation was publicised on the RCGP website, in the RCGP news and the RCGP 7 days bulletin

External distribution list:

Colleges & Faculties & Membership organisations:
College of Emergency Medicine (CEM)
Royal College of Anaesthetists
Faculty of Dental Surgery
Royal College of Obstetricians and Gynacaelogists
Faculty of Occupational Medicine
Royal College of Opthalmologists
Royal College of Paediatrics & Child Health
Royal College of Pathologists
Faculty of Pharmaceutical Medicine
Royal College of Physicians of Edinburgh
Royal College of Physicians of Ireland
Royal College of Physicians of London
Royal College of Physicians & Surgeons of Glasgow
Royal College of Psychiatrists
Faculty of Public Health
Royal College of Radiologists
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Surgeons of Ireland
Academy of Medical Royal Colleges
Royal College of Nursing
Nursing & Midwifery Council
General Medical Council
Royal College of Midwives
Association for the Study of Medical Education
British Association of Medical Managers
NHS Confederation
Academy of Medical Sciences
General Practitioners Committee of the BMA
British Medical Association
Community Practitioners and Health Visitors Association
Association of Medical Secretaries Practice Managers and Receptionists
College of Optometrists
Allied Health Professionals Foundation

Charities and other healthcare organisations
Age Concern
Alzheimer's Society
Asthma UK
Barnado's
Cancerbackup
Carers UK
Childline
Commission for Patient and Public Involvement in Health
Diabetes UK
Foundation for People with Learning Disabilities
Gingerbread
Help the Aged
UCL Insitute of Child Health
Mencap
The Men's Health Forum
The Mental Health Foundation
MIND
National Association of Councils for Voluntary Services
The National Childbirth Trust
The National Pharmaceutical Association
NSPCC
NCH Children's Charities
The Patient's Association
The Princess Royal Trust for Carers
Race for Health
Release
RNIB
RNID
Royal Pharmaceutical Society of Great Britain
Sane
Scope
Scottish Intercollegiate Guidelines Network
Stroke Association
Terrence Higgins Trust
National Association of Patient Participation
The Refugee Council

Public Bodies

Current Job Title
Director, Care Quality Commission Establishment, Department of Health
National Clinical Director for Mental Health, Department of Health
Chief Nursing Officer and Director-General, Department of Health
Director-General, Social Care, Local Government and Care Partnerships Directorate, Department of Health
Director, Performance, Department of Health
Director, Emergency Preparedness, Department of Health
Director, Prison Health, HM Prison Service
Director, Human Resources, Department of Health
Chair, Medicines and Healthcare Products Regulatory Agency
Director, Deputy Head of Group and Head of Prescriptions, Pricing and Supply, Medicines, Pharmacy and Industry Group, Department of Health
Head of Strategy, Department of Health
Director-General, Workforce, Department of Health
Director of Finance and Investment, Department of Health
Chief Dental Officer, Department of Health
Director, Public Health, Government Office for the East of England
Director-General, Research and Development, Department of Health
Director, Reducing Health Inequalities, Department of Health
National Director, Pandemic Influenza Preparedness, Department of Health
Director, Policy Support Unit, Department of Health
Chief Medical Officer, Department of Health
Director-General, Finance and Operations, Department of Health
Director, Primary Care, Department of Health
Director, DH Development and Delivery, Department of Health
Director of Planning, Department of Health
Director, Workforce Capacity, Analysis and HR, Department of Health
Director, Education and Pay Portfolio, Department of Health
Director, Secretariat, Department of Health
Deputy Director, Research and Development, Department of Health
Chief Scientist and Director-General, Health Improvement and Protection Directorate, Department of Health
Head, Medicines Pharmacy and Industry, NHS Medical Directorate, Department of Health
Director-General, Solicitor to the DWP and the Department of Health

Inspections and Standards Director
Director, International Affairs, Department of Health
Director of Licensing, Medicines and Healthcare products Regulatory Agency
Director, Public Health, Government Office for the North
Director-General, Communications Directorate, Department of Health
Regional Director, Public Health, Government Office for Yorkshire and the Humber
Chair, Healthcare Commission
NHS Medical Director and Director-General, Department of Health
Director, Legal Services, Office of the Solicitors, Department of Health/Department for Work and Pensions
Associate Medical Director, Department of Health
Director, DH Group Financial Controller, Department of Health
Chief Analyst and Chief Economist, Policy and Strategy Directorate, Department of Health
Financial Controller, Department of Health
Director, Healthcare Quality, Department of Health
Director, Social Care Policy and Innovation, Social Care, Local Government and Care Partnerships Directorate, Department of Health
Director, Business Partnering Team, Department of Health
Director, Financial Planning and Allocations, Department of Health
Chief Executive, National Health Service, Department of Health
Director-General, Policy and Strategy Directorate, Department of Health
Director, Customer Services, Department of Health
Programme Lead, System Management and New Enterprise, Performance, Commissioning and System Managment Directorate, Department of Health
Director of Vigilance and Risk Management, Medicines and Healthcare products Regulatory Agency
Director, System Management and New Enterprise, Department of Health
Director and Chief Pharmaceutical Officer, Medicines, Pharmacy and Industry Group, Department of Health
Head of Operational Research, Policy and Strategy Directorate, Department of Health
Regional Director of Public Health, Government Office for the South West and South West Strategic Authority
National Director, Equality and Human Rights, Department of Health
Director, Public Health, Government Office for the West Midlands
Deputy Regional Director, Public Health Group, Government

Office for the North East
Director, Estates, Facilities and Gateway Review, Department of Health
Chair, Health Protection Agency and Chair, National Radiological Protection Board
Permanent Secretary, Department of Health
Deputy Regional Director, Public Health, Government Office for the East Midlands
Chief Executive, Healthcare Commission
Chief Statistician and Head of Profession, DH Wide Statistics Team, Department of Health
Head, System Management and Regulation, Department of Health
Chief Executive, Medicines and Healthcare Products Regulatory Agency

All PCOs and SHAs (or equivalent) in England, Scotland, Wales and Northern Ireland

All members of parliament

Selected members of the House of Lords

All members of Scottish Parliament

All members of Welsh Assembly

All members of Northern Ireland Assembly

RCGP Internal distribution list:

Council
Devolved Councils
RCGP Faculties
Patient Partnership Group
Ethics
Rural Practice Standing Group
Health Inequalities Standing Group
Health Informatics Standing Group
Associated in Training Committee
Professional Development Board
Postgraduate Training Board
International

Appendix 2: List of Respondents

Respondent	Organisation
	Royal National Institute of Blind People (RNIB)
Aidan Egleston	Dispensing Doctors' Association
Kathryn Oliver	RCGP Leicester Faculty
Rob Hogan (President)	College of Optometrists
Tim Ballard	RCGP member
Malcolm Ward	RCGP member
Duncan Keeley	RCGP member
Michael Taylor (Chairman)	Family Doctor Association
	Postgraduate Medical Education and Training Board (PMETB)
Alison Behn	RCGP Essex Faculty
Andy Adams (President)	Royal College of Radiologists
	British Medical Association (BMA)
Iain Gilchrist	Primary Care Rheumatology Society
Oliver Heald MP	Conservative Party
Amanda Howe	Society for Academic Primary Care
Arul Sabaratnam	Royal College of Obstetricians and Gynaecologists
Jean-Pierre Jacquet	College National des Generalistes Enseignants
Robert Morley	RCGP member
David Coggon (President)	Faculty of Occupational Medicine
Paul Weddell	P3
Gordon Conochie	The Princess Royal Trust for Carers
Andrew Dowson	Migraine in Primary Care Health Advisors
Trevor Gomersall	Grosvenor Medical Centre Patient Panel
Patrick Bower	RCGP member
Derek Chase	Central London Healthcare
Helena McKeown	RCGP member
Orest Mulka	RCGP member
Jas Bilkhu	East Midlands Healthcare Workforce Deanery
Andrew Spooner	RCGP member
Mayur Lakhani	RCGP member
Alasdair Dutton	RCGP member
Neil Munro	RCGP member
Andrew Lee	Section of Public Health, School of Health and Related Research, University of Sheffield / Rotherham Primary Care Trust
Peter Campion	RCGP member
Linda Harris	RCGP member

Nigel Sparrow	RCGP member
David Polkinghorn	RCGP member
Jill Edwards	RCGP member
	Royal College of Surgeons, England
	NHS South East Coast
Leonard Jacob	RCGP member
Dr Kathryn Gully, Senior Medical Officer	Welsh Assembly
Ralph Curr	RCGP Tamar Faculty
David Ennis	Royal College of Paediatrics and Child Health
Claire Taylor	RCGP GP Trainee Representative
	RCGP Vale of Trent Faculty
Beth Taylor	Royal Pharmaceutical Society
Chris Evennett	NHS South Central
Dr Rodney Burnham	Royal College of Physicians
Christine Johnson	RCGP member
	RCGP Scotland
	RCGP Beds & Herts Faculty
	The College of Family Physicians of Canada