

Primary Care Federations

Putting patients first

A plan for primary care in the 21st century from the
Royal College of General Practitioners



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Foreword

The primary care service, largely delivered by general practitioners (GPs) and their staff, is an enduring success of the NHS. It delivers nine out of ten patient contacts and provides accessible, high quality, personal care in familiar, local surroundings. Family doctors are highly trusted and achieve very high satisfaction ratings. Yet no public service can stand still and there is always room for improvement.

The NHS has improved dramatically over the last few years. Increased levels of funding have led to improved patient outcomes and reduced waiting times but as the Secretary of State for Health, Alan Johnson, said when launching Lord Darzi's recent review of the NHS, we also know that despite these improvements we've spent a lot of time talking about the means of change - payment by results, practice based commissioning, patient choice - and have sometimes forgotten the ends - the things that really matter to staff and patients like safer, high quality care.

In the first part of his review Lord Darzi recommended the establishment of a network of large health centres across London to provide up to 50% of outpatient treatment currently carried out in hospitals. Such centres - sometimes referred to as polyclinics - have become the leitmotif of Lord Darzi's review.

These new centres have been vigorously opposed by the British Medical Association (BMA). While the government insists the health centres represent new

and additional capacity the BMA claims they threaten the very existence of some local GP surgeries.

The Royal College of General Practitioners is concerned that in this battle of words between the government and the BMA the patient is being forgotten. We must not lose sight of our primary objective which is to ensure the very best possible care for all NHS patients. In this context, and in this paper, we seek to refocus the debate. Instead of arguing the pros and cons of buildings and real estate we should be concentrating on the day-to-day needs of patients.

We believe there is a place for large health centres - as described by Professor Darzi - but we do not believe they are the only route towards high-quality, integrated health services in every community. There will be towns, cities and rural areas up and down Britain where an alternative approach - one that builds on the current strengths of the GP-led primary care service - may offer an equally effective or better route towards improved patient care.

This paper sets out an approach to the development of primary care that will ensure its strengths are augmented, its services extended and it is fit to meet the new challenges ahead. It involves the development of GP-led Primary Care Federations. Our proposal is quite simply... health centres where appropriate, Primary Care Federations where possible.

A handwritten signature in black ink, appearing to read 'Stephen Field', with a horizontal line underneath.

Professor Stephen Field FRCGP
Chairman, Royal College of General Practitioners

Executive summary

In the NHS of the early 21st century it is increasingly clear that GPs, their staff and other primary care professionals all need to work together in ever closer alliances and networks.

A Primary Care Federation is an association of general practices and community primary care teams that come together to share responsibility for developing high quality, patient focussed services for their local community.

There could and should be a range of Federation structures from a relatively loose alliance to a highly managed model. Federations would be based on a collective legal entity such as a social enterprise, limited company or charity.

Federations would help ensure the continued viability of primary care – and the important personal link between the patient and the GP – in a period when small or single handed practices, operating in isolation, are finding it increasingly difficult to maintain the necessary levels of safety and clinical governance.

Primary Care Federations would also offer economies of scale that could lead to valuable efficiency gains that could be ploughed back into more services.

Federations would have high calibre management and could develop the collective delivery of certain “back office” functions such as finance and human resources.

With more GPs involved Federations would have the critical mass to ensure that different GPs could concentrate on different priorities. They would be able to develop more effective services for promoting health and preventing ill-health.

Federations would improve the range of primary care services by moving services from hospital settings and developing as many services as possible within the community including enhanced diagnostic services.

Primary Care Federations would offer advantages to GPs and their staff not least of which is the freedom to deliver a more professional and comprehensive service. But the greatest advantages are those that improve services for patients. These would include:

- Better access to GP services with opening hours that reflect the needs of the local community
- Different ways of accessing services with booked appointments and unscheduled, “walk in” clinics
- Services in reassuring GP settings rather than in hospitals or hi-tech health centres
- Strong patient involvement with patient representation on Federation boards
- Tailored services specifically designed to address very local needs
- A greater emphasis upon health promotion
- Continuity of care with patients able to choose between their own GP or another in the Federation

In coming together as Federations, GP practices would be expected to explain clearly how they proposed to work together and what values they shared. Typically a new Federation would need:

- A formal legal structure
- A management board (including patient representatives)
- An executive management team
- A written public constitution
- A public communication strategy
- A public engagement strategy

Primary Care Federations would be likely to publish an annual report and prospectus of services and would be likely to need a comprehensive website.



The developing world of primary care

Primary care has advanced hugely over the last 50 years. Many people regard the UK's primary care system as the best in the world but there is no room for complacency and we should always be striving for continuous improvement. Primary care incorporates the important values of personal care, continuity of care, generalism, a holistic approach to patients and an integration of care at an individual level. Prevention of ill health is an equal priority to the treatment of sick patients.

The case load in primary care is increasing in size and complexity. As the population of Britain gets older, the number of people with major diseases, such as heart disease, dementia and diabetes, increases. The number of people with multiple, long-term diseases is also increasing. The rising incidence of obesity and the desire among people to have more control over their own care will increase demand for primary care services too. The promotion of healthy living and the prevention of ill health are important agendas that will require major inputs from primary care. This ever greater complexity of care is occurring in the context of widening health inequalities. The rich have always, on average, enjoyed better health than the poor, but the gap is increasing.

We cannot be complacent concerning the quality of care that all patients receive. While standards are at historical highs, there remain some unacceptable variations in the access and quality of care; there are still too many patients put at risk through inappropriate prescriptions, delayed diagnosis or failure to follow accepted best clinical practice. Clinical governance, revalidation and provider accreditation are mechanisms to address these issues, but more will need to be done.

A key historical strength of primary care has been the long term relationship and continuity of care between a patient and their GP. The recent new GP contract involving out of hours cover has greatly enhanced family friendly working conditions but has made good personal continuity of care more challenging.

Across all public services users are expressing higher expectations. For primary care this means that infrequently attending patients, for example the relatively fit people in work, are asking for better access at times convenient to them. There has been great investment in GP premises over recent decades, but there are still surgeries, particularly in cities, located in inadequate buildings.

Some general practices have too many registered patients for the numbers of doctors and nurses available

while others have not realised the potential for multi-disciplinary team working. Although smaller and single-handed practices are often popular with their patients, their ability to expand the range of services on offer may be less than that of larger practices.

And there are long established barriers between primary care and other sectors, especially hospitals and social services. A person with cancer, for example, should expect and receive coherent care from a variety of generalists and specialists working together to deliver best outcomes. This is seldom the reality experienced by patients in Britain.

There is a strong case for the transfer of many services (including the appropriate personnel and equipment) from hospitals into primary care settings. As technologies, such as MRI scanning, mature they are suitable for location nearer to the people who need them. Many clinical services, such as dermatology, mental health and diabetes care, do not need to be predominantly hospital based.

The Royal College of General Practitioners Road Map published in September 2007 – before Lord Darzi's review was announced – introduced the concept of Primary Care Federations providing NHS services. Federations of GP practices would share resources, expertise and services. This model would favour the continuation of the GP as an independent contractor. Though practices would retain their independence, they would also be part of a larger corporate entity.

Despite many gloomy protestations, general practice remains a desired career option for young doctors, providing a satisfying career combined with a good quality of life and a large degree of personal autonomy. Amongst the public, general practitioners still command the most respect of all the professions.

GPs are good at adapting to change and seizing opportunities for improvement. It is time for the profession and the government to embrace a new way of working. The traditional small business model of general practice is unsustainable in the long term but in seeking to replace it we must not throw out the baby with the bath water.

We must maintain small, community based teams that deliver care across the health, social and psychological domains but such teams need to work in mutually supportive networks. The Primary Care Federation would provide a good framework for such networks.

Primary Care Federations - the key features

In the NHS of the early 21st century it is increasingly clear that GPs, their staff and other primary care professionals all need to work together in ever closer alliances and networks.

A Primary Care Federation is an association of general practices and community primary care teams that come together to share responsibility for developing high quality, patient focussed services for their local community. A Federation would develop and improve primary care services, and could commission high quality specialist care.

We believe there could and should be a range of Federation structures from a relatively loose alliance to a highly managed model. Federations would be based on a collective legal entity such as a social enterprise or limited company. An organic approach to development is desirable.

Federations would have an important role in ensuring a well trained primary care workforce. The size and strength of Federations would be sufficient to ensure they could take effective leadership of the education and training of all staff and could support appropriate clinical research. Education, training and personal development would be the remit of a single accountable director of the Federation. Federations could also facilitate the development of different types of learning networks including clinical networks to share best practice and a network for continuous professional development.

Federations would help ensure the continued viability of primary care – and the important personal link between the patient and the GP – in a period when small or single handed practices, operating in isolation, are finding it increasingly difficult to maintain the necessary levels of safety and clinical governance.

Primary Care Federations would also offer economies of scale that could lead to valuable efficiency gains that could be ploughed back into more services. And one of the key incentives for GPs to develop Federations is that they would be well placed to bid for PCT contracts as key primary care providers.

The benefits arising from the development of Federations are many and various. They would enable GPs to preserve traditional primary care values, they would also enable GPs to maintain a high degree of autonomy and they would enable GPs with special interests to develop their skills and share them across the Federation. Overall more can be achieved by GP practices working together than by individual practices working in isolation.

Perhaps, however, the greatest single benefit of Primary Care Federations is that existing buildings would be used more effectively. Instead of developing large new health centres Federations would involve the creative use of existing buildings wherever such buildings were well adapted for the delivery of primary care services.



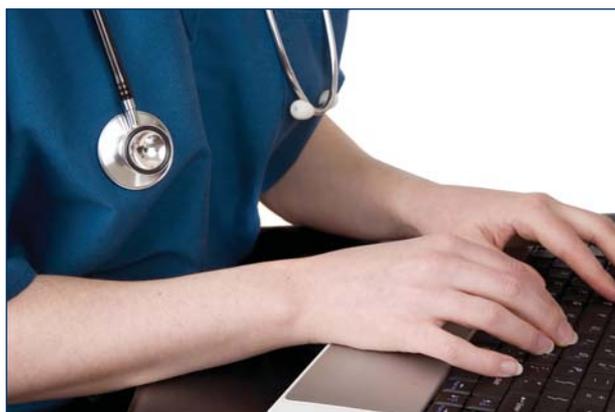
Federations would have a number of key features:

- They would have high calibre management and could develop the collective delivery of certain “back office” functions such as finance and human resources.
- Federations would be funded and held to account by the NHS to achieve key improvements for patient care and safety.
- There would be a marked rise in the number of internal referrals between clinicians within the Federation as it began to use the diverse skills and interests of members more effectively. Federations may even choose to employ specialists such as dermatologists or specialist diabetes nurses.
- With more GPs involved Federations would have the critical mass to ensure that different GPs could concentrate on different priorities. They would be able to develop more effective services for promoting health and preventing ill-health. The focus would be on helping people to stay healthy. This would include developing more proactive strategies to identify local people at risk of illness and offering them support to address such risks.
- Federations would improve the range of primary care services by moving services from hospital settings and developing as many services as possible within the community including enhanced diagnostic services.
- Federations would offer the potential for innovation and the sharing of best practice and would establish much stronger links with other services such as pharmacies, optical services, dentistry, community nurses, health visitors, mental health services and social services. They would also support the diffusion of new technologies such as telemedicine.
- Federations would improve the quality of patient care and patient safety by ensuring good governance across the organisation. This governance function would include support for effective annual appraisals and revalidation for medical members and other staff.

- A new focus would be strategic leadership and management in primary care with directors from key stakeholders on the Federation’s board working with strong representation from local patients and public to ensure the continuous improvement of future services.
- Federations would be able to redesign certain health services so they could be delivered closer to the patient. Many of these services would be delivered in GP practices or local community hospitals.
- Federations would be able to monitor the cost effectiveness of services provided with the view to releasing savings that could be invested in additional patient services.

Federations would also be well placed to play a full part in the commissioning process. Practice-based commissioning is a policy intended to give more decision-making power over NHS resources to general practitioners and allow them to design and deliver completely new services. It has a number of underlying policy objectives including delivering more cost effective and convenient forms of treatment outside hospital. Practice-based commissioning is a key strand of recent NHS reform policy in England alongside payment by results and patient choice.

Primary Care Federations would be in a strong position to play a major role as practice-based commissioners.



Case study - Epsom Downs Integrated Care Services

Epsom Downs Integrated Care Services (EDICS) is a collaborative venture involving a federation of 20 GP practices in Surrey. It assists GPs and patients to navigate their way through the complex and growing maze of alternative service options and increases the local health care choices available to patients.

EDICS deals with more than 17,000 patient referrals a year. Until four years ago every referral involved a trip to hospital for the patient. Today well over half of these out-patient consultations take place in the communities where patients live. This results in greater convenience for the patient and enables local hospitals to concentrate on the more complex and severe cases which require their more high-tech approach.

Instead of operating from a large central clinic, EDICS makes use of any local facilities that are available and suitable. Over the last three years, the EDICS team has established nearly 30 new community clinics. These are run in existing surgeries or community centres by specialist consultants, GPs with special interests (GPwSIs), or other specialist practitioners.

All EDICS systems are compatible with Choose and Book, the Patient Choice programme, and 18-week booking methodology.

EDICS was established as a specialist personal medical services (SPMS) company under NHS rules. EDICS has also worked to establish two similar organisations in the local area and supported the start-up of a third in Southend.

EDICS medical director, Dr Anne Hollings said “What we have done may seem simple and obvious, but it has taken a great deal of commitment from all those involved. We have enabled consultants, GPs, nurses and surgery staff to draw on the skills from all their colleagues in the local area. Patients now have more choice and can be seen in an environment where they feel most comfortable. We aim to increase efficiency and reduce waste in the system to maximise the use of the skills and facilities available in our area.”

When EDICS first started operating as a new venture not everyone understood why it was necessary or how it worked but as Anne Hollings explains “Our practices stuck together through thick and thin because we all became convinced this was the right way to organise services.”

Primary Care Federations - benefits to patients

Primary Care Federations certainly offer advantages to GPs and their staff not least of which is the freedom to deliver a more professional and comprehensive service. But the greatest advantages are those that improve services for patients.

Many of these benefits accrue from the fact that Primary Care Federations are about collaboration and co-operation rather than about competition. They are about GPs and their staff working together and as we approach the 60th anniversary of the NHS there could be no greater tribute to values and ethos of public health care than the creation of Primary Care Federations around the country.

The key benefits to patients include:

- **Better access to GP services.** Primary Care Federations would offer longer opening hours (including weekends and evenings) in a pattern that reflected the needs of the local community. This might include early morning or evening opening at some surgeries and weekend opening at others.
- **Different ways of accessing services.** This would include the ability to attend scheduled, booked appointments and unscheduled, “walk in” clinics.
- **Services closer to home.** Patients would be able to see their own GP at the nearby surgery but they would also be able to see other GPs in the Federation who may have special skills or interests in their particular condition.
- **Services in reassuring settings.** It is clear that many patients do not like the idea of being treated in hospitals or hi-tech health centres unless it is really necessary and often it is not. Primary Care Federations would offer care and treatment in familiar and reassuring GP surgeries and community hospitals.
- **Involving patients.** Primary Care Federations would involve patients, their families and their carers in designing and developing the provision of services and care. There would be patient directors on the Federation’s board and the evidence suggests that patient input leads to an improved patient experience.
- **Tailored services.** Primary Care Federations would be able to tailor local services for their local communities. An ageing population would mean more services for older people, more women of child bearing age would mean more maternity services.
- **A wider range of services.** Primary Care Federations would create economies of scale. Because they would have access to a larger number of doctors, nurses and other health care professionals all working together Primary Care Federations would be able to focus detailed attention on key areas in a manner that small GP practices cannot currently do. This would lead to things like specialist dermatology clinics, a major focus on health inequalities and more services dealing with long term conditions.
- **Health promotion.** Primary Care Federations would also be able to put greater emphasis upon the promotion of healthy lifestyles and run lifestyle clinics to help address things like obesity, alcohol misuse, smoking and so on.
- **Improved choice.** Primary Care Federations would offer patients improved choice. Where a clinician or primary care team develops specific skills or services – perhaps, for example, as a GP with Special Interest – those skills would be made available to patients and the public across the Federation. Patients would be able to see their own GP first but then be referred to another GP for more specific advice.
- **Children’s services.** Primary Care Federations would be able to develop much more sophisticated networks of care for children bringing health care together with social care, schools, local authorities, housing departments and the school nursing service.
- **Continuity of care.** This would be one of the Federation’s greatest strengths. While enabling greater professionalism and skills development through training, education, continuous professional development and the sharing of best practice, Federations would also enable patients to maintain the strongest possible link with their personal GP.

Case study – The Croydon Federation

In Croydon, south London, a group of 16 GP practices have combined to form the Croydon Federation. It serves a population of 140,000 and involves some 85 GPs and their staff. It was launched in November 2007 and is currently governed by a simple legal accountability agreement though the 16 practices are considering a range of longer term structural alternatives.

Dr Agnelo Fernandes, a Croydon GP and the chair of the Croydon Federation, says: “The Royal College of General Practitioners’ Road Map document was the real driver behind our decision to form the Croydon Federation. Our number one priority was to bring diagnostics into the community. “Too many people were waiting to go to hospital for simple diagnostic tests which could be done in local GP surgeries, and we had no direct access to MRI or echocardiograms. We designated six of our 16 practices as diagnostic sites and today most local ultrasound and every echo cardiogram takes place in one of these practices. And perhaps the most remarkable thing is that this was achieved in just three months between November 2007 and February 2008. We could never have done this unless we had the necessary critical mass of so many practices all working together.”

In addition all GPs in the Federation now have access to a new leg ulcer clinic which went live in April 2008. It is based in two of the 16 practices and is a real response to local needs.

The Federation has a management group involving every member practice along with local patients and staff are finding that beneficial change can happen a lot more quickly than it used to. “There are challenges, of course,” says Dr Fernandes, “but now we can really be fleet of foot and that is very important.”

The Federation is already taking education and training very seriously and has become a learning set for the London Deanery.

Primary Care Federations - governance and structure

Practices, specialists and community teams that join together to form a Primary Care Federation will need a formal or legal structure in which to work. A number of options are available and Federations should be free to select the model that best matches their local needs. Form should follow function.

Structural options include:

- Formal commissioning consortia
- Social enterprise companies
- Charities
- Companies limited by guarantee
- Companies limited by shares
- Specialist personal medical services (SPMS) companies

Any of these models could meet the definition of a Primary Care Federation.

In coming together as Federations, GP practices would be expected to explain clearly how they proposed to work together and what values they shared. As Federations will consist of practices and professionals that are rooted in local communities, this exercise will provide a great opportunity to actively canvas patient views on how Federations should operate and how they would be governed. Other stakeholders, such as local authorities, NHS Trusts and local voluntary organisations should also have a strong voice.

According to the European Commission governance is the body of rules, processes and behaviours that affect the way in which powers are exercised particularly as regards openness, participation, accountability, effectiveness and coherence.

In designing the governance of Federations, healthcare providers and local people can work together to develop models that are fair, fit for purpose and transparent. Ways of incorporating patients' input must be explicitly stated, if Federations are to be truly rooted in local communities.

Ideally, governance arrangements will be light touch, with low levels of bureaucracy, yet robust, so that practices who value their place within a Federation will abide by the agreements made in setting up the Federation. Federations will also need to be accountable to funding and commissioning bodies, such as PCTs, and to the independent health regulator, the Care Quality Commission.

Governance frameworks are widely available and specific arrangements will also need to relate to the form of legal entity that the Federation chooses to adopt. The differing nature of Federations, ranging from fairly loose arrangements for joint provision of some services, through to tightly managed organisations running large commissioning budgets and with shared back office functions, will result in a variety of governance models.

Typically a new Federation would need:

- A formal legal structure
- A management board (including representatives of patients, public and other key stakeholders)
- An executive management team
- A written public constitution detailing the Federation's membership, responsibilities, management arrangements, decision making processes, vision and values
- A public communication strategy that explains how the Federation will communicate effectively with its publics
- A public engagement strategy that details how the Federation will engage with and listen to its key publics



Primary Care Federations would be likely to publish an annual report and prospectus of services and would be likely to need a comprehensive website. They could also add real value to their local health communities by sharing “back office” functions such as finance, accountancy, human resources, payroll and so on.

Patients and communities should expect very high standards of safety and quality. In coming together to form a new Federation, practices and professionals should relish the challenge of building in safety and quality from the outset and seize the opportunities provided by learning from each other and from patients.

In agreeing how to work together, Federations could look to the framework set out by the National Patient Safety Agency, ‘Seven Steps to Patient Safety in Primary Care’. By their nature, Federations will be looking at new and innovative ways to provide care and will be creating new ways of working, including the provision of specialist services and diagnostic facilities outside of traditional hospital settings. Great care must be taken to establish and run these services so as to maximise quality of care and health outcomes.

Incorporating the principles set out in ‘Seven Steps’ will allow Federations to develop their services and working practices to build a local health community that will be as good and safe as design and forethought will allow. The seven steps include a commitment to building a safety culture, leading and supporting staff, involving patients and the public and sharing safety lessons.

The ‘Seven Steps’ framework, together with other mechanisms such as RCGP Provider Accreditation can provide Federations with a structured approach to building safety and quality into their fabric from the outset. Together with good clinical and corporate governance, and effective financial controls, these

systems can allow Federations to satisfy the aspirations of patients, the public and local and national government for safe, high-quality and cost-effective care. This approach builds on the strengths of traditional general practice as a local service, rooted in communities, yet allows a more co-operative system that can commission and host a wider range and choice of services providing integrated care closer to home for patients.

Size will be dependent on local circumstances. If the Federation is small (fewer than 10,000 patients) it may be easier to run but may not have enough influence within the local health economy. If, however, the Federation is large (more than 200,000 patients) it may be difficult to manage and require a more complex infrastructure.

The constituent members of any Federation would be GP practices but the management should include multi-professional representation including nurses, pharmacists, social workers or other health professionals. This would ensure that experience is broad enough to change services effectively.



Case study – Lincolnshire GPs

GPs in rural Lincolnshire have formed a cluster of 14 practices and with the support and help of Lincolnshire Primary Care Trust, local clinical teams in primary and secondary care and local communities they have developed a plan to ensure the sustainability of their local hospital.

Their model includes primary care led acute medical beds with clear admission guidelines and consultant support and training, a GP led Accident and Emergency Centre, a Primary Care Access centre and additional diagnostics. The aim is to deliver integrated care as close to patients' homes as possible.

The GPs decided to develop a collaborative venture to help address common problems including an inadequate out-of-hours service, poor access to diagnostics and a threat to the local hospital. The out-of-hours service is now delivered by local GPs.

The Lincolnshire GPs initiated echocardiograms in local surgeries, proved they could be trusted with open access MRI scanning for back pain and now have access to all diagnostic CT and MRI scans with routine waiting times down from nine months to two weeks.

They set up a limited provider company for the 14 Practices which is run by a management board and in September they plan to launch a multi-disciplinary musculoskeletal service and integrated training for local GPs.

Conclusion

General practice has made huge strides since the NHS was created sixty years ago. The next phase of development must be about practices working together to cover larger populations and to work in partnership with other organisations to provide truly integrated health, community and social care services.

As health care becomes ever more complex and sophisticated general practice faces some big challenges.

- How do we integrate, really effectively, all the services that impact upon the health and wellbeing of patients?
- How do we link with partner agencies such as local authorities and the voluntary sector to reduce health inequalities?
- How does primary care engage with the emerging agenda of “social marketing” to bring about the necessary lifestyle changes without which real health improvements will be impossible?

Addressing these challenges will require GPs to work together in larger organisations supporting larger populations. But addressing the care needs of a large population in a wider geographical area is more challenging than addressing the needs of a smaller practice population. It is, nonetheless, a necessary next step and it represents an opportunity for GPs to improve and expand the range of services they offer to patients. The Primary Care Federation would be an ideal model for the delivery of this improvement and expansion.

