

TOOLKIT TO SUPPORT THE DEVELOPMENT OF PRIMARY CARE FEDERATIONS

Authors

Candace Imison, The Kings Fund

Sally Williams, for The King's Fund

Judith Smith, The Nuffield Trust

Christian Dingwall, Hempsons Solicitors

The Kings Fund >

**Ideas that change
health care**

HEMPSONS



The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

FOREWORD

WHAT IS A FEDERATION?

THE TOOLKIT OVERVIEW

1. [COMING TOGETHER – WHERE DO WE BEGIN?](#)
2. [DECIDING ON A FEDERATION’S LEGAL STRUCTURE](#)
3. [GOVERNANCE](#)
4. [INVOLVING PATIENTS AND THE PUBLIC](#)
5. [ENGAGING THE WIDER PRIMARY CARE WORKFORCE](#)
6. [IMPROVING QUALITY AND SAFETY](#)
7. [TRAINING & EDUCATION](#)
8. [DEVELOPING & REDESIGNING SERVICES](#)
9. [TACKLING PUBLIC HEALTH ISSUES](#)
10. [SHARING BACK OFFICE FUNCTIONS](#)
11. [WORKING WITH AN EXTERNAL PARTNER](#)

General practice, and our work as GPs, is always evolving and improving for the benefit of patients. The RCGP is proud to lead and inspire much of this development both in the UK and globally. Recently, we set out our vision for the future of general practice in our Roadmap, where we described our concept of Federations - groups of practices collaborating to provide a greater range of services. Potentially these could be run more efficiently to harness the skills, equipment and premises of general practice.

*In the years since we published the Roadmap, we have been delighted to see the way in which GPs and practices have embraced the idea of Federations and the range of federated models that have emerged. Many practices are already working in Federations and many more are actively considering coming together in this way. In the meantime, the Government has published its white paper, *Equity and Excellence: Liberating the NHS* and has set out its plans for General Practice Commissioning Consortia.*

We believe that Federations, as providers of services, can work well alongside Consortia, and that there are considerable opportunities for Federations to maximise benefits for patients.

This Toolkit provides a useful compendium of practical advice for existing and fledgling Federations. It draws upon the experience of Federations so far, and we commend it to you as an essential resource in taking general practice forward to the next level.

Professor Steve Field CBE FRCP FRCGP
Chairman of Council, Royal College of General Practitioners

WHAT IS A FEDERATION?

A Federation is a group of practices and primary care teams working together, sharing responsibility for developing and delivering high quality, patient focussed services for their local communities. The Toolkit outlines 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 healthcare teams are already making federations work in practice.

THE TOOLKIT

Overview

Background

The concept of a primary care Federation was first set by the Royal College of General Practitioners in September 2007. Its publication, *The RCGP Roadmap*, focused on a model where practices would work together more closely to share resources, expertise and services. A Federation, whilst not typically part of the day-to-day language of NHS general practice and primary care, has however gradually come further to the fore, usually in relation to practices grouping together for either commissioning or service provision activity. Indeed, prior to recent policy announcements, it had been mooted that Federations might be both providers and commissioners, taking advantage of the GP's position as a provider, co-ordinator and commissioner (via referrals) of care (e.g. The Nuffield Trust and NHS Alliance, 2009).

The reasons why practices might choose to federate, aside from forming a commissioning organisation, have been revealed in a national survey of members of the RCGP carried out in May 2010 as part of the development of this toolkit. These reasons include:

- Strengthening the capacity of practices to develop new services out of hospital
- To form an entity that can tender for services offered by a future GP commissioning consortium
- To make efficiency savings/economies of scale, for example in back office functions or the procurement of practice services
- To improve local service integration across practices and other providers
- To enhance the capacity of practices to compete with external private sector companies
- To strengthen clinical governance and improve the quality and safety of services
- To develop training and education capacity

This toolkit aims to help practices fulfil each of these ambitions by describing how federating can help, providing examples from existing Federations, and links to resources that can provide practical advice and support.

The NHS White Paper

Following the election of a new Coalition Government in May 2010 and the subsequent publication of an NHS White Paper *Equity and Excellence: liberating the NHS* in July, it has become clear that primary care groupings will fall into two broad categories – statutory commissioning consortia that will become the main purchaser of care for a local population, and provider groups or organisations that will deliver an extended range of community-based health services, under contract to GP commissioning consortia or other commissioners such as local authorities and the proposed NHS Commissioning Board.

This toolkit

This toolkit focuses on providing advice and support to those practitioners and managers in primary care who are thinking about, or have embarked upon, **developing a Federation for the purposes of providing services in a collaborative manner**. This approach is taken for pragmatic reasons, given that the form and function of proposed new GP commissioning consortia are still in development.

It should be noted, however, that this toolkit draws heavily on the experience of existing practice-based commissioning consortia and on the extensive research evidence about different forms of primary care-led commissioning. This is in order that the toolkit can benefit from some of the most relevant evidence on the workings of primary care organisations, and because a reading of research from both provider and commissioner bodies reveals very consistent messages about issues such as clinical engagement, management support infrastructure, governance, and ownership.

The toolkit seeks to draw on the practical experience of existing primary care organisations or Federations, to inform local clinicians and managers seeking to establish a Federation in their own area. Where appropriate, research evidence is also used to inform the advice given, and there is a strong focus on signposting practical resources developed by a wide range of management, academic, national and international experts.

What the toolkit is not

This guidance does not explicitly address the establishment of statutory GP-led commissioning consortia although this has been a core ambition for many groups of practices. However, some of the guidance may be useful to the development of consortia and many of the examples we use are Federations that grew from practice based commissioning (PBC) consortia.

Nothing in this toolkit constitutes legal or other professional advice. It is made available on the basis that the Royal College of General Practitioners, the authors of the toolkit and their respective organisations do not accept any liability for any fact, error or opinion that it may contain. You should always obtain suitable legal or other professional advice before applying information in this toolkit to particular circumstances. The toolkit contains links to websites and to material contained in other resources and websites. The Royal College of General Practitioners, the authors of this toolkit and

their respective organisations are not responsible for the content of the resources and websites which you may be able to access from this toolkit.

LEARNING FROM RESEARCH EVIDENCE

For the purposes of this toolkit, a GP or primary care Federation is understood as:

an association of GP practices that come together (sometimes with community primary care teams) to share responsibility for a range of functions, which may include developing, providing, or commissioning services, training and education, back office functions, safety and clinical governance.

A Federation can clearly take a number of forms, and carry out various functions. For this toolkit, it is assumed that a Federation will exist for the purposes of developing shared provision of services across general practices and other primary and community health providers.

When assessing evidence of relevance to primary care Federations, the project team examined studies of: GP fundholding consortia; GP multifunds; locality and GP commissioning; total purchasing pilots; primary care groups; practice-based commissioning consortia; Personal Medical Services (PMS) organisations and practice groups; general practice networks formed for research, training or other purposes; organisations formed to bid for provider contracts (including out-of-hours services); and GP associations or membership organisations. Consideration was also given to studies of medical groups and primary care organisations in the international context, including independent practitioner associations in New Zealand and the USA, divisions of general practice in Australia, and equivalent groups in Canada.

Ten lessons from the research evidence

From an assessment of the evidence, ten key lessons have been distilled that are particularly pertinent to those embarking on the development of a primary care Federation.

- 1) **The motivations for practices to federate vary**, and include: a response to a perceived threat in the external environment; a desire to gain economies of scale in (often specialised) service delivery; to share risk in healthcare purchasing or commissioning; for training and education purposes; to organise out-of-hours care; to bid for primary care service contracts; and to undertake clinical governance activities.
- 2) **Function affects form** – the size and legal entity will depend on the purpose for which the primary care organisation has been developed. For example, for running out-of-hours or other urgent care services, a larger organisation with sophisticated risk-sharing arrangements is likely to make sense, whereas a joint provider of extended primary care services or a clinical governance group might be smaller and operate as a network.

Inevitable trade-offs will have to be made between the engagement of practitioners and other local stakeholders, and scale for management and risk.

- 3) **Independence from the statutory sector accords longevity.** A key question for practices thinking about a Federation is whether they want to join together in an entity that protects their independence, or as some form of state/health system network. International evidence suggests that the former will enable some immunity from health system reorganisation, and the ability to use the Federation for the purposes desired by the practitioners themselves (avoiding appropriation by others/the state).
- 4) **Involving doctors is relatively easy – it is harder to be more inclusive.** Most primary care organisations tend to be doctor-initiated / led, and even where they seek to be more inclusive they rarely seem to involve nurses, allied health professionals and others in a significant or strategic manner. There is some risk of compromising medical engagement if groups become more inclusive. The involvement of patients and the public in primary care organisations has proved challenging in many cases, and as with health professionals other than doctors, significant or strategic influence by patients and the public is rare.
- 5) **Primary care organisations are good at planning and developing services within primary care and community settings** – those services that are closest to the concerns of GPs and practice staff. Practice-based services, prescribing, and intermediate care are most commonly reported as objectives. Primary care organisations are also effective in enabling shared clinical governance, peer review, and audit. There is much less evidence about groups' effectiveness in relation to commissioning secondary and specialised services.
- 6) **Primary care organisations are more likely to make substantive change where they have direct control of budgets** and where there are direct financial incentives for professionals. An ability to develop alternatives to hospital admission, shape innovative forms of care, and improve local primary care is a key motivator for those leading such organisations. Avoidance of externally imposed structural reorganisation is also a key factor in enabling primary care organisations to get on and make desired service changes.
- 7) **Clinical leadership and engagement are essential** to the development and success of primary care organisations, and require constant nurturing and attention. A sense of ownership of the organisation is critical for clinicians. Where this is compromised, groups typically flounder or fold. Organisational development support will be required, especially as groups become larger and/or take on a greater range of responsibilities.
- 8) **High quality management and infrastructure support is critical** to the success of primary care organisations, and its importance and scale are typically underestimated at the outset. It takes time to establish a fully functioning federated organisation, typically at least two years. Management and other infrastructure support needs to feel 'owned' by the clinicians

leading the primary care organisation. Senior general managerial leadership is critical alongside high calibre clinical leadership.

- 9) **Primary care organisations increase transaction costs within local health economies –** there is a cost to federating practices, providing management support, and engaging primary care professionals in activities beyond their practices. Such costs have to be weighed against anticipated and actual benefits, and also considered in relation to how far they add to, or replace, other management costs in the wider local health system.

10) Major service transformation will require highly organised primary care as a bedrock.

Whilst policy in many countries calls for shifts of care from hospital to community settings, along with improved care for people with chronic illness and reductions in avoidable hospital admissions, there is little evidence of such service shifts happening in a significant manner within the NHS. Research points to the need for highly organised (and appropriately incentivised) primary care as a prerequisite for this.

[Key research reports and resources](#)

HOW THE TOOLKIT WAS DEVELOPED

This toolkit has been developed by a joint team from The King's Fund, The Nuffield Trust and Hempsons solicitors. The team has worked under the guidance of a steering group from the Royal College of General Practitioners and an external reference group that included front line practitioners working within Federations as well as other senior staff from across the NHS.

The toolkit content has been informed by the following:

- An online survey of all members of the RCGP, carried out in May 2010. This sought views of on Federations and experience of working within them. The survey explored the factors that had contributed to the success and the obstacles faced in developing Federations. The survey also sought examples of good practice. [Click here for more details about the survey and the main findings.](#)
- A review of the international literature on GPs working in federated models to identify what factors enable or obstruct federated working, and what Federations do well and less well.
- Semi-structured interviews with those currently leading or working in a Federation to explore and illuminate the different opportunities offered by federated working and how best to achieve these.
- Expert legal advice from the lawyers within the project team.
- Desk research on relevant policy and managerial best practice.

1. COMING TOGETHER – WHERE DO WE BEGIN?

INTRODUCTION

In this section we describe some of the key building blocks in developing a Federation. We provide some [advice](#) on how to address each of these building blocks. In [resources](#) we provide links to a range of external guidance that will help those leading the process of change. There is some specific advice on [medical indemnity issues](#). We also include a [checklist](#) to help people assess whether they have the key elements in place for successful working as a Federation. Finally, we provide two [case studies](#) that explore some of the factors that contribute to the successful establishment a Federation.

Later sections provide more detailed guidance on the [organisational options](#) and [governance](#).

DEVELOPING A FEDERATION

Figure 1:

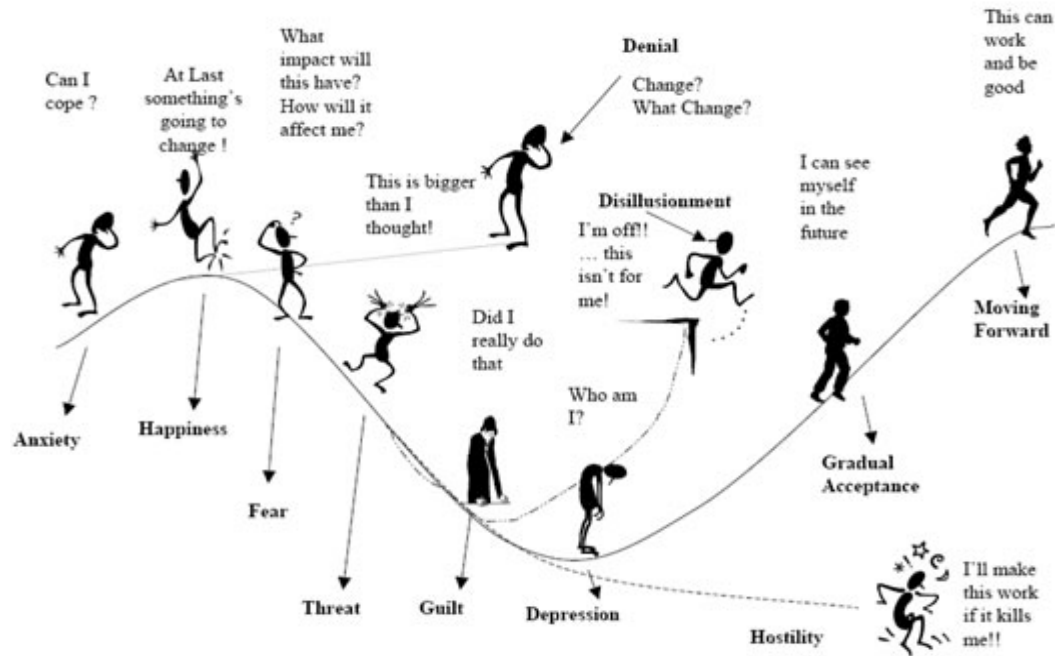


Practices may come together to form a Federation for a wide variety of reasons. In most instances it is likely that the original impetus may come from a relatively small number of practices or individuals. These individuals and practices then have the challenge of taking their partners and other practices with them as they develop the Federation.

Two thirds of those who responded to the [RCGP survey](#) said that the greatest help in establishing a Federation was being able to build on established working relationships. Building and strengthening the relationships between practices is a critical foundation for any prospective Federation. This requires effective communication through the whole process of change (see **Figure 2** below). As this

model of change reveals, the process of change can be difficult and may generate resistance and hostility in people who will ultimately come to accept and support the change.

Figure 2 - The process of transition



© 2000 / 3 JM Fisher. Free use for personal and organisational development, provided this notice is retained. Not to be sold or copied for general publication. A free resource from www.businessballs.com.

In [resources](#) we provide links to resources that will help in the process of managing change. The [toolkit](#) produced by Leicestershire, Northamptonshire and Rutland Strategic Health Authority provides useful guidance and describes some common ingredients to successfully managing change and communications during the process of change.

Successfully managing change

1. Communicate relentlessly

Perhaps the most important activity of all. Effective communication can motivate, overcome resistance, lay out the pros and cons of change, and help give people a stake in the process.

2. Enlist the support and involvement of key people

To ensure the momentum and buy-in to a change process, identify key stakeholders and ensure that they are involved and their contribution is valued. Use this team as agents of change.

3. Crafting a good plan

Where possible, create a simple plan of action through the change, which clearly defines roles and responsibilities. Get people involved in the plan, especially if they are directly affected by it. Make sure that the plan is built in small, achievable chunks.

4. Support the plan with consistent behaviours

Whatever the characteristics of the change are, it is important to be seen to be 'walking the talk'. People are only likely to adopt change if it is demonstrated by those leading the change.

5. Develop 'enabling structures'

Recognise what needs to happen to support the change. Training workshops, communication sessions and meetings will help people understand the reasons for the change, and buy-in to the process.

6. Celebrate milestones

When milestones are achieved, celebrate the fact that progress has been made.

Recognising progress will maintain motivation and stakeholder interest, and give confidence that the longer term vision is achievable. Identifying "quick wins" can be a valuable impetus to change.

Building a common purpose

A key binding force for people within an organisation is a shared mission and vision. As the [Washington GP Practices](#) case study shows, if this is missing it can be difficult to hold people together and make progress towards common goals. Developing the shared vision also takes time. As the case study reveals, people giving a commitment to join an organisation does not mean that they understand and share its vision. Having a specific project to work on can help clarify the vision.

Gaining external support

The [RCGP online survey](#) revealed that a critical factor for practices successfully getting together was support from the local PCT - both strategic and financial. The [Tower Hamlets](#) case study provides a good example of how a PCT can use their primary care resources to develop federated working and the benefits this delivers.

Over the next few years, until PCTs are abolished in March 2013, there is a window of opportunity for GPs to seek that support from their local PCT. Once GP consortia are established it may be more difficult to seek financial support given the potential conflicts in interest. GPs will then need to generate the resources for central support internally or through working an external private sector provider.

The section on [governance](#) discusses how practices can manage the relationship between providing and commissioning services if they are involved in both.

The experience of many Federations is that there is often a poor understanding of their ambitions by others, not only PCTs but healthcare providers such as acute trusts, and that this can be a major obstacle. Just as Federations need to invest time in communicating internally, they need to invest

time in external communications. It is also important to build trust with external stakeholders, transparency and openness can facilitate this.

Developing the organisation

The sections on [organisational form](#) and [governance](#) give detailed guidance on developing the organisational structure and processes. One piece of advice, from [Assura](#) that has helped establish a number of GP Federations, is not to make things too complex. For example, putting lots of stipulations in an organisational agreement can cause delays and extra expense.

Size of the organisation

An important dimension for any Federation to consider is its size. The larger the Federation the easier it will be to fund corporate running costs - the cost of running an organisation of 25 practices may not be substantially greater than one comprising 5 practices. However, as the number of practices grow then so does the communications and engagement challenge. Some areas have developed a locality structure within the wider Federation as a means of addressing this (see the [governance](#) section for more details). The [RCGP online survey](#) revealed a wide variation in the size of current Federations. Around 20% had five or fewer practices, and just over 15% had more than 20 practices.

Developing the people

The list of skills and competencies that a Federation may need to call upon can appear daunting. These skills echo those that have been identified in research into primary care organisations over the past 15 years.

- Leadership
- Financial - control and forecasting
- Project management
- Business case development
- Human Resources
- Contract management
- Communications and marketing
- Public engagement
- IT and data analysis
- Clinical governance

The reality is that many Federations have been set up with no additional or specialist staff, only the goodwill and commitment of existing practice partners and staff. However, most find that this is not sustainable and that additional staff with specialist skills are needed, and the clinical leaders of the Federation need dedicated paid-for sessions for their management input. Project management and business case skills are particularly valuable, and may not be present among current practice staff. Leadership development will also be important. The [resources](#) section provides links to a number of relevant materials and guidance.

Other issues to consider

There are a number of other practical and legal issues to consider when developing a Federation. The following section on [organisational structures](#) provides further guidance on the interdependence between legal form and some of these issues, for example pension rights.

Organisations taking on staff may need to consider the implications of TUPE.

TUPE -Transfer of Undertakings (Protection of Employment) Regulations 2006

Employees may transfer to a Federation under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) from a current service provider. If TUPE applies, then staff that transfer to the Federation will retain most of their pre-transfer terms and conditions of employment, including collective agreements and existing working practices that fall short of contract terms.

One important exception to TUPE is that it does not extend to receipt of exactly the same pension rights, but under current Government policy the existing workforce should be offered broadly comparable pension terms. It may therefore be advantageous if the Federation's legal structure and service contracts enable its workforce to have membership of the NHS pension scheme.

Further information is available from:

<http://www.legislation.gov.uk/uksi/2006/246/contents/made>

Clinical indemnity. The Federation will need to ensure that it has its own full insurance cover for clinical negligence liabilities in addition to insurance for employer and public liability.

[Click here for link to MDU paper on clinical indemnity](#)

WASHINGTON GP PRACTICES, Tyne and Wear

This case study reveals the importance for a Federation of creating a shared mission and vision.

Key characteristics

- Second attempt by GPs within the new town of Washington, to create a successful Federation – GPs learnt important lessons about developing a shared vision and mission from their first attempt at federated working.
- Loose association of practices, although preparing to adopt a more formal federated structure.
- Covers population of around 66,000; relatively isolated community close to Gateshead and Sunderland.

Learning – where to begin

- SunWest Social Enterprise, a community interest company (CIC), was set up in 2008 to ensure that its ten member practices were ready to bid for a practice as a result of Lord Darzi's review of the NHS. Divisions emerged when a for-profit organisation, involving two of the practices, sought to bid in competition with the not-for-profit CIC. This undermined the spirit of collaborative working and the Federation was abandoned.
- Dr Ashley Liston was a member of SunWest Social Enterprise and is now closely involved in the association of Washington GP Practices that has replaced it. He says: 'The £1 joining fee for the CIC was a poor measure of commitment for developing a business'. Member practices had attended practice based commissioning (PBC) meetings, but collaborative working was not sufficiently established and members were unprepared for the level of commitment the CIC required. 'When the challenge came we weren't up to the test', says Dr Liston.
- It underlined the importance of developing a shared vision amongst member practices. 'It is easy to develop a CIC. What really matters is developing the culture of collaborative working', says Dr Liston.
- Dr Liston and colleagues have focused on getting practices to come together and share ideas and skills, from collaborating around the annual winter flu campaign, to networking amongst practice managers. Education also has an important thread in developing collaborative working. With the help of PCT funding, a range of educational events have been developed for the patch. More details about Washington GP Practices' work around [education and training](#).
- The shared vision for the local Washington Practices is for a Federation that provides support in five key areas: education, practice business development, submitting bids for contracts (for example for enhanced services), preparing for Care Quality Commission registration, and quality assurance and clinical governance.

Key advice

‘A key dilemma is whether you run with it with energetic and committed individuals or do you wait for everyone to come on board’, says Dr Liston. ‘There is a critical mass of practices and people that you need, but I don’t think you need to have everyone on board.’ Washington GP Practices has been driven forward by a few committed individuals, and support is growing all the time.

Dr Liston adds: ‘Local knowledge is everything – you need to have a sense of who has to be on board for it to be viable’.

WHERE TO BEGIN – CASE STUDY 2

TOWER HAMLETS, East London

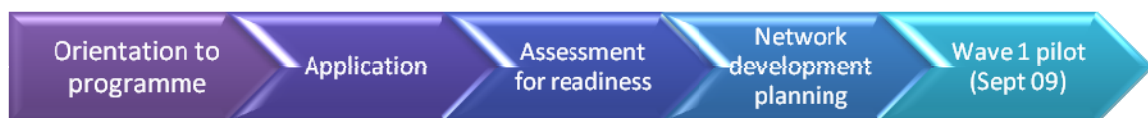
This case study provides a good example of how active support from a PCT can facilitate the establishment of a Federation.

Key characteristics

- The 36 Tower Hamlets practices have formed eight Federations (called ‘networks’) with the strategic and financial help of the PCT.
- Each network covers a population of between 23,000 and 38,000, in the 3rd most deprived borough in England.
- Loose associations of practices, which is beginning to form legal structures.

Learning – where to begin

- A vision for an integrated system built around federated networks of services was first developed by the PCT in Tower Hamlets in 2006. The key motivations for establishing networks included focusing on population health across a geography, encouraging collaborative working with a wide range of partners, and having sufficient scale for specialisation of staff.
- The network development process began in April 2009 and the first wave of networks was launched in September 2009.



- NHS Tower Hamlets provided each network with a management allowance of £150,000. This allowed each network to develop its own management infrastructure, including a senior manager and a co-ordinator, as well as cover to release GPs to provide senior clinical leadership.

- To help networks get started, the PCT provided a tailored organisational development programme. Networks identified a range of gaps:
 - Governance represented 35% of development needs
 - Culture and team work represented 20% of development needs
 - Leadership and management skills represented 12% of development needs
- On the basis of these identified gaps, networks put together Network Development Plans. The PCT formed Network Support Teams to support networks with organisational development. The Support Teams also served as communication links between the networks and the PCT, and helped to ensure the smooth running of the networks and address any problems.
- Once underway, the networks commissioned management consultants to help them work on four key areas: governance, culture and teamwork, leadership and management, and information technology.
- The PCT agreed with each network performance targets focused around the redesign of ten care packages. The first care package was developed for Type 2 diabetes.

Key advice

- Dr Tzortziou Brown, a GP in Tower Hamlets, says, 'It is natural that some practices may be more ready than others. Strong clinical leadership, agreeing common aims and a close working relationship with the PCT have been very important, especially in the initial stages of our Federations.'
- She adds that the networks have facilitated collaborative relationships not only among GPs and other clinicians, but also with a wide range of partner, including schools and charities.

WHERE TO BEGIN - CHECKLIST

We provide below a checklist for those seeking to or in the process of developing a Federation to help people assess whether they have the key elements in place for successful working as a Federation.

Getting together	We have identified the practices that will form part of the Federation	
	We have good working relationships between the practices that will form part of the Federation	
	We have a clear communications strategy to engage practices that will form part of the Federation	
	We have identified some early milestones and “quick wins” as early markers of success	
Leadership	The overall leader of the Federation is in place	
	The other key leaders, for example - governance lead or medical director are in place	
	We have identified a core group of leaders to act as “agents of change”	
Building a common purpose	We have a clear vision of what we want the Federation to achieve	
	All the constituent practices understand and share that vision	
Getting external support	We have identified all the key stakeholders that will be critical to our success	
	We have engaged with all the key stakeholders	
	All the key stakeholders understand our vision and support it	
Developing the organisation	We have agreed an organisational model for the Federation that enables the Federation to carry out all its objectives including providing services, employing staff and addressing conflicts of interest	
	We have a governance model that supports the active engagement of all practices and their staff	
	We have a governance model that supports the active engagement of patients and the public	
	We have a financial model that supports the corporate infrastructure we need	

Internal governance	There is a documented approach to internal governance	
	There are agreed decision making processes in place - for example regular board meetings	
	There is formal agreement in place laying out the basis of membership of the Federation with procedures for addressing non compliance.	
Conflicts of Interest	There is a documented approach to how conflicts of interest will be addressed	
Developing our staff	We have a good understanding of the current competencies of staff and leaders of the Federation	
	<p>We have identified the gaps in our current competencies</p> <ul style="list-style-type: none"> • Financial - financial control and forecasting • Project Management • Business case development • Human Resources • Contract management • Communications and marketing • Public engagement • Information and IT including data analysis • Clinical governance 	
	We have a plan to address the gaps in our current competencies	
Legal Indemnity	We have arranged appropriate legal indemnity cover	
Providing services	Where necessary - we have registered with CQC	

2. DECIDING ON A FEDERATION'S LEGAL STRUCTURE

INTRODUCTION & OVERVIEW

A Federation's legal structure comprises:

- Its **legal form** – the type of organisation that the law recognises. It may be incorporated (e.g. a limited company) or unincorporated (e.g. a partnership); and it may be regulated by statute (e.g. under the Companies Act 2006 or Partnership Act 1890) or not (e.g. an unincorporated association).
- Its **framework (or constitution) of ownership, governance and management**. This may be prescribed by statute (by reference to the organisation's legal form) and/or decided by the organisation's members (subject to what is statutorily prescribed). It may also be determined by the business activities that the organisation will undertake and the business sector that it will work within.

A number of legal forms could be employed to create a collective legal entity as a Federation:

- [Private company limited by shares \(CLS\)](#)
- [Private company limited by guarantee \(CLG\)](#)
- [Community Interest Company \(CIC\) limited by shares or guarantee](#)
- [Industrial and Provident Society \(IPS\)](#)
- [Charity](#)
- [Limited Liability Partnership \(LLP\)](#)

Each legal form has key characteristics, which will determine its suitability for use by the Federation. A table summarising the characteristics for each legal form is available [here](#).

The choice of the legal form will also depend on several other factors, including:

- The primary role of the Federation;
- The governance requirements: Who will be involved in the organisation, and how? Who should control it, and how far should their power extend? The answers to these questions will help to work out an appropriate governance structure, which will help determine which legal form should be used and how it should be adapted to fit particular circumstances;
- The key features of the Federation: i.e. funding, employee and patient engagement and representation, incentives for GPs, access to the NHS Pension Scheme, access to NHS indemnity arrangements, assets, corporate support, etc.

Depending on what a Federation is set up to achieve, **more than one corporate vehicle may need to be employed**. This is illustrated by the two case studies on organisational form. [Leodis](#) is comprised of three organisations: an LLP commissioning organisation, a provider company limited by shares, and a joint venture company limited by shares. Similarly, [Badger](#) has used different legal vehicles for different enterprises and now four companies sit under the Badger umbrella.

For each legal form, the corporate and commercial independence of individual GP practices can be maintained whilst at the same time encouraging service integration, shared values / single culture, efficiency and economies of scale.

A checklist that GPs and managers can use to design the form, structure and governance of the company is available [here](#).

Social enterprise

A Federation can operate as a social enterprise (SE), which is a business established to address a social or environmental need.

An SE is not defined by its legal form but by its framework: its social aims and outcomes; the basis on which its social mission is embedded in its structure and governance; and the way it uses the profits it generates through trading activities. CLGs, CICs, Charities and IPSs are typical business vehicles used to set up SEs.

Key characteristics of an SE:

- Profits are reinvested to achieve social objectives
- Dividends are capped to prevent or restrict the distribution of profits
- Assets may be locked to restrict their transfer.

LEODIS, Leeds

Leodis provides an example of an organisation that has developed different organisational forms for different functions.

Key characteristics

- Three organisations under the Leodis umbrella – one for commissioning, one for provision and one for estates.
- 121 GP members, from 27 practices, covering a registered population of over 216,000.
- For more details see www.leodishealthcare.co.uk



Learning – organisational form

- ‘GPs recognised that they needed a governance structure that would encourage the PCT and a huge local acute trust to take them seriously’, says Dr Harris, GP Chair.
- Leodis Healthcare LLP was set up first. Practices handed over funds from their Directed Enhanced Services (DES) payments to provide the capital to establish the organisation. In doing so they committed to share risk and sign up to a unified commissioning plan. A LLP was chosen as it reduced liability for individual members embarking on a new venture.
- During the first year, the possibilities in terms of the provider agenda became clear and Leodis Care Limited was set up as a provider organisation. The limited company structure was chosen to allow Leodis to compete on an equal footing with other private providers coming into the market. It is structured as an ‘NHS Ltd company’ – only members of the NHS family can be shareholders – which allows it to use the NHS pension scheme.
- In the second year, an issue around the facilities and space in which to support shifts of care into community settings prompted Leodis Care Limited to enter into partnership with Community Ventures Leeds and set up Leodis Community Ventures Limited.
- Leodis is considering developing an additional organisational structure to enable it to manage long term conditions, non-elective care and care of the elderly. It is exploring with H3Plus and Calibre, the other two established commissioning consortia in Leeds, along with the PCT’s adult community services, the possibility of forming an integrated Community Interest Company (CIC) covering a population of around 490,000. This remains at an early stage of development.

Key advice

- ‘Although like minded GPs should be forming consortia and defining the principles by which they may wish to work together, my advice would be to wait before committing to a formal legal structure’, says Dr Harris.
- ‘It’s a journey because situations change’, says Mr Reid. ‘The fundamental principle that won’t change is that resources in the system depend hugely on the way GPs operate and clever PCTs will want to harness that on a population basis, from really robust organisations’.

BADGER, Birmingham

Badger provides an example of an organisation with a well developed corporate structure and one that has used different legal vehicles for different enterprises but incorporated them into one governance structure.

Key characteristics

- Badger, which stands for *Birmingham And District GP Emergency Rooms*, is an out of hours cooperative.
- It was set up in 1996 as a company limited by guarantee.
- Over 300 clinicians (250 GPs and 50 nurses) in 90 practices have opted into the cooperative, covering a patient base of 500,000.
- The cooperative developed on the back of a strong corporate culture amongst GPs on the east side of Birmingham.
- Badger’s success led to approaches to take on other work, which did not sit well with its ethos as a mutual, not-for-profit organisation. So it decided to establish other companies, each serving a different function and providing a range of services.



Learning – organisational structure

- Overseeing Badger and its subsidiary companies is a board of directors consisting of five GP directors (elected from the membership on an annual basis), Chief Executive, Medical Director, Finance Director.
- Decisions by the board are translated into action by the executive team (Chief Executive, Medical Director, Finance Director, Operations Director, Director of Quality and Compliance, Clinical Director of Medicine). An operations board manage projects at an operational level (Head of Human Resources, Business Development Manager).
- The leadership team consults the membership about any significant decisions, such as a change in direction for the organisation. Depending on the issue, it may hold a general meeting or conduct a survey with a subsection of the membership. It then communicates any decision and monitors its implementation.
- Every quarter, the 300 clinician members of Badger receive a report on their performance covering, for example, repeat prescriptions, and compliance with A&E and 999 policies. The reports enable individuals to benchmark themselves against their peers. ‘Anyone who is less than half or more than half the average is asked to give me a ring’, says Badger’s Medical Director, Dr Fay Wilson. Those who need it are offered support to help them improve their compliance and overall performance.
- ‘As a vehicle, it is not so different to a commercial company. It is run on a lean commercial basis, but it still has a public sector ethos’, says Dr Wilson. This public sector ethos is evident in the fact that dividends have never been paid in any of Badger’s for-profit companies. All profits go to Badger and are spent on services.

Key advice

- ‘Don’t start with structures, instead look at what the organisation is trying to do, who should be involved and how it would look from someone else’s perspective – particularly GP colleagues and patients’, advises Dr Wilson.

3. GOVERNANCE

INTRODUCTION

This section looks at the issue of “governance” for a Federation: the leadership, direction and control of the Federation through its structures and processes. The [vision and overview](#) discussion sets out some of the core principles of good governance and the key messages and advice from the five [case studies](#). A core element of good governance is a high performing board. In [further advice](#) we describe some of the key features of a high performing board, as well as providing advice on managing conflicts of interest. In [resources](#) we provide links to resources that provide further advice and guidance as well as links to training resources to support leadership and board development.

VISION & OVERVIEW

The exact governance model adopted by a Federation will depend on their organisational form and function. A looser association of practices will clearly require a less formal governance model to a Federation that employs staff and has significant income and expenditure. For those Federations with a legal form, there will be certain governance requirements set out within the Memorandum and Articles of Association (see section on [legal structures](#) for more information).

However, whatever the legal or organisational form, the principles of good governance would be expected to apply, that is systems and processes that support the Federation in:-

1. Focusing on the organisation’s purpose and on outcomes for citizens and service users
2. Performing effectively in clearly defined functions and roles
3. Promoting values for the whole organisation and demonstrating the values of good governance through behaviour
4. Taking informed, transparent decisions and managing risk
5. Developing the capacity and capability of the governing body to be effective
6. Engaging stakeholders and making accountability real.

(Source: [The Good Governance Standard for Public Services](#))

The vision in practice

The case studies for good governance provide some contrasting models, each adapted to their local circumstances and function.

[Brent GP Federation](#) While the primary function of Brent GP Federation is practice based commissioning it provides valuable insight to good governance for GPs wishing to work collectively. Of particular note are the clarity of roles and the competency framework for council members. [Principia](#) The primary function of Principia is also practice based commissioning. It provides an example of a strong governance framework with clear lines of accountability and a competence framework for board members.

[Ipscom](#) The primary function of IPSCOM is practice based commissioning, however it provides a good example of GP engagement.

[Somerset ConFederation](#) This case study provides an example of a supra-cluster arrangement in which a loose association of practice clusters has supported the extended provision of services.

[GAT-NET](#) case study provides an example of GPs creating a clear separation between their commissioning and provider functions in order to avoid conflicts of interest.

Case studies advice on governance

- Don't start with structures, look at what the organisation is trying to do and design the structures to fit
- Be pragmatic and design something that manages risk but also represents value for money - people's time costs money
- Strong governance is reliant upon robust information - data is easy to access but meaningful analysis is critical if the board is to do its job
- Have a code of conduct or legal agreement that binds together GPs, managers and practice staff
- Have defined roles and responsibilities with clear lines of accountability
- Have clear demarcation between the provision and commissioning of services and ensure compliance with competition law and guidance

GOVERNANCE – FURTHER ADVICE

The Good Governance Standard for Public Services (see resources) provides good practical advice for any organisation wishing to develop a robust governance model. There is a particularly useful checklist in Appendix A with a set of questions for governing bodies to ask themselves to assess the robustness of their governance systems and processes. They also set out the roles and functions of a governing body or board.

The primary functions of the governing body are to:

- establish the organisation's strategic direction and aims, in conjunction with the executive
- ensure accountability to the public for the organisation's performance
- assure that the organisation is managed with probity and integrity

Ways of achieving these primary functions include:

- constructively challenging and scrutinising the executive
- ensuring that the voice of the public is heard in decision making
- forging strategic partnerships with other organisations

Source: The Good Governance Standard for Public Services

The literature on governance also makes clear that a board's culture and behaviour can be as important as the structures and processes for its success. Sonnenfield (see resources) argued that the following elements were particularly important.

- A climate of trust and candour.

- A climate in which dissent is not seen as disloyalty.
- A fluid portfolio for directors so individuals are not typecast into rigid positions.
- Individual accountability with directors gathering information and updating board on strategic and operational issues.
- Regular evaluation of the Board's performance.

Attention also needs to be paid to ensuring the Board has the skills and capabilities to carry out its functions. The recent guidance, *The Healthy NHS Board* (see resources) suggests that Boards need to pay attention to four key areas: Board composition, ensuring the right balance of knowledge and skills; whole board and individual performance appraisal providing opportunities to reflect on and improve performance; board learning and development, providing opportunities for board members and the board as a whole to develop their skills; appointment and remuneration of board members, ensuring formal, rigorous and transparent appointment mechanisms are in place.

Managing conflicts of Interest

Doctors have strict professional duties about conflicts of interest. They include a duty that if a doctor has a financial or commercial interest in an organisation to which he or she plans to refer a patient for treatment or investigation, he or she must tell the patient about his or her interest. When treating NHS patients he or she must also tell the healthcare purchaser. If a doctor has a financial or commercial interest in a business case being considered by his or her Primary Care Trust under practice based commissioning (PBC) arrangements, he or she should declare his or her interest and exclude him- or herself from related decisions in accordance with the Department of Health and local PCT guidance. It is expected that an equivalent duty will apply when GP commissioning replaces PBC.

It is therefore important to ensure clear demarcation between GPs' engagement in providing and commissioning of services. The White Paper consultation on commissioning says that this requires transparency over how commissioning decisions are made and the value of the services commissioned from GP practices. The expectation is that the majority of services will be commissioned under the "any willing provider" model. Under this model a provider is "accredited" by the commissioner and then becomes one of the choice options for local patients, paid for under a "call off" contract with an agreed price per patient. The White Paper consultation suggests that GP consortia can use or adapt established protocols to audit referral patterns to ensure probity. It also suggests that if GP practices wish to bid in a major procurement, the procurement could be managed by another party such as the NHS Commissioning Board or Local Authority.

Since the publication of the White Paper, the Department of Health has reissued its ["Procurement guide for commissioners of NHS-funded services"](#). The guide provides an interim set of guidance for commissioners including any shadow GP consortia. (NB The Department of Health anticipates updating the guidance substantially in 2011/12). The procurement guide sets out four key principles of procurement that commissioners should comply with alongside the ten principles for cooperation and procurement (see figure below and resources section for full reference). These principles are designed to ensure transparency and avoid conflicts of interest, as well as protect competition and choice.

1. Transparency

At any stage, commissioners should be able to publicly account for expenditure, by contract and by provider, and in terms of services commissioned and quantity provided. There needs to be an auditable documentation trail regarding key decisions that can be subject to public scrutiny.

2. Proportionality

The level of resources a commissioner puts forward into the procurement process should be proportionate to the value, complexity and risk of the services contracted, i.e. more resources will be required where higher benefits/costs/savings/quality can be gained.

3. Non-discrimination

The commissioning process, including any form of procurement, should be non-discriminatory and transparent at all times, neither including nor favouring nor excluding any particular provider.

4. Equality of treatment

The procurement process should not give an advantage to any market sector (public, private, voluntary, charitable and social enterprise).

It is important to note that if GPs engage in anti-competitive behaviour or abuse their market position, then they may be at risk of regulatory intervention or even criminal liabilities under the Competition Act 1998 and the Enterprise Act 2002. Further resources are available at www.ccpanel.org.uk and www.competition-commission.org.uk .

Figure 1 The ten principles for cooperation and competition

Obligations on commissioners	Cooperation and agreements	Conduct of individual organisations	Mergers and vertical integration
<p>1 Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations.</p>	<p>4 Commissioners and providers must cooperate to improve services and deliver seamless and sustainable care to patients.</p>	<p>7 Providers must not refuse to accept services or to supply essential services to commissioners where this restricts commissioner or patient choice against patients' and taxpayers' interests.</p>	<p>10 Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interests, for example because they will deliver significant improvements in the quality of care.</p>
<p>2 Commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010.</p>	<p>5 Commissioners and providers should promote patient choice, including – where appropriate – choice of any willing provider, and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.</p>	<p>8 Commissioners and providers must not discriminate unduly between patients and must promote equality.</p>	
<p>3 Payment regimes and financial intervention in the system must be transparent and fair.</p>	<p>6 Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients' and taxpayers' interests.</p>	<p>9 Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS.</p>	

Source: [Principles and Rules for Cooperation and Competition](#) - Department of Health 2010

BRENT GP FEDERATION, Middlesex

The primary function of the Brent GP Federation is practice based commissioning but it provides valuable insight to good governance for GPs wishing to work collectively. Of particular note are the clarity of roles within the Federation and the competency framework for council members.

Key characteristics

- A practice based commissioning (PBC) consortium that brings together five PBC clusters to provide a cohesive voice to commissioning issues that require a borough-wide approach.
- Established in 2008; no formal legal structure.
- It covers 71 practices and a registered population of around 356,000, in one of the most ethnically diverse communities in the UK and the 53rd most deprived borough in England.
- The five clusters are each comprised of between 10 and 16 practices, and have registered patient populations of between 56,000 to 83,000.
- It is in the process of setting up a provider-arm social enterprise company, limited by guarantee, to enable it to bid to provide an urgent care centre.
- For more details go to www.brentfed.nhs.uk

Learning – governance

- Each of the five clusters has its own board, which meets monthly and functions separately, with its own [governance structure](#). Each cluster also has a full time administrator, paid for by the PCT, to practices, organise meetings and training sessions, and liaise with other cluster administrators.
- The five clusters nominate two representatives to sit on the Federation Council (either a clinical lead and a management lead, or two clinical leads). These nominated individuals are interviewed by the PEC chair and the PCT Director of Commissioning and must demonstrate the required competencies to represent their cluster effectively and deliver a portfolio of responsibilities. Candidates are assessed against an agreement [competency standard](#).
- Each Federation Council lead is appointed for two years initially, with the possibility of an extension, and given a portfolio of responsibilities. There are seven clinical and three managerial leads, who share responsibilities across acute, mental health, and community services, as well as systems, budgets and governance.
- The PCT pays each Federation lead a salary (the equivalent to a PEC salary); they work under delegated authority from the PCT and are performance managed on how they perform in

relation to their portfolio of responsibilities against agreed [terms of reference](#). Clinical leads undergo annual appraisal with the PEC Chair and Director of Primary Care Commissioning.

- Together, the Federation leads and PCT representatives form the Federation Executive – a decision-making committee chaired by the PCT Director of Primary Care Commissioning. The Federation Council is supported by a PCT administrator, PBC Associate Director and manager.
- The position of chair rotates every three months to ensure that all five clusters are equally represented. The Federation Council and Executive both meet monthly to discuss cluster or Federation-wide progress on commissioning plans and update members on activities.
- Prior to the formation of the Federation, the five PBC clusters worked in isolation and were not fully exposed to other groups' progress. The Federation structure allows flexibility to be locality-specific when appropriate (for example, developing services to meet specific local needs), but also to come together as a Federation of clinical commissioners, sharing expertise, skills and resources. This frees up GPs' time and reduces the cost of commissioning. 'The beauty of this is that you have two levels of commissioning, which allow you to flex and address issues at different levels', says Dr Ethie Kong, Clinical Lead for the Harness cluster and current Federation Chair.

Key advice

- 'Having a big umbrella body is about joining forces and resources', says Dr Kong. She considers five key factors to be critical to setting up an overarching Federation:
 1. A partnership between clinical and managerial leaders
 2. Leaders with credibility, so that they can get buy-in locally
 3. Trust between practices and between clusters (that being part of an overarching Federation will be beneficial for GPs and patients)
 4. A code of conduct or legal agreement that binds together GPs, managers and practice staff
 5. Patient involvement at all levels
- Performance management has to be rigorous enough to ensure that members deliver for their local constituencies and on their portfolios of responsibilities', says Caroline Kerby, Management Lead for the Harness cluster.

GOVERNANCE – CASE STUDY 2

PRINCIPIA – PARTNERS IN HEALTH, Nottingham

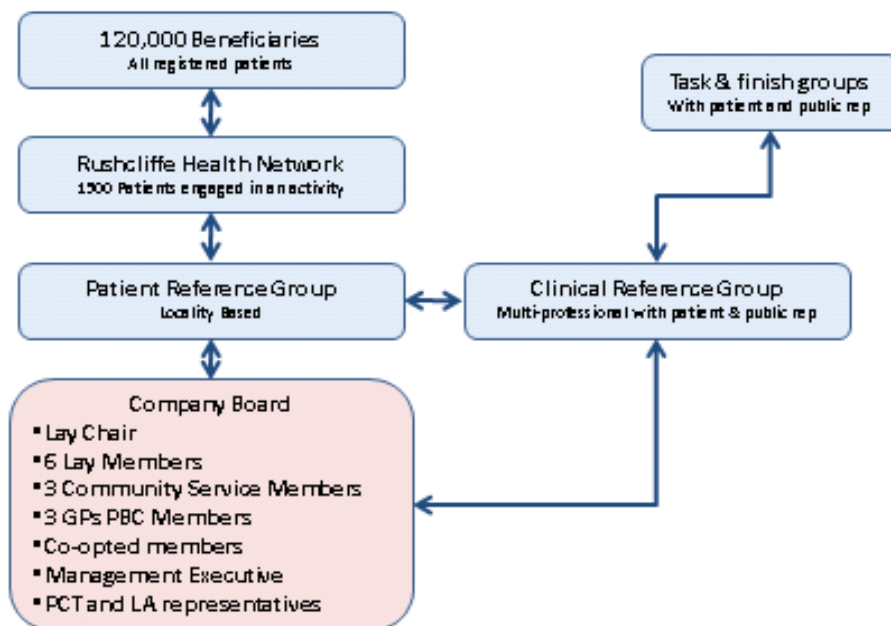
While the primary function of Principia is practice based commissioning it provides an example of a strong governance framework with clear lines of accountability and a competence framework for board members.

Key characteristics

- An organisation that both commissions and delivers services for the community of Rushcliffe – commissioning is its primary function.
- Established in 2006 as a social enterprise company, limited by guarantee.
- It is comprised of 16 GP practices and covers a population of just over 120,000; the population is relatively healthy with higher than average life expectancy.
- One of the Department of Health's 16 integrated care organisation pilots.
- For more details see www.principia.nhs.uk

Learning – governance

Principia governance structure



- Three core sets of stakeholders are represented in Principia's governance structure: patients and the public, PCT community services (around 140 whole time equivalent community staff) and over 100 GPs.

- The board has a lay chair and lay majority. The [Articles of Association](#) set out the roles and responsibilities of board members. The twelve board members are elected, and no more than two directors can be co-opted by those that have been elected. All board members (whether patients, GPs or provider staff) are paid £2,000 per annum (2010/11).
- The role of the board is to control all investment decisions and determine new business opportunities. It formally agrees models of care and pathways and protocols, and receives reports of performance against these and agrees any necessary remedial action.
- The Board also ensures that the interests of the community, the people providing the organisation's services, and other organisations relevant to the operations of Principia are properly represented.
- The directors are required to ensure that the board has the skills and experience it needs to operate effectively. To support this, Principia has developed a core competency list for its directors and [person specification for the community directors](#).
- The Clinical Reference Group (CRG) provides a focus for clinical engagement which is further reinforced through a network of practice based commissioning leads. The CRG is charged with improving patient outcomes through evidence based pathways, encouraging innovation and driving up efficiency and productivity.
- A Practice Based Commissioning Consortium Agreement sets out clear roles and responsibilities for GP Practices, Principia and the local PCT.
- The patient reference group ensures wider representation across Rushcliffe, including seldom-heard groups as well as supporting wider public and patient engagement.

Key advice

- Principia advises making strong governance, including a culture of accountability and stewardship, a priority.
- Governance structures need to be underpinned by robust information – meaningful analysis of data is critical if a board is to do its job properly.

IPSCOM, Suffolk

While the primary function of IPSCOM is practice based commissioning it provides a good model for GP engagement.

Key characteristics

- It is a practice based commissioning (PBC) consortium covering all 16 practices in Ipswich and a population of around 160,000.
- It was established in 2006 and became a company limited by guarantee in 2007.
- No profit is taken by members, but is instead reinvested into the consortium.
- For more about IPSCOM go to www.ipscom.co.uk

Learning – governance

- ‘IPSCOM’s strength from our beginning has been our organisation’s inclusive nature – membership is open to all Ipswich practices, and all are represented within the Company’, according to Dr Jim Duncan, Chair of IPSCOM.¹ Inclusiveness is demonstrated in the way that all the programmes developed by IPSCOM are designed to be suitable for offer to all member practices.
- There is an elected board of five directors (four GPs and a practice manager). There is also a chief executive, a secretary and a clinical director (retired GP). All of the directors and executive staff are paid for through a management allowance grant from Suffolk PCT. Board meetings are also attended by a representative from the PCT who helps with applications for funding.
- Each member practice is expected to send one GP to attend monthly educational meetings (for example, these have included talks on urology and cardiology). In return, practices are paid £70, using allowances from the PCT. The focus of these meetings is on engaging with colleagues within the Federation and sharing ideas. A strong attendance by GPs is reported and local hospital departments have been very keen to input, helping to strengthen relationships between local GPs and specialists.
- Other mechanisms by which IPSCOM engages with member practices include the hosting of a biannual special interest group, which gives GPs and consultants an opportunity to get together and share ideas, for example, around diabetes and cardiology.

¹ Chair’s report, AGM, May 2009

- The IPSCOM board regularly emails members, and produces a monthly, single-page newsletter [June 2010 newsletter](#). IPSCOM's website is also used to prompt members' views, for example, on how to reduce referrals into hospital (www.ipscom.co.uk).

Key advice

- Think though how the Federation will include and engage member practices on an ongoing basis.
- Dr Owen Thurtle, one of the GP directors of IPSCOM says, 'We are GPs, so we understand how pressed for time colleagues are and make sure that our contact with them is kept brief and useful'.

GOVERNANCE – CASE STUDY 4

SOMERSET CONFEDERATION, Somerset

This case study provides an example of a supra-cluster arrangement in which a loose association of practice clusters has supported the extended provision of services.

Key characteristics

- It is a county-wide, supra-cluster provider organisation, which brings together the nine Federations in Somerset. It currently has no formal legal status.
- It was established in 2010 and covers a population of around 560,000.
- The nine Federations evolved when the PCT put out to tender the running of a centre following Lord Darzi's review of the NHS. The Federations grew from out of hours cooperatives, in terms of how practices joined forces.
- Most of the nine Federations are loose associations; only one Federation has adopted a formal legal structure and become a company limited by shares.

Learning – governance

- The Somerset ConFederation was originally established to identify and disseminate good practice amongst member Federations. Its focus has since extended to coordinate the provision of primary care, and possibly also community care services, on a county-wide basis.
- The ConFederation has an elected chair, vice-chair and secretary. Two representatives from each Federation attend ConFederation meetings, ideally a GP and practice manager, as well as the chief executive of WyvernHealth.com – the county-wide practice based commissioning (PBC) consortium for Somerset <http://www.wyvernhealth.com/>. The local medical committee provides the secretariat. The ConFederation does not hold a budget and Federations fund their own representatives to attend. It is run very much on the basis of goodwill. 'At the moment, it tends to be the willing and the coerced that come', says Dr Yoxall.

- The ConFederation cannot bind member Federations into decisions and instead emphasis is placed on persuading and influencing Federations, by highlighting the benefits of collaborative working. Chief Executive of NHS Somerset, Ian Tipney, has said that the main challenge for the patch is getting sufficient buy-in of all GP practices to redesign local services². The ConFederation seeks to do this by ensuring that Federations are lined up and facing in the same direction, should an opportunity arise to submit a county-wide bid to provide services.
- It is still early days for the ConFederation; it anticipates that its role will largely be a coordinating one, with the nine Federations holding the contracts to provide services. However, it is considering becoming a community interest company, run along social enterprise lines, comprised of its PCT provider services (Somerset Community Health), along with the social care provider arm of the local authority and other interested organisations. ‘Nothing has been ruled out for how the Somerset ConFederation might develop its role’, says Bernard Newmarch, Chair of Taunton and Area Health Federation of GP Practices, one of the nine Federations that belong to the Somerset ConFederation.

Key advice

- ‘Informal structures work very well in localities that are inherently cooperative. If you are working in a locality where there are significant differences between groups of GPs and practices, a more formal structure may be needed’, says Dr Harry Yoxall, Secretary to Somerset ConFederation.
- ‘The current arrangements cost very little and enable GPs to be galvanised on a county wide basis very quickly’, adds Dr Yoxall.
- The downside of the current arrangement is that the ConFederation cannot submit any bids as it does not yet have a formal legal structure.

GOVERNANCE – CASE STUDY 5

GAT-NET COMMISSIONING CONSORTIUM & GATESHEAD COMMUNITY BASED CARE, Tyne and Wear

This case study provides an example of GPs creating a clear separation of commissioning and provider functions to avoid conflicts of interest.

Key characteristics

- GAT-NET Commissioning Consortium represents the merger of three practice based commissioning (PBC) consortia in Gateshead. It covers 35 practices and a population of around 200,000, in an area that is both urban and rural, and with pockets of high deprivation. It is a loose association of practices.

² NHS ConFederation conference 23-25 June 2010

- Gateshead Community Based Care is a separate provider arm, to which the same 35 practices belong. It is a not-for-profit community interest company, limited by guarantee.

Learning – organisational form

Governance structure

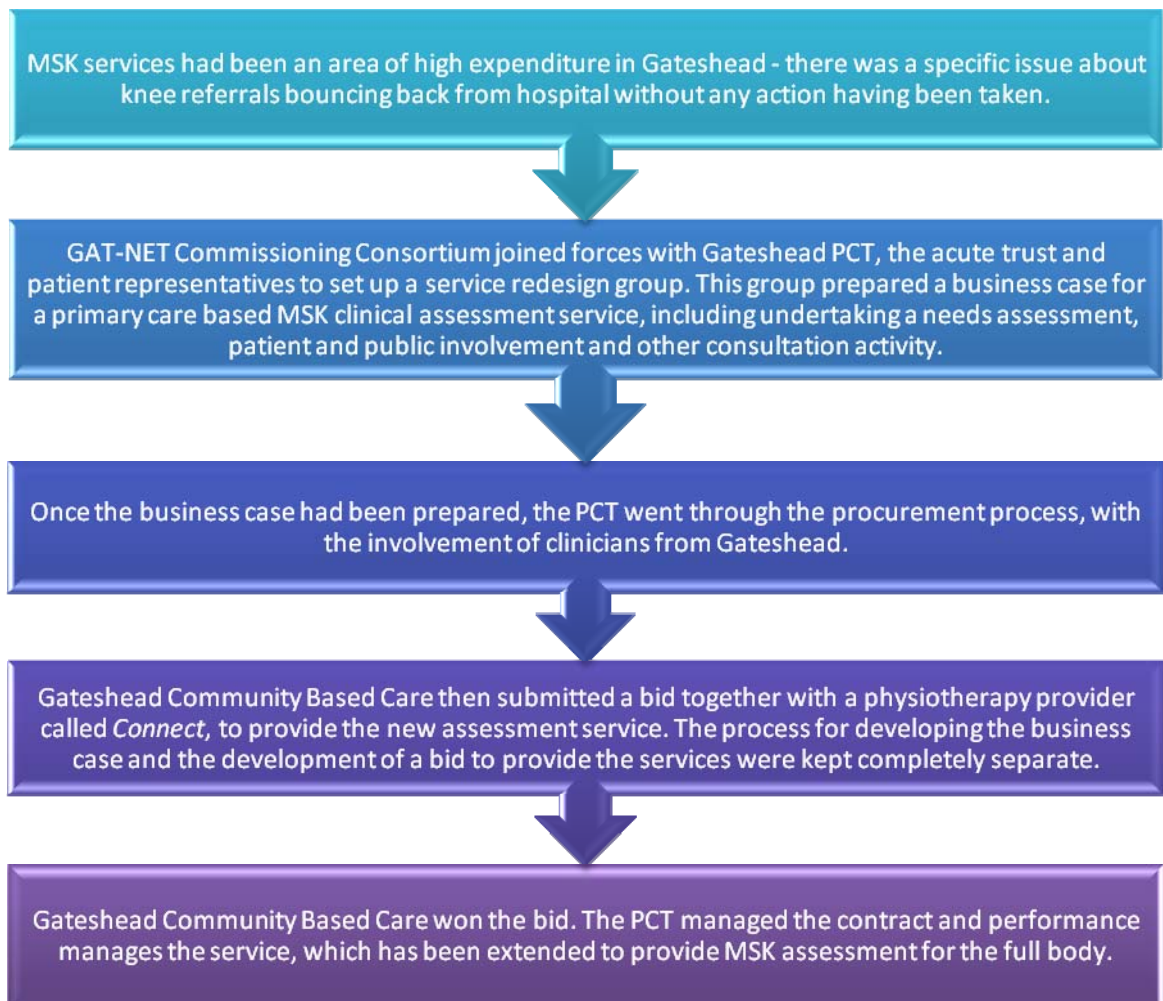
- Each organisation has its own elected board of GPs and practice managers.
- Members of the commissioning board have a job description, setting out clearly their roles and responsibilities, and undergo annual appraisal. There is a clear separation on the board between corporate members and clinical leads, who tend not to get involved in the business side of the organisation.
- Members of the provider board cannot sit on the commissioning board.
- Regular meetings are held with the 35 practices and each organisation holds an AGM. Neither organisation employs executive staff.

Funding

- The commissioning consortium has received £92,000 from the PCT leadership fund, enabling it to pay its eight clinical leads £77/hour to spend around a session a week as clinical champions. In addition, a PBC Manager, PBC Assistant Manager and administrators are provided and paid for by the PCT.
- No external funding has been available for the provider arm. Each of the 35 practices has contributed 10 pence per registered patient.

Click here for details of GAT-NET [board chair role description](#), the [role description for the clinical lead](#), and details of the [key responsibilities for board members](#).

The separation of commissioning from provision has been an important feature of federated working for Gateshead GPs. By having two distinct organisations that separate commissioning from the provision of services, practices have been able to overcome a potential conflict of interest. A good example of this is a new primary care based musculoskeletal (MSK) assessment service.



- GAT-NET Commissioning Consortium plans to adopt a formal legal structure to strengthen its functions as a commissioner. Gateshead Community Based Care is also seeking to strengthen its structure and has asked practices if they will top slice PBC incentive scheme money to fund the appointment of a manager.

Key advice

- ‘My advice is to keep commissioning completely separate from the provision of services, and to have different people leading on these different functions. This is the best way to ensure that there is clarity about the role you’re playing and to achieve openness and transparency of working,’ says Sheinaz Stansfield, Organisational Development Lead for GAT-NET Commissioning Consortium.
- She adds that it is also practical to have different people leading the demanding agendas of commissioning and provision.

4. INVOLVING PATIENTS & THE PUBLIC

INTRODUCTION

In this section we explore the benefits of involving patients and the public and the mechanisms for doing this. The evidence shows that this is an activity that GP groupings and indeed the wider NHS can find difficult. We hope that the case studies and resources we provide will help GPs reap the benefits of active patient and public involvement.

The [vision and overview](#) sets out some of the benefits of patient and public involvement with advice from the [case study](#) sites on successful engagement. In [further advice](#) we provide some of the key learning from some of the literature in this area. In [resources](#) we provide links to some of the work done by the National Association for Patient Participation, with support from the RCGP and NHS Alliance, to support patients and practices to work more closely together.

VISION & OVERVIEW

Greater involvement of patients is core to the RCGP vision for Federations. Patient engagement can be a major catalyst for improvement, and bring benefits to patients and professionals alike. Patients should play an active part in the Federation. Federations should involve patients, their families and carers in designing and developing the provision of services and care.

The vision in practice

The case studies for patient and public involvement provide graphic examples of how Federations can engage and involve patients and the benefits that this can bring.

[Principia](#) provides an example of a Federation engaging patients and the public at every level of the organisation. The company's mantra is "not a single decision should be made without patients being involved from the outset". One of Principia's lead GPs, Stephen Shortt, described the impact of the patient perspective as "humbling" and something that had had a profound impact on the dynamic of commissioning decisions.

[Pathfinder Healthcare Developments](#) has used a network of "community champions" both as a sounding board for service developments but also a vehicle to communicate public health messages. By going out to communities, as opposed to expecting them to come to health services, the community champions have enabled practices to engage with people who are often hard to reach.

Case studies' advice on engaging patients

- Don't over complicate the process, make it easy to understand
- Get patients and the public to the table, whoever they are, just start and build networks
- Treat lay representatives as equals with their own areas of expertise and treat them as allies working towards the same target but from a different direction

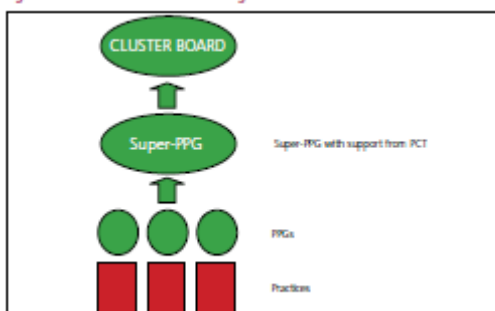
- Senior clinicians need to be totally signed up. This has to be at the heart of what they do and how they do it.
- Make sure patient and public engagement is at the forefront of any new service development.

INVOLVING PATIENTS AND THE PUBLIC – FURTHER ADVICE

The NHS Service Delivery and Organisation R&D programme has commissioned two literature reviews on successful patient and public involvement. Some of the key messages from these sources are:-

- Patient participation can bring about significant cultural change from an “us and them” scenario to a united team of patients and practice staff working towards a single vision.
- Patient participation requires active support and encouragement - both in terms of logistics and patients seeing their views responded to.
- Active patient participation can relieve hard-pressed staff from everyday tasks and help practices understand the gap between their own perception of need and the patients’ own views.
- At practice level support from practice managers is particularly important.
- Strong communication is essential - using a variety of media and mechanisms.
- It is important that patients are able to drive the agenda and not seen only as a group to consult and react to the agenda set by the professionals.
- Front line staff are likely to need training to help them appreciate why and how service users are involved.
- Service users may need training to enable them to take part.
- It can be challenging to engage people who have little time - such as those who work full time or young mothers.
- The Federated model of general practice provides an opportunity for practice based patient participation groups to pool resources and expertise.

Figure 1. A Practice Based Commissioning model



Picture Source:

http://www.growingppgs.com/fileadmin/user_upload/Campaign/295937_GPP_QualityResponsiveness_acc.pdf

PATIENT AND PUBLIC INVOLVEMENT – CASE STUDY 1

PRINCIPIA – PARTNERS IN HEALTH, Nottingham

While the primary function of Principia is practice based commissioning it provides valuable insight into effective patient engagement and its benefits.

Key characteristics

- An organisation that both commissions and delivers services for the community of Rushcliffe – commissioning is its primary function.
- Established in 2006 as a social enterprise company, limited by guarantee.
- It is comprised of 16 GP practices and covers a population of just over 120,000; the population is relatively healthy with higher than average life expectancy.
- One of the Department of Health’s 16 integrated care organisation pilots.
- For more details see www.principia.nhs.uk

Principia - Patient Engagement Mechanisms

Patient selection process	Engagement Mechanism	Area of influence
Patients nominate themselves and are then selected against a set of competency criteria	Board 6 Lay Directors and Lay Chair	Strategic direction and governance of Principia as a commissioning organisation including performance and financial management
Patients nominate themselves and are then selected against a set of competency criteria	Patient reference group (PRG)	Development of commissioning strategy
Selected from members of Board and PRG	Annual practice visit - a patient rep	Performance management of practices against commissioning goals
?	Practice engagement group	Practice operation - inc. opening hours & facilities
People nominate themselves - encouraged via website and annual engagement event run by the local council	Health Network Network of c700 lay people	Receive regular newsletters, invited to events, surveys, participate in consultations

Learning – patient and public involvement

- Principia’s governance structure ensures patient and public involvement at every level of the organisation. Its mantra is that ‘not a single decision should be made without patients being involved from the outset’.
- In addition to the main mechanisms for patient engagement set out above, any task and finish group or other decision-making process has patient representation. The lay chair of the board also has the casting vote.

- Stephen Shortt, one of the GP founders of Principia, said that patients' views genuinely had a profound impact on commissioning decisions, as well as on the day-to-day running of their local practices. Examples of patient impact include: influencing the procurement of physiotherapy services to include a broader range of providers and drive down waiting times; influencing the provision of extended hours in primary care (arguing for early morning and late evening provision, rather than weekend opening); and influencing information provision within their local surgeries.
- The experience at Principia has been that patients participate, have sophisticated discussions with clinicians, and can provide useful challenge to territorial or defensive behaviour.

Key advice

- Andy Warren, PPI lead for Principia advises to keep the rules of engagement and the selection process for lay representatives easy to understand and implement. He also suggests treating lay representatives as equals with their own areas of expertise, and as allies working towards the same target but from a different direction.
- Vicky Bailey, General Manager for Principia, says, 'Don't over complicate it. Just get the patients/members of the public to the table, doesn't matter who they are, just start and build the networks.' Ms Bailey believes that Federations that fail to engage patients will hold themselves back – patient involvement is the catalyst for change and improvement.

PATIENT AND PUBLIC INVOLVEMENT – CASE STUDY 2

PATHFINDER HEALTHCARE DEVELOPMENTS, Smethwick

Pathfinder Healthcare Developments has used a network of “community champions” both as a sounding board for service developments but also a vehicle to communicate public health messages. By going out to communities, as opposed to expecting them to come to health services, the community champions have enabled practices to engage with people who are often hard to reach.

Key characteristics

- A provider organisation that grew out of a ten-year partnership between two inner city partnerships in Smethwick, West Midlands. One of the two GP partnerships, Smethwick Medical Centre, now owns Pathfinder Healthcare Developments (PHD).
- Set up in 2008, as a Community Interest Company (CIC), it is a social enterprise organisation – ‘this means we reinvest our profits and assets for the public good’.
- Covers a population of 12,000; one of the most deprived areas outside London, with a high minority ethnic population.
- PHD is comprised of three practices. It is led by three GP directors, a nursing director, business director and a non-executive director. They are supported by a business manager and a financial manager, as well as staff running specific projects (such as its asylum seeker and refugee service).

- For more details see www.path-finderhd.com

Learning – patient and public involvement

- PHD is committed to genuine involvement with its local communities. As part of the *Healthy Communities Collaborative*, it bid and won funding to deliver a patient-led programme of community activity in Sandwell on behalf of Sandwell Primary Care Trust (PCT). This included developing a network of community champions that PHD could work with to disseminate health and wellbeing messages.
- A group of 45 community champions – a mix of patients and active community workers – has been established. PHD uses the community champions to test its thinking and ideas for service development, such as its plans for the creation of a [health and wellbeing centre](#) and around [proactive care management](#).
- It also uses the champions as a vehicle to transmit public health messages to friends, family, colleagues and neighbours, and into the wider community. For example, PHD holds *Healthy Community Collaborative* events at supermarkets, where community champions will invite members of the public for screening and provide information about community groups. The champions have also been trained to help members of the public undertake online health assessments.
- Other activities involving the community champions include awareness raising sessions in the waiting areas of PHD health centres, informing patients about services and inviting participation with the champions group; a Health Education Day at a community centre; events in after-school clubs; and health checks carried out in local workplaces.
- The PHD community champions meet monthly to plan activities to raise health and wellbeing awareness. Initially a senior GP would facilitate the meetings, but clinicians have stepped back as the group has taken off and now the PHD Operations Manager chairs meetings.
- PHD's efforts to involve and engage local communities through its community champions have been extremely well received by the public and patients. By going out to communities – as opposed to expecting them to come to health services – PHD has been able to engage with people who are often hard to reach. Dr Niti Pall, Chair of PHD, gives the example of a Muslim woman who had not left her house for a decade and has now become a community champion helping to reach other Muslim women.
- The PHD community champions are currently formalising what they do and setting up a patient reference group, which PHD promises will be an important part of everything it does in the future: 'Experience tells us that it is essential to evolve a service with the people who use it because they feel part of its development. This means it is more likely to succeed and to be well-used by its target community'.

Key advice

- 'You need to have senior clinicians totally signed up. You cannot do this as a hobby; you have to put it at the heart of what you do', advises Dr Pall.
- She adds: 'Whenever you are thinking about setting up a new service or service redesign you need to put patient and public engagement at the forefront of what you do'.

5. ENGAGING THE WIDER PRIMARY CARE WORKFORCE

INTRODUCTION

This section looks at the opportunities for Federations to engage with the wider primary care workforce within general practice and beyond. The evidence shows that like patient and public involvement, this is an area which is often poorly exploited by Federations. It is notable that this was an area where we struggled to find many good case studies.

The [vision and overview](#) describe some of the potential opportunities to engage the wider primary care workforce and encourages Federations to take more action in this area. The [case study](#) provides an example of how general practice can use the wider primary care workforce to redesign the process of care. In [resources](#) we provide links to - organisations providing support to the wider primary care workforce; a toolkit for general practice nurses; and more general advice and guidance.

VISION & OVERVIEW

Federations provide opportunities to develop and engage the wider primary care workforce within general practice and beyond, including pharmacies, optical services and dentistry. Being part of a larger organisation enables practices to support the development of new roles and exploit opportunities to change the skill mix within practices. The larger grouping can also facilitate communications with other primary care organisations in the area.

The vision in practice

In developing this toolkit we found many examples of practice nurses and practice managers being an active part of the Federation and its development. There were also examples of Federations providing training and development opportunities to nursing and other practice staff. However, there were relatively few examples of Federations being used as a significant vehicle to develop other health care professionals within the primary care team or engage with other primary care staff outside the practices. The example we have used, [Westongrove Partnership](#), provides a good example of the scale of opportunity within primary care to deploy non medical staff and allow GPs to focus on the management of the more complex patients.

In the resources section there are links to a variety of resources which support the development of wider primary care team and promote joint working across primary care.

Key advice

- Federations provide opportunities to develop and engage the wider primary care workforce
- Use Federations to think creatively about how best to use the wider workforce to meet the needs of patients

- While staff may benefit from being part of a larger grouping, they also value being part of a practice, don't lose the local identity within the bigger whole.

ENGAGING THE WIDER PRIMARY CARE WORKFORCE – CASE STUDY 1

WESTONGROVE PARTNERSHIP, Buckinghamshire

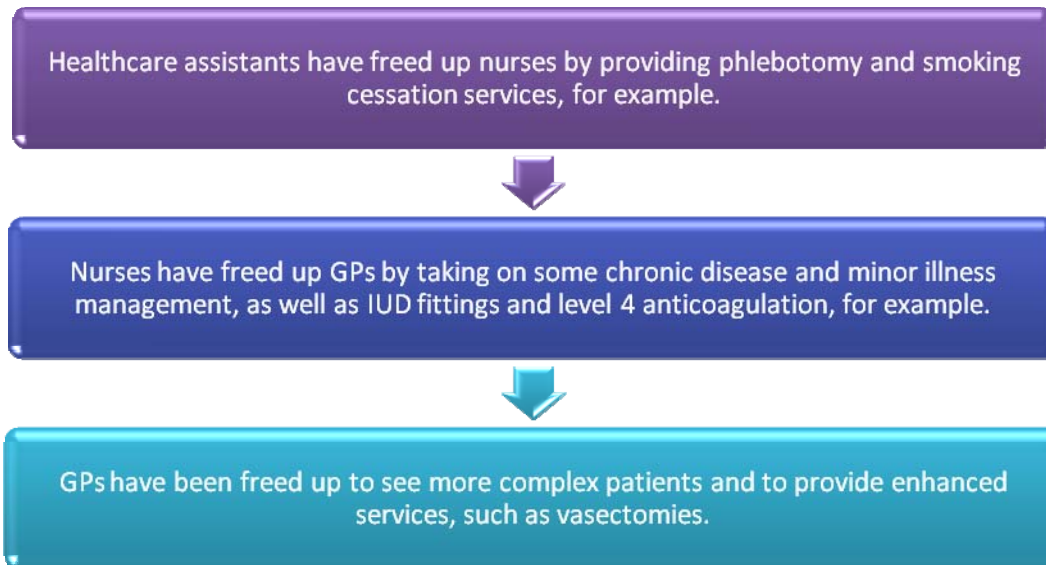
Key characteristics

- A provider organisation, that brings together three neighbouring practices.
- It was established 1998. The three practices retained their own practice agreements and the Westongrove Partnership agreement became the vehicle for federated working.
- Covers a population of around 27,000 patients.
- It is comprised of nine GP partners; each leads in a particular area, including clinical governance, contracting, and GP training. They are supported by a general manager, an operations manager, a finance manager and a nurse manager. Day to day issues at each site – such as staff rotas and patient queries – are dealt with by a site manager.
- Westongrove Partnership holds a PMS contract with the PCT; the way the contract is delivered at the three sites varies according to the individual partnership.

Learning – engaging the wider primary care workforce

- A key feature of the Westongrove Partnership is its emphasis on capitalising on a broad skill mix of health professionals. Amongst the staff it employs are 12 salaried GPs, and 20 nurses and healthcare assistants with skills and experience ranging from basic phlebotomy to nurse practitioner.
- It has been particularly keen to draw on the skills of nurses and healthcare assistants, both to expand the range of services it is able to offer and to free up its general practitioners to provide more care for their more complex patients. It has a big nursing team of fifteen nurses and five healthcare assistants, who are shared across the practices. These include eight nurses specialising in minor illness nursing, five nurses specialising in chronic disease management, and a treatment room nurse.
- The emphasis on multidisciplinary working carries through to the Westongrove Partnership's strong focus on education and training. Louise Grant, General Manager of the Westongrove Partnership identifies education and training as 'a huge area of benefit' as a result of the practices having joined together. For example, GP trainees benefit from shared tutorials, practice swaps, and a wider clinical field to draw upon. Education and development programmes for the wider primary care workforce benefit from a cross-fertilisation of ideas and a wider clinical field. It has also helped to strengthen clinical governance – for example, significant event reviews are informed by a wider clinical field of opinion and expertise.

- Overall, the Partnership has greater capacity to provide enhanced services, including more staff to move between practices – which means closer to patients – and a greater range of skills to draw upon.



Key advice

- 'The primary benefit of freeing up GPs is for them to see more complex patients – i.e. if nurses are doing long term conditions reviews and minor illness it improves access for more complex conditions or for those above a nurse's expertise. For example, better for a patient with an ear infection to be seen by a nurse so that there is an appointment free for the patient with cancer', says Ms Grant.
- She advises GPs to help the wider primary care workforce identify the values that they share in common. She says: 'While GPs and managers may see the benefits of coming together with other practices, this may not be so clear for other staff. A lesson from us is not to force a new corporate identity too far'.

6. IMPROVING QUALITY & SAFETY

INTRODUCTION

This section explores the opportunities for Federations to improve the quality and safety of patient care. For many this is one of the chief benefits of the federated model.

In the [vision and overview](#) we lay out a framework for quality and safety improvement. The [Optimus](#) case study provides a good example of a Federation with a major focus on quality and safety improvement including working towards the [RCGP Quality Practice Award](#). In [further advice](#) we provide further practical guidance for Federations on strengthening clinical governance within practices and across the Federation. In [resources](#) we provide an overview of the RCGP Quality Practice award as well as links to relevant toolkits and guidance on good governance and driving quality improvement in primary care.

VISION & OVERVIEW

Working within a Federation provides practices with new opportunities to strengthen the quality and safety of the care they deliver. The Framework established by the National Patient Safety Agency ("[Seven steps to patient safety for primary care](#)") provides an evidence based template for best practice.

THE SEVEN STEPS TO PATIENT SAFETY

STEP 1	Build a safety culture Create a culture that is open and fair
STEP 2	Lead and support your staff Establish a clear and strong focus on patient safety throughout the organisation
STEP 3	Integrate your risk management activity Develop systems and processes to manage your risks and identify and assess things that could go wrong
STEP 4	Promote reporting Ensure your staff can easily report incidents locally
STEP 5	Involve and communicate with patients and the public Develop ways to communicate openly with and listen to patients
STEP 6	Learn and share safety lessons Encourage staff to use root cause analysis to learn how and why incidents happen
STEP 7	Implement solutions to prevent harm Embed lessons through changes to practice, process and system

Following these seven steps is the path to strong clinical governance.

The vision in practice

[Optimus](#), a Federation of seven practices, provides a good example of how practices coming together can drive up quality. A key objective for Optimus is to ensure patients receive care in “a

quality assured environment". The shared management resource has been used to help develop a governance structure including sharing and developing best practice, a regular programme of audit, and benchmarking. Each practice within Optimus is also working towards the [RCGP Quality Practice Award](#).

QUALITY & SAFETY – FURTHER ADVICE

Martin Rowland & Richard Baker's *Clinical Governance: a practical guide for primary care teams* (see resources & extra advice) provides useful practical advice for practices and Federations wishing to strengthen clinical governance and improve quality and safety.

They help set clinical governance in a primary care context, and set out some of the key attributes of clinical governance in this context.

Clinical Governance is:-

- Managing your practice well to provide high quality care
- About every member of staff recognising their role in providing high quality care
- About improving care using whatever method is most suitable
- Being externally accountable for your care.

Rowland and Baker set out some first steps - which can be applied to work within a Federation

- *Where are we now?*
What governance mechanisms are currently in place?
Which practices are already accredited under the QPA [Quality Practice Award](#) scheme?
- *Who is going to be responsible for clinical governance in the Federation?*
What support will they have?
What dedicated time will they be able to give to the role?
- *What governance mechanisms will the Federation put in place?*
Consider - risk management; information systems; audit; significant event audit; professional development; identifying local priorities

They also suggest means of identifying problem areas - some of which can be applied to Federations, in particular:-

- Audit of particular conditions - this could be linked to national guidance and priorities
- Obtaining feedback from clinical supervisions and training
- Significant event audits
- Reviewing complaints
- Surveying patients

Following this guidance will require the Federation to identify a clinical governance lead and develop a clear plan of action.

OPTIMUS, Lincolnshire

Optimus is a Federation of seven practices and provides a good example of how practices coming together can drive up quality.

Key characteristics

- The Optimus consortium of practices was launched in 2008. It is in the process of becoming a company limited by shares.
- Optimus is comprised of seven practices (30 GPs), covering a population of around 50,000 in the urban area of central Lincoln.
- The seven practices each contribute £2,000 per year to cover the cost of a part-time chief executive. The executive team, which includes two (unpaid) GPs, is responsible for planning consortium activity. Plans then go through the strategic board. Each practice is invited to send a GP and practice manager to the monthly board meetings (each practice has one vote). Implementation of policies is led by the seven practice managers.
- See <http://www.birchwoodmedicalpractice.com/Optimus%20Group.htm>

Learning – improving quality & safety

- An emphasis on improving quality and safety is embedded in the core functions of Optimus, which include an objective to support practices to work collaboratively, benchmark clinical standards and share management good practice (such as achieving and evidencing Care Quality Commission standards). Optimus seeks to ensure that the patients of its practices ‘receive the best care in a quality assured environment’.
- Optimus is signed up to the Quality Practice Award (QPA) scheme, run by the RCGP, which aims to provide assurance around areas such as clinical care, policies, and team values. Each Optimus practice works individually for the QPA, but learning is shared across the consortium (e.g. one practice developed an audit tool for smoking cessation, which was then run across the seven practices). The Optimus board receives information about the performance of practices, including quality markers, as part of the QPA scheme. The aim is to get all seven practices to the same high standard.
- Dr Sunil Hindocha, one of the GP executive leads, explains that the seven practices were already delivering ‘pretty high standards’ before the consortium came together. However, there have been real improvements in patient care in clinical areas, like hypertension, where Optimus has focused attention. Participating in the QPA scheme has resulted in the practices undertaking more audits, which has also led to service improvements. Benefits in terms of quality have also come from the sharing of expertise, skills and resources across the seven practices.

- As it develops, Optimus intends to provide patients with a 'kite-mark' designed to reassure them of the quality of care they can expect from their practice. Member practices that fall below expected standards will be offered support to understand and remedy any issues. It is envisaged that any practices wishing to join Optimus would need to demonstrate how they meet standards for accreditation or have a plan on how to get there quickly.
- Another way in which Optimus supports quality and safety is through the collaborative development of policies that are shared across the seven practices. These include policies around health and safety, waste management, and new staff induction – see [list of policies](#). A website is under development, along with an intranet that will enable easy access for member practices to consortium-wide policies and other documents.
- Once a policy has been agreed, all member practices are committed to following it – there is no opt out. Entry and exit criteria have been agreed within the consortium, and processes have been established for managing practices that are underperforming or refuse to comply.
- An emphasis on patient and public engagement underpins Optimus' approach to quality. NHS Lincolnshire (the PCT) has helped to develop a structure for patient and public involvement (PPI). Each practice has its own PPI group and there is a consortium-wide Patient Liaison Group, which meets four times a year.

Key advice

- 'You need to be clear about the purpose of the Federation. This is about primary care – the 'day job' – making sure that we, as providers, deliver as we should be', says Dr Hindocha.
- He adds that federated working can grow very quickly once like-minded colleagues come together. 'Optimus started from two of us meeting up. It is not about the practices, it is about colleagues working together for their patients.'

7. TRAINING & EDUCATION

INTRODUCTION

This section lays out the opportunities offered to Federations to develop training and education for their staff, not only to support individual professional development but to support wider strategic objectives, for example the development of new services.

In [vision and overview](#) we summarise some of the examples of good practice that we found and the opportunities that these bring. The [case studies](#) lay out the detail of the case studies approaches to training and education. In [resources](#) we provide links to a number of organisations providing education for people working within primary care including electronic and remote learning programmes.

VISION & OVERVIEW

Federations can take a strong lead on the education and training of all staff, medical and non medical, and link this activity to local service, quality and safety priorities.

The vision in practice

Many of the Federations that we spoke to had taken a lead in developing training for staff and helping to set local training priorities for existing programmes. Our two case studies provide some useful examples of good practice.

[Brent GP Federation](#) a PBC consortium in north London, provides a number of examples of good practice in this area including:-

- Undertaking a skills and capacity audit
- Providing training to support new care pathway implementation
- Providing access to online resources
- Targeting training at local priority areas such as referral practice.

[Washington GP Practices](#) provides a good example of a Federation that has developed learning activities not just for GPs but for nurses and other practice staff including practice managers.

Key messages and advice

- Federations give practices new opportunities to share best practice and develop new skills in their staff.
- Sharing best practice across practices can be as beneficial for managerial and nursing staff as it is for GPs.
- Peer review provides a powerful learning opportunity for GPs.

BRENT GP FEDERATION, Middlesex

While the primary function of the Brent GP Federation is practice based commissioning it still provides a good example of some of the mechanisms for and benefits of training and education within primary care.

Key characteristics

- A practice based commissioning (PBC) consortium that brings together five PBC clusters to provide a cohesive voice to commissioning issues that require a borough-wide approach.
- Established in 2008; no formal legal structure.
- It covers 71 practices and a registered population of around 356,000, in one of the most ethnically diverse communities in the UK and the 53rd most deprived borough in England.
- The five clusters are each comprised of between 10 and 16 practices, and have registered patient populations of between 56,000 to 83,000.
- It is in the process of setting up a provider-arm social enterprise company, limited by guarantee, to enable it to bid to provide an urgent care centre.
- For more details go to www.brentfed.nhs.uk

Learning – training & education

- The Brent GP Federation supports GP development and training in a number of ways. For example:
 - it has undertaken a skills and capacity audit, which will be used by each cluster to support applications for training or funding;
 - its website contains useful links for GPs, including tips on evaluating the reliability of online medical information;

<http://www.brentfed.nhs.uk/info.aspx?p=1&pr=WEMPBC>
 - it supports peer review of referrals by suggesting a framework for practices to undertake their own educational audit of referrals – see [‘A practice-based format for discussing GP referrals.’](#)

- The Federation is clear that implementing changes to care pathways relies on local GPs having access to appropriate training support. Two Brent wide pathway plans have been agreed, and the clusters also have their own plans that, once proven to be effective, are shared across Brent. A good example of this is the musculoskeletal (MSK) Plan developed by the [Kilburn PBC Cluster](#).

- The focus of the MSK plan has been twofold: to up skill GPs in the management of common muscular skeletal conditions, and to provide quick access to physiotherapy for a wider referral criteria. The overall aim is to reduce the number of patients who develop chronic problems.
- During 2008 the Kilburn Cluster commissioned a series of 14 training sessions for GPs within the cluster on common MSK conditions. These training sessions were provided in practice premises; each session lasting an hour. A physiotherapist was commissioned to provide the training and paid for out of practice based commissioning incentive money.
- Between 70% and 80% of GPs in Kilburn attended the training. Feedback from GPs was very positive and patient information materials supported GPs to put their training into practice.
- As a result of its education sessions the Kilburn locality witnessed a reduction in Trauma and Orthopaedic acute referrals of 17.5% during April – July 2009, compared to the same period the previous year. Across Brent, one other Federation cluster experienced a small decrease; the other three all had increased referrals. The other four clusters are arranging similar education sessions on the back of Kilburn’s success. An evaluation is underway of the physiotherapy therapy service that was commissioned under ‘any willing provider’.

Key advice

- Jenny Poole, Kilburn Management Lead says that local engagement is crucial to forming a cohesive local group. ‘If that local group wants to form an overarching Federation, it’s really important that you have your ground force’.
- In terms of education and training, Ms Poole say, ‘GPs learn from each other and peer learning can really get them debating and change their practice’. Across the Federation data on referral patterns is shared and discussed in an open and supportive way.

TRAINING & EDUCATION - CASE STUDY 2

WASHINGTON GP PRACTICES, Tyne and Wear

Washington GP Practices provides a good example of a Federation that has developed learning activities not just for GPs but for nurses and other practice staff including practice managers.

Key characteristics

- Second attempt by GPs within the new town of Washington, to create a successful Federation – GPs learnt important lessons about developing a shared vision and mission from their first attempt at federated working.
- Loose association of practices, although preparing to adopt a more formal federated structure.

- Covers population of around 66,000; relatively isolated community close to Gateshead and Sunderland.

Learning – training & education

- With the help of £15,000 of funding from the PCT (bid for as part of practice based commissioning incentive money), a range of educational events have brought together GPs and practice staff within Washington to network, share ideas and skills.



- The events have all had a very positive impact:
 - **GP events:** traditional clinical topics have been the most engaging and received the most positive feedback from GPs.
 - **Practice staff events:** networking and sharing ideas is reported to have been a revelation for practice staff, and practice managers have been freed up to share skills and expertise with each other.
 - **Walk-in centre events:** staff at these centres had previously found it difficult to access good clinical skill courses. The clinical skills training they have received under the collaborative arrangements has been very well received and there are plans to

- **Patient event:** the first patient event was to be held in August 2010.
- Included in the bid for the educational events, were plans to develop a school of primary care education. Dr Ashley Liston, a GP tutor within the patch who led the bid, describes aspirations for a school of primary care education that is multidisciplinary, learner-centred and focused on the local community. It will pull together the four streams of educational events (outlined above) and provide education for GPs, other health professionals, practice staff and patients. Patient involvement will be a key feature. The Federation will support practices in delivering this.

Key advice

- Dr Liston's advice for GPs interested in providing education and training as part of a Federation is to work with a GP tutor to explore the potential. He adds: 'It is the federated model of local people doing something together that they couldn't do individually'.

8. DEVELOPING & REDESIGNING SERVICES

INTRODUCTION

Federations can provide a platform for extended provision of services within primary care, separate but supportive to the GP consortia that are to be established as statutory bodies with the responsibility for commissioning healthcare services. The White Paper “Equity and Excellence: Liberating the NHS” envisages that the Consortium (that is the statutory body) will not be able to provide services but will be able to commission services from its constituent practices providing there are appropriate safeguards against there being any conflicts of interests (hyperlink to section on governance), and with transparency in the decision making process. Addressing [conflicts of interests](#) is discussed further in the [governance section](#).

In this section we describe some of the opportunities for extended primary care provision. In [vision and overview](#) we describe those opportunities and summarise the advice from the [case studies](#) on developing new services. In [further advice](#) we provide some guidance on developing business cases and highlight some of the key legal and regulatory issues raised by providing services. In [resources](#) we provide an overview of the regulatory requirements and links to relevant guidance.

VISION & OVERVIEW

By working together practices can develop new services that improve the quality of patient care, particularly those with long term or chronic conditions, and bring services closer to patients. Practices can also develop more integrated care by creating organisations that incorporate broader elements of service provision including community nursing and some elements of hospital care.

The vision in practice

Two out of three of the case studies for developing and redesigning services are practice based commissioning consortia that used their collective action around commissioning to stimulate new ways of providing services in their practices. The third is an integrated care model. They show the wide range of services that can be developed through joint working and the benefits that they can bring to patients.

[Croydon Federation](#) shows the benefits of bringing a broader range of diagnostics into primary care and shows how use of clinical champions and patient feedback can be valuable aids to taking forward new service developments.

[Colchester Practice Based Commissioning \(PBC\) Group](#) has developed a wide range of new services. We describe here their new screening tools and pathways for at risk patients as well as the development of a new role to help maintain people in their homes.

[LADMS \(Louth and District Medical Services\)](#) provides an example of GPs working together to develop an integrated care model. They have taken over the running of certain elements of their local hospital including the A&E/Urgent Care centre and medical wards.

Case studies' advice on developing new services

- Commissioning and provision need to be clearly separated with transparency in the process and ways of working.
- Actively develop clinical leaders and distribute clinical leadership across practices.
- Use patient feedback and benchmarking as stimulants to change and improvement.
- The business case for new services should be well evidenced and underpinned by financial and activity analysis.
- Continued support for newly developed services can be strengthened through robust evaluation with measurement of the baseline position and the service's impact, including obtaining user and other stakeholder feedback.
- Pursue some "quick wins" to encourage participation and help people see the shared vision in practice.
- Don't assume everyone shares the vision for new services - work hard to engage practices and develop a shared understanding.

DEVELOPING NEW SERVICES – FURTHER ADVICE

A number of our case studies highlight the importance of making a good business case for new service developments. A business case helps obtain management commitment and approval for investment in new services, through providing an evidence-based rationale for the investment. The [OGC](#) provides a range of relevant guidance and materials. This includes a business case check list.

Business Case - Fitness for purpose checklist:

- Is the business need clearly stated?
- Have the benefits been clearly identified?
- Are the reason for and benefits of the service development consistent with the organisation's strategy?
- Is it clear what will define a successful outcome?
- Is it clear what the preferred option is?
- Is it clear why this is the preferred option?
- Is it clear how the necessary funding will be put in place?
- Is it clear how the benefits will be realised?
- Are the risks faced by the project explicitly stated?
- Are the plans for addressing those risks explicitly stated?

A Federation will have to tender to commissioners for service contracts in accordance with the NHS [Principles and Rules of Cooperation and Competition](#). Procurement of health services is also regulated under that Public Contracts Regulations 2006, but the level of regulation is limited because

health services are classified as “Part B”. This means that it is exempt from many of the requirements of an EU-regulated procurement process. However, the effect of the NHS Principles and Rules of Cooperation and Competition and the PCT Procurement Guide is to require commissioners to act in accordance with EU procurement principles of equality, transparency, non-discrimination and proportionality. For example, commissioners must ordinarily advertise tendering opportunities on the Supply2Health website.

If the Federation, as a separate legal entity, wishes to provide services it may have to register with the [Care Quality Commission](#). The [resources](#) section provides further guidance.

DEVELOPING & REDESIGNING SERVICES – CASE STUDY 1

CROYDON FEDERATION OF GENERAL PRACTICES, Greater London

While the primary function of the Croydon Federation is practice based commissioning it still provides a good example of the opportunities to develop services within primary care and some of the means to do this, for example the use of clinical leads to stimulate developments in different clinical areas.

Key characteristics

- Comprised of 16 practices across Croydon, covering an urban population of around 140,000.
- Established in 2007, as a loose association of practices with [a legal accountability agreement](#).

Learning – developing new services

- The Federation has developed a number of award winning and innovative services, redesigned pathways and brought services closer to patients. Three notable examples include around diagnostics; urgent care access; and the use of clinical champions.
- *Diagnostics:* This was one of the Federation’s first projects and brought ultrasound and echo to six practices, which served all of the Federation’s patients. It also enabled practices to make direct referrals for MRI. The new services have reduced waiting times, made services more accessible to patients and avoided referrals into secondary care. The direct access to diagnostics has also enabled a number of care pathways to be redesigned including heart failure, low back pain, musculoskeletal and gynaecology. It took less than three months from conception to implementation to deliver this improved access to diagnostics, and the project won a Health Service Journal (HSJ) award in 2008.
- *Urgent Care Access:* This three-month rapid improvement project helped member practices respond better to patients’ urgent care needs, and was a finalist for an HSJ award in 2009 under the ‘improving access’ category. A baseline assessment of each practice examined capacity versus patient demand, patient experience, and other relevant practice factors (such as receptionist skills, and the way in which telephone calls and home visits were

managed and prioritised). Each practice learnt something different and made different interventions to improve their service as a result. These have included:

- providing extra training for reception staff;
- changing the way in which home visits are prioritised;
- changing telephone systems;
- improved on-line and email access for patients.

At the end of the project 98.6% of 1,200 patients surveyed, positively rated the responsiveness of their GP practice in addressing their urgent care needs. The Federation is now exploring ways in which to improve urgent care for children.

- *Use of clinical champions:* The clinical champion programme began in 2008 with clinical leaders identified for priority areas including heart failure, learning difficulties, cardiac arrhythmias, COPD, paediatrics and mental health. This leadership has proved to be immensely valuable in providing focus and impetus to service improvement, as well as a means of distributing leadership across all sixteen practices. For example:
 - The Learning Disability Champion encouraged practices to undertake extended health checks for their learning disability patients using a specially designed web-based assessment tool, which exposed significant unmet needs.
 - The Mental Health Clinical Champion successfully completed a brief intervention to a psychological therapies pilot, which aimed to improve outcomes and reduce the wait for patients to see a psychologist.

Key advice

- Dr Agnelo Fernandes, one of the Croydon Federation's clinical leaders, gives the following advice for Federations working to develop services:
 - Try and get some quick wins to encourage participation and help people see the shared vision in practice. In Croydon, the quick win was delivering access to diagnostics.
 - Actively develop clinical leaders and distribute clinical leadership across practices, for example as the clinical champions have done for Croydon.
 - Patient feedback and benchmarking can be valuable stimulants to change and improve. In Croydon, this was evident in the Urgent Access programme.

DEVELOPING & REDESIGNING SERVICES – CASE STUDY 2

COLCHESTER PRACTICE BASED COMMISSIONING (PBC) GROUP, Essex

While the primary function of the Colchester PBC Group is practice based commissioning it provides a good example of the opportunities to develop services within primary care.

Key characteristics

- Established as a not-for-profit company, limited by guarantee to undertake commissioning work.
- It has 23 member practices and serves a population of 180,000 patients in Colchester.
- Annual indicative budget of over £140 million.

Learning – developing new services

- Colchester PBC Group has worked with the PCT and the local authority to drive the development of a number of services. Three examples are described below.
- *Screening for Atrial Fibrillation (AF) at Flu Vaccination:* This innovative service enables practices to screen patients for AF – a major cause of stroke – when attending for flu vaccination. Initially 20 practices in the cluster took part, screening 16,079 patients, of which 101 were identified with previously undiagnosed AF. Many of the benefits of this service are long term due to the preventative nature of the scheme. The service has been presented to the National Priority Project on Stroke and has won the Management in Practice Award for the opportunistic AF Screening within the Flu Vaccination programme.
- *GP Care Advisors (GPCAS):* This service was jointly commissioned by the PCT and the local authority following a proposal made by Colchester PBC Group. The role of the GPCAs is to facilitate access to social care and self-help support to help people maintain their independence at home. GPCAs assess the person’s current needs and identify the support that will enable them to remain independent. Four practices employ the GPCAs and manage the provision of this service on behalf of the other practices in the PBC Group. The service is reported to have been very successful and highly valued by patients.
- *DVT Assessment and Treatment Service – with direct access to ultrasound:* This initiative involved the development of a risk assessment tool that, with direct access to ultrasound, enabled GPs to assess the severity and risk of patients with potential DVTs. It has allowed many patients to get immediate reassurance and avoided the need for a hospital visit.

Key advice

- Funding for the development of new services can come from a mix of sources: GP practice contributions (direct and via DES) as well as direct PCT and local authority support.
- Colchester has managed conflicts of interest by creating a clear separation of commissioning and providing. GPs with an interest in providing a service cannot participate in discussions about who should be commissioned and the PCT has overseen all procurements.
- The original business case for new services were well evidenced and underpinned by financial and activity analysis.
- Continued support for newly developed services has been strengthened through robust evaluation with measurement of the baseline position and the impact of the service, including obtaining feedback from service users and other stakeholders.

LADMS, Lincolnshire

LADMS provides an example of GPs working together to develop an integrated care model. They have taken over the running of certain elements of their local hospital including the A&E/Urgent Care centre and medical wards.

Key characteristics

- LADMS – Louth And District Medical Services – is a provider company limited by shares.
- It is comprised of 14 practices in rural Lincolnshire, covering a population of around 100,000.
- All of the 42 GPs belonging to LADMS bought a £1,000 share; other practice staff and also specialists are eligible to purchase shares.
- The [board structure](#) comprises a chair, chief executive, medical director, business director, chief operating officer and four other directors. The directors are employed by LADMS on a part-time basis.
- LADMS has a strong working relationship with Lincolnshire Community Health Services (LCHS), the PCT provider arm, and draws on LCHS structures, for example, in relation to clinical governance and community engagement.
- Six practices (a subset of the 14 member practices) are working more closely, for example by sharing back office functions, and hope to form LADMS Primary Care.

Learning – developing new services

- Poor access to diagnostic services had already prompted LADMS to bid to provide diagnostic services in the community. The 14 member practices started providing echocardiograms in local surgeries, as well as diagnostic MRI and CT scans. Waiting times for echocardiograms dropped from between four and six months to just two weeks; and MRI waits fell from 10 months to less than six weeks.
- LADMS was keen to build on these successes, so when the sustainability of County Hospital Louth, part of United Lincolnshire Hospitals NHS Trust, was in doubt, the 14 practices decided to pursue a more integrated model of care delivery. ‘As a cluster, we focused on the fact that if we didn’t do something, the hospital would shut’, says Dr Neal Parkes, Medical Director of LADMS.
- Ownership of the hospital site transferred from the NHS Trust to NHS Lincolnshire. The PCT then publicly consulted on four models of care, of which one was for LADMS to work with LCHS to run the Accident and Emergency Department/GP led Urgent Care Centre and the medical wards of the hospital, with the secondary care Trust continuing to run the surgical departments.
- LADMS holds a subcontract with NHS Lincolnshire and therefore did not have to bid to run the hospital services. It was awarded a three-year contract as a preferred provider, which

began on 1st April 2010. The changes have meant that hospital consultants, administrative staff and nurses are now employed by LCHS, while LADMS employs GPs and staff grade doctors working within the hospital. Surgical and secretarial staff continue to be employed by the NHS Trust.

- Consultants are reported to have been supportive of the integrated model. 'We had to have consultants on the ground talking to us to develop a safe structure', says Dr Parkes. However, it is too early to assess the impact of this new way of integrated working in Louth. The LADMS board is looking for evidence of impact on patient pathways – by controlling the route patients take and what happens to them, LADMS can then control the budget. Lincolnshire University is being commissioned to undertake a formal evaluation.
- The LADMS directors deliberately chose a legal model that provides them with flexibility in the future. 'We tried to set up a company that is more than fit for purpose than just integrated working with one hospital – it is fit for multiple purposes', says Dr David Hughes, Chief Executive of LADMS. For example, LADMS plans to launch an internet pharmacy, as part of a joint venture, by the end of 2010.
- The requirements LADMS had in terms of legal form included being able to pay NHS pensions and employ NHS staff (should they wish to expand the range of staff they employ within the hospital), TUPE staff across to the organisation, and protect the shares held by people who leave the organisation.

Key advice

- Dr Parkes advises: 'Don't presume that everyone understands and shares your vision. It may not be clear and obvious to all'. Investment of time is needed to engage with key stakeholders to ensure they both understand and share the vision.
- Developing new services requires significant engagement with senior decision makers in commissioning organisations. 'You've got to engage at the top and keep it there because decisions are made at that level', says Dr Hughes
- Good legal advice is key to making sure you adopt the right organisational model for new services.

INTRODUCTION

The White Paper “Equity and Excellence: Liberating the NHS” sets out proposals for the transfer of PCT health improvement functions to local authorities. This will mean that Directors of Public Health will move to local authorities where they will lead the process of joint strategic needs assessments (JSNA) - setting out local health improvement priorities. The aim of a JSNA is to:

- Provide analyses of data to show the health and well-being status of local communities.
- Define where inequalities exist.
- Use local community views and evidence of effectiveness of interventions to shape the future investment and disinvestments of services.

Federations can play a valuable role in helping to address the health needs articulated in a JSNA. This section lays out some of the innovative ways in which GPs working together can support health improvement in their local population.

In [vision and overview](#) we describe some of the opportunities for health improvement and the key advice from the [case studies](#). In [resources](#) we provide links to relevant NICE guidance on public health interventions and NHS Evidence’s National Library for Public Health.

VISION & OVERVIEW

As well as developing new healthcare services Federations provide new opportunities to develop services for their local population that promote health and prevent ill-health. This includes strategies to identify local people at risk of illness and offering them support to address such risks.

The vision in practice

Both the case studies have formed close relationships with their local community in order to develop and provide services that address the needs of their population.

[Salford Health Matters](#) has undertaken a wide range of public health activities working closely with their local public health department to identify pockets of deprivation and high need. They have had particular success with a social prescribing service.

[Pathfinder Healthcare Developments](#) has worked with local community groups to respond to those in greatest need. They are planning a healthy living centre as a focus for their public health activity.

Case studies’ advice on public health activity

- Be really honest about what you believe a GP practice should be all about. Each Federation will need to align their own values, culture and practice.
- Do seek out public health information and advice but don’t be put off by public health data and numbers - this is about local people and their needs.
- You can achieve a lot more by working with others such as those voluntary sector groups already with established community connections.

SALFORD HEALTH MATTERS, Salford

Salford Health Matters has undertaken a wide range of public health activities working closely with their local public health department to identify pockets of deprivation and high need.

Key characteristics

- Salford Health Matters (SHM) was established in 2007 as a community interest company.
- It provides services to a population of over 13,000, from five centres across Salford, including a GP surgery, healthy living centre, and homeless medical project.
- There is a board of directors, including a non-executive, lay chair and three executive clinicians (two GPs, one advanced practitioner). For more details see SHM's [organisational chart](#).
- It is a social enterprise company and a Department of Health Social Enterprise Pathfinder. Any profits are reinvested in health and for the benefit of the local community. The [annual report](#) and [company profile](#) provide further details about the organisation.

Learning – public health

- SHM provides a range of essential primary care services, but its contract with the PCT also has a strong public health focus. It provides all additional and enhanced services currently commissioned by Salford PCT, including sexual health, epilepsy, dermatology, child health surveillance and minor surgery.
- S
HM has a mission to 'add years to life and life to years for 30,000 people', by 2012. A desire to improve the health and wellbeing of the people of Salford drives what it describes as its 'social mission'. Its business objectives are designed to make a broader range of services available for patients, preventing ill health and making it easier to access specialist help. These include, by 2012, providing additional services and opportunities that address the determinants of ill-health for the 3,000 people most in need in terms of unemployment, fuel poverty, mental health and social isolation. Click here to see SHM's full [business plan](#).
- SHM has pinpointed a range of preventative health and wellbeing opportunities, including health trainers, the Expert Patient Programme, social prescribing, community health development workers and developing community activities (for example, exercise, employment, education, housing, food, social support). Securing these opportunities could involve SHM developing projects in partnership with other organisations, securing grant or seeking local authority funding, as well as submitting PBC bids.
- The organisation already supports programmes for healthy nutrition, exercise, social support and personal development. For example, it has established a social prescribing service,

Refresh, giving people access to a wide range of non-medical services to improve their mental health and emotional wellbeing, reduce social isolation and improve physical health. Activities include allotments, laughter workshops, gym passes and art classes. Other services designed to support health and prevent illness include access to primary health care services for homeless people in Salford.

- Neil Turton, Chief Executive of SHM, describes the information systems underpinning its public health activity as ‘high quality’. The public health department of the local council has helped SHM identify pockets of deprivation and high need. SHM has then profiled the population in those areas and designed services to meet the needs of those people, from social prescribing to health awareness campaigns.
- An evaluation of the social prescribing service has demonstrated positive outcomes for 260 people seen: 76% increased well-being, with a reduction in depression; 64% reduced their prescriptions and 55% reduced their use of GPs; 30% decreased or quit smoking and 20% decreased alcohol consumption; 31 people entered into voluntary work and 64 people into training courses.
- The organisation has also seen significant improvements in quality metrics, with an increase in Quality and Outcomes Framework (QOF) scores from 53% to 93% over 18 months. Improvements in access to primary care are also reported, with increased appointments, appointment times, and extended opening hours. Patient satisfaction scores have also increased.

Key advice

- ‘When it comes to public health, the skill mix of staff needed to deliver the model of care needs a lot of thinking through’, reflects Mr Turton.
- He also advises GPs wishing to develop public health activity on a federated basis ‘to be really honest about what you believe a GP practice should be all about. You need to explore alignment in terms of values, culture and practice’.

PUBLIC HEALTH – CASE STUDY 2

PATHFINDER HEALTHCARE DEVELOPMENTS, Smethwick

Pathfinder Healthcare Developments has worked with local community groups to respond to those in greatest need. They are planning a healthy living centre as a focus for their public health activity.

Key characteristics

- A provider organisation that grew out of a ten-year partnership between two inner city partnerships in Smethwick, West Midlands. One of the two GP partnerships, Smethwick Medical Centre, now owns Pathfinder Healthcare Developments (PHD).

- Set up in 2008, as a Community Interest Company (CIC), it is a social enterprise organisation – ‘this means we reinvest our profits and assets for the public good’.
- Covers a population of 12,000; one of the most deprived areas outside London, with a high minority ethnic population.
- PHD is comprised of three practices. It is led by three GP directors, a nursing director, business director and a non-executive director. They are supported by a business manager and a financial manager, as well as staff running specific projects (such as its asylum seeker and refugee service).
- For more details see www.path-finderhd.com

Learning – public health

- PHD has been influenced by national and international research evidence showing that the most effective way to combat poverty and poor health outcomes is to combine services and activity ‘and offer a quality of life solution’. It therefore decided to develop *Smethwick Wellbeing Centre*, a health and wellbeing centre to serve the needs of Smethwick community. ‘We’ve been working in this community for so long but health inequalities are increasing’, says Dr Niti Pall about PHD’s motivations to embark on a project of this scale.
- The Centre is designed to build on learning from investment in Healthy Living Centres, initiated by the Department of Health in 2007. It is PHD’s intention that the Centre will be a sustainable, landmark building, made using innovative sustainable materials so that it creates a carbon neutral footprint. ‘It will be a thriving, healthy environment serving the needs of the local community’.
- PHD is working with two partners to establish the Centre: Sandwell Asian Family Support Services, and the Director of the Public Health Institute in Sandwell. A social enterprise bid raised £500,000 to cover the project management costs. The cost of the total project is estimated to be in the region of £15 million. PHD is seeking funding from the NHS, local authorities, charities, retailers and commercial banks. The aim is to have the Centre up and running within three years.

The Smethwick Wellbeing Centre

primary healthcare services for 25,000 people – Dr Pall’s practice would relocate to the centre and, she hopes, be joined by other general practices

a long-term conditions hub – Diabetes UK, Heart UK and Asthma UK have expressed an interest in providing services from the centre

services for people with learning disabilities – Sandwell Asian Family Support Services, a charity that provides a range of care and support services for South Asian children, young people and adults with a disability, is one of the partners in this project

an academic public health practice unit for Sandwell

retail and leisure facilities that support lifestyle change, such as a health spar and catering college

- Dr Pall maintains that the Centre will be a success if it is used, if general practice is put at the heart of it, and if the community feels a sense of ownership.

Key advice

- ‘Be brave, don’t get scared by the numbers’, is Dr Pall’s advice to GPs considering embarking on an initiative like this. ‘There will be people in your area who can be partners. You have to go and find them’.

10. SHARING BACK OFFICE FUNCTIONS

INTRODUCTION

In this section we look at the opportunities for Federations to share back office functions. Despite the opportunities for practices to make savings through sharing functions this was an area where we struggled to identify many case studies.

In [vision and overview](#) we lay out the main opportunities to share back office functions and the key learning from the [case studies](#). In [resources](#) we provide a link to the LMC Buying Groups Federation which helps GPs negotiate discounts on goods and services.

VISION & OVERVIEW

Sharing back office functions across a number of practices provides opportunities to improve the quality of support available to practices and save money. As the administrative burden within practices grows there is increasing value in a central business function serving a number of practices. Bulk purchasing, shared staffing and other overhead costs also provide opportunities for practices to make savings without compromising patient care.

The vision in practice

Our two case studies offer two different approaches to sharing back office functions.

[Badger](#) has created distinct organisations to provide shared services, for example, one that provides an estates management function.

[Salford Health Matters](#) has set up a central business unit to provide support for human resources, information technology, finance, contracts and performance, and patient involvement.

Case studies advice on sharing back office functions

- Don't forget that people and relationships are central to whether this works or not - invest time in developing a shared culture and trust between practices.
- It is important to hold onto a common vision of what the practices are trying to achieve.
- Agreements should also be formalised and written down. Legal advice can be useful here.

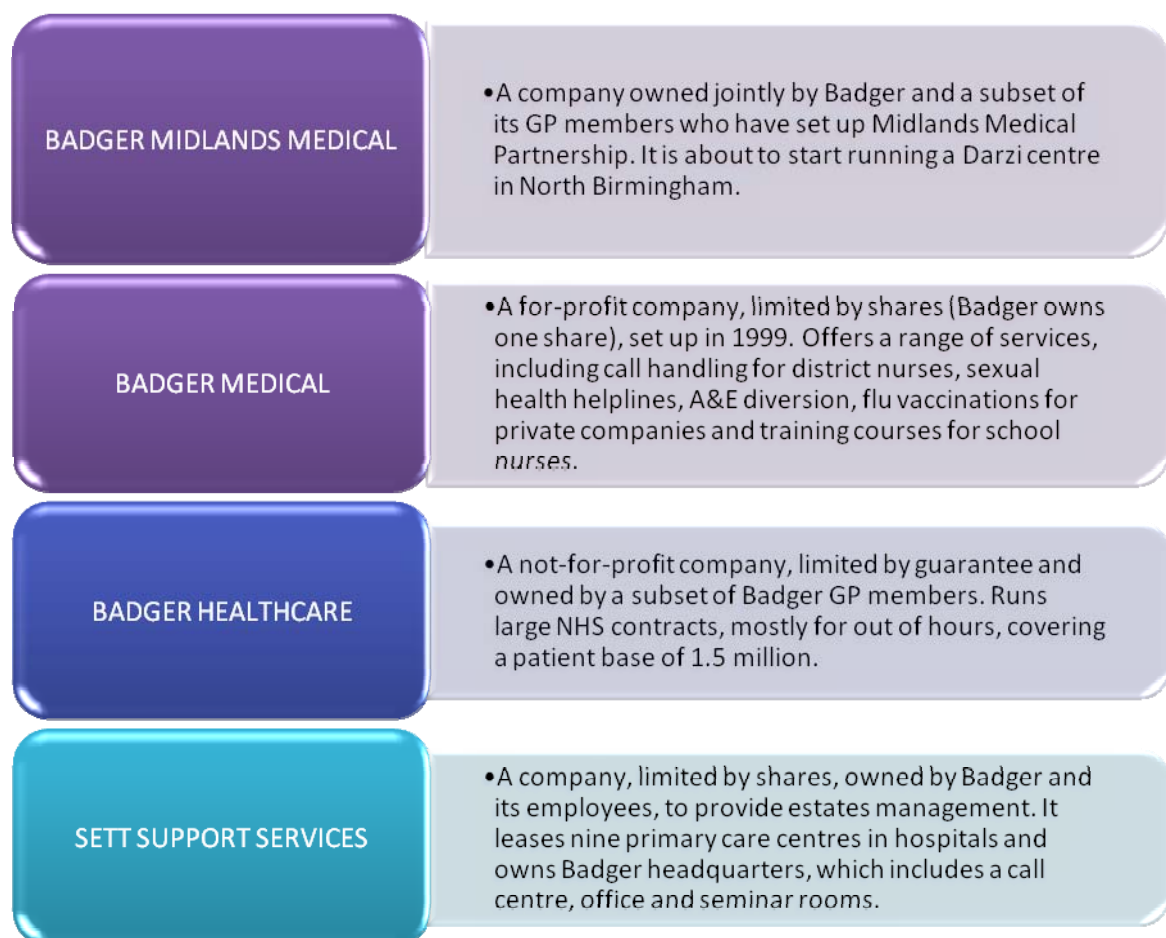
SHARING BACK OFFICE FUNCTIONS – CASE STUDY 1

BADGER, Birmingham

Badger has created distinct organisations to provide shared services, for example, one that provides an estates management function.

Key characteristics

- Badger, which stands for *Birmingham And District GP Emergency Rooms*, is an out of hours cooperative.
- It was set up in 1996 as a company limited by guarantee.
- Over 300 clinicians (250 GPs and 50 nurses) in 90 practices have opted into the cooperative, covering a patient base of 500,000.
- The cooperative developed on the back of a strong corporate culture amongst GPs on the east side of Birmingham.
- Badger's success led to approaches to take on other work, which did not sit well with its ethos as a mutual, not-for-profit organisation. So it decided to establish other companies, each serving a different function and providing a range of services.



Learning – sharing back office functions

- Badger is a mutual, so its key organising principle is that members provide services for each other. The primary focus has been on providing out of hours services and cover for unscheduled care for GPs who have opted in to the cooperative.
- There are other ways in which Badger members share resources. Member practices can draw on its application forms, for example, for doctors wishing to work with Badger as [associates](#) or other documents, such as [staff feedback forms](#).
- Badger also provides one of the original GP vocational training programmes for out of hours, and a Continuing Professional Development (CPD) club focused on out of hours and providing around 20 sessions a year.
- Badger has its own human resources (HR) department and payroll and has been approached about providing HR services to local practices, but has not yet explored the potential here.
- Dr Fay Wilson, Medical Director of Badger, describes the buy-in that being part of a cooperative creates. Staff turnover is reported to be low amongst call centre staff, as well as GPs and nursing staff. A sense of belonging is also important. 'It is about being part of something that goes beyond the function – part of an organisation that does other things for them, such as peer support'.

Key advice

- 'You need to be continually thinking about individual practices and individual patients, but have the big vision in mind', says Dr Wilson.

SHARING BACK OFFICE FUNCTIONS – CASE STUDY 2

SALFORD HEALTH MATTERS, Salford

Salford Health Matters has set up a central business unit to provide support for human resources, information technology, finance, contracts and performance, and patient involvement.

Key characteristics

- Salford Health Matters (SHM) was established in 2007 as a community interest company.
- It provides services to a population of over 13,000, from five centres across Salford, including a GP surgery, healthy living centre, and homeless medical project.

- There is a board of directors, including a non-executive, lay chair and three executive clinicians (two GPs, one advanced practitioner). For more details see SHM's [organisational chart](#).
- It is a social enterprise company and a Department of Health Social Enterprise Pathfinder. Any profits are reinvested in health and for the benefit of the local community. The [annual report](#) and [company profile](#) provide further details about the organisation.

Learning – sharing back office functions

- SHM purposefully set up a central business unit to coordinate and rationalise activity across the three practices in areas such as human resources, information technology and informatics, finance, contracts and performance, and patient involvement. The central business unit has its own building (away from the three practices) and dedicated staff, including a chief executive, financial manager, and a contracts and performance manager. Team leaders are based at each of the three sites.
- This model has benefits in terms of economies of scale, and it allows the organisation to develop expertise and skill-up staff in key areas, says Neil Turton, chief executive of SHM. Contract performance and human resources are distinct specialisms within the organisation, for example.
- An intranet provides staff across the three sites with access to organisational policies and other information online, including SHM's common clinical system. Mr Turton highlights training and payroll as other 'quick wins'.
- Mr Turton describes SHM's central business unit as 'upwardly scalable' and adds that the organisation is able to 'absorb easily' other practices. SHM will put this to the test if it wins a bid currently underway to take on another practice.

Key advice

- 'There is loads of really useful information available about how to form a good partnership – people and relationships are at the centre of this', says Mr Turton. He adds: 'Enshrine agreements in something contestable and transparent and don't be shy about using a lawyer!'

11. WORKING WITH AN EXTERNAL PARTNER

INTRODUCTION

This section looks at the opportunities and challenges for Federations of working with an external partner.

In [vision and overview](#) we describe what an external partner can bring to Federation and the key ingredients to making the relationship work. In [further advice](#) and [resources](#) we provide some more evidence on what contributes to successful partnership working. Finally our two [case studies](#) look at the relationship from two different angles - one from the Federation perspective and the other the external partner.

VISION & OVERVIEW

As described in the first section - “Where do we begin?”, establishing a Federation can be a daunting task and demands new skills and capabilities of general practice. An external partner can help provide those missing skills and give impetus to change. They can also provide skills to support service development as well as supporting the Federation’s corporate functions. See diagram below.



The vision in practice

15% of the respondents to the RCGP online survey said that their Federation was working with an external partner. The case studies provide a description of that relationship from two perspectives, the GP Federation and the external partner. The [Pathfinder Healthcare Developments](#) example describes a successful partnership between a Federation and a private company to develop a new model of care for high risk patients. The [Assura](#) example provides a distillation of Assura's experience as a commercial organisation supporting GPs to work in Federations.

Advice from the case studies on engaging with an external partner

- Being very clear about what the partnership with an external partner aims to deliver
- The importance of a "like-minded approach" between the external partner and the Federation
- Ensuring the external partner can be flexible and respond to the Federation's specific needs but the Federation also being open to new ways of doing things

FURTHER ADVICE

Existing research and practical experience highlights the following key ingredients for successful partnership working with external organisations ([Naylor & Goodwin 2010](#))

- Shared vision, values and culture
- Clearly articulated goals which are understood by both partners, and which are defined in terms of the client's needs rather than the consultant's expertise and products
- Identification of clear evaluation criteria by which success will be judged
- Agreement between client and consultant around the best means of achieving these goals, including the requirements and expectations of both parties
- Flexibility - external partner not imposing a "ready made" solution
- Commitment, buy-in and support from all the members of the Federation
- Honest communication, ideally with a specified individual acting as a point of liaison between the two parties
- In order to secure buy-in, leaders will need to actively communicate the purpose of working with an external partner at an early stage with all members of the Federation.

PATHFINDER HEALTHCARE DEVELOPMENTS, Smethwick

The Pathfinder Healthcare Developments example describes a successful partnership between a Federation and a private company to develop a new model of care for high risk patients.

Key characteristics

- A provider organisation that grew out of a ten-year partnership between two inner city partnerships in Smethwick, West Midlands. One of the two GP partnerships, Smethwick Medical Centre, now owns Pathfinder Healthcare Developments (PHD).
- Set up in 2008, as a Community Interest Company (CIC), it is a social enterprise organisation – ‘this means we reinvest our profits and assets for the public good’.
- Covers a population of 12,000; one of the most deprived areas outside London, with a high minority ethnic population.
- PHD is comprised of three practices. It is led by three GP directors, a nursing director, business director and a non-executive director. They are supported by a business manager and a financial manager, as well as staff running specific projects (such as its asylum seeker and refugee service).
- For more details see www.path-finderhd.com

Learning – working with an external partner

- PHD highlights a strong history of working with partner organisations to deliver new ways of tackling health inequalities. One of its most successful examples of joint working has been its collaboration with Aetna, one of the largest health maintenance organisations in the world (www.aetna.com). The collaboration has centred on five [redesign projects](#), one of which is a [care management programme](#).
- ‘The reason we sought out an external partner is because we didn’t have the know-how locally’, says Dr Niti Pall, Chair and Clinical Lead for PHD. Dr Pall met with a number of potential partners, including BUPA and Humana, before deciding to work with Aetna. One of the main reasons Aetna was chosen was for its enthusiasm to develop a bespoke solution in partnership (rather than provide an ‘off-the-shelf’ product).
- A programme board was set up, which meets every fifteen days. This is ‘strategic and drain blocking’ and the centrepiece of the joint working. The board is comprised of GP leads, Aetna representatives, the Chair of PHD’s Patient Participation Group, and members of the operational team running the programme. Aetna provides a project manager, who works to the programme board.
- About £500,000 was raised to run the Programme. Half of this was raised through Big Issue Invest, an ethical investment bank and subsidiary of *The Big Issue* magazine, which invests in

social enterprises (to find out more go to www.bigissueinvest.com). Aetna contributed funding and the PCT paid for the risk stratification.

- An independent evaluation of the programme has revealed positive patient feedback, with 90% of patients reporting satisfaction with the way the programme has been run, the services provided and their health status. A six month study on urgent admissions confirmed that patients enrolled in the programme had half the number of urgent admissions compared to the same time period a year before the programme was implemented, and compared with a control group of similarly risk stratified patients. In practice, this has meant the avoidance of 200 hospital admissions within a six month period.
- The Programme has not made any money, and profit has not been a motivator. Vincent Sai of Aetna says that the motivation for Aetna in undertaking the joint venture has been ‘to demonstrate our ability to translate our know-how around commissioning into a UK setting, and be part of a very meaningful innovation’.

Key advice

- Dr Pall has the following advice for GPs considering collaborating with an external partner: ‘Check out the capability of potential partners – Google them, talk to them, and ask other people what they know of them. A lot of it is about finding a partner that feels right and has a like-minded approach’.
- Dr Pall suggests GPs ask whether the external partner can be sufficiently flexible, or whether they are likely to prescribe a ready-made solution.
- Finally, check all clinicians are onboard, as well as other members of the team, particularly practice managers and patient participation groups. ‘The team have got to want to do it, or it won’t work’, says Dr Pall.
- Aetna’s Vincent Sai has the following advice: ‘Identify your need first and whether you have the skills yourself. Then be very open about looking to others for help. Be open-minded and don’t shut out options’.

WORKING WITH AN EXTERNAL PARTNER – CASE STUDY 2

ASSURA MEDICAL

Key characteristics

- Works as a joint venture partner with groups of GP practices in the form of limited liability partnerships (LLP).
- There are 30 Assura GP partnerships spread across the country; they vary in size from 6 to 27 practices. They provide a range of NHS services, from large walk-in centres and GP

practices, to intermediate services (such as musculoskeletal services and dermatology), services designed to prevent admission, and support services (such as a learning disability service).

- The Assura GP partnerships are led by the GPs involved, who form a majority on the board of the LLP.

Learning – working with an external partner

- ‘Securing a contract to provide an innovative service, implementing it smoothly, providing a high standard of care for patients which achieves high satisfaction and good clinical outcomes, generating savings for PCTs and income for the partnership are all measurable achievements of successful partnership working’, according to Dr Vivienne McVey, Medical Director of Assura Medical.
- The key factors needed for partnerships to succeed are:
 - a shared vision, values and culture
 - a commitment to being a partnership that is well understood by all involved
 - honest communication
 - an organisational and decision-making structure which is fit for purpose
 - clearly understood roles, accountabilities and responsibilities described in an appropriate legal framework to protect all those involved
 - excellent management
- A shared vision and values is particularly important. Assumptions can easily be made about the values of healthcare organisations (both within and outside the NHS). Whilst there may be common themes (such as providing high quality care for patients), underlying values may be very different and need to be explored. Examples of this are to what degree the organisation wishes to be competitive with others, the extent to which the organisation believes the pursuit of efficiency or profit drives up quality, and its attitude towards taking risks.
- The financial base is also important. The partnership needs to have enough financial stability to assure PCTs and others of its credibility, and enough investment to enable it to keep going if it loses a contract, for example.
- Partnering with a commercial organisation means that the partnership will be classed as an independent healthcare provider. The requirements of both quality and financial regulation (including pension provision for staff providing NHS services) for independent organisations providing NHS services in the community are different to equivalent NHS providers.
- Partnership working with an organisation with a national footprint can provide the opportunity to form new support networks with other GPs doing similar things across the country.

Key advice

- 'Successful partnership working occurs where the partnership is clear about what it wants to achieve as this determines the skills and functions needed. Success is more likely where the partners between them cover the range of functions and skills needed and use these skills to best effect to create a thriving business', says Dr McVey.

Legal advice and resources

COMPANY LIMITED BY SHARES (CLS)

Key Features

- An incorporated entity formed for the purpose of operating a business.
- Commonly used for profit-maximising businesses in the private sector, but can be adapted to incorporate [social enterprise](#) characteristics.
- Owned by its members ('shareholders') whose liability is limited to the amount unpaid on their shares (this is what is meant by 'limited liability').
- In exchange for shares, the members are commonly entitled to a distribution of profits by way of dividends. They are also able to benefit from capital appreciation in the value of the business by selling their shares to third parties (provided there is a market for them).
- Shares can be formed in different classes in order to attach different rights to each class. So, for example, employees can own a distinct class of shares.
- A two-tier structure separates ownership and management: the daily control and management of the company is delegated to the Board of Directors. Members can remove directors and usually reserve the right to appoint them also.

Advantages and Disadvantages

- The benefits of incorporation: a separate legal entity independent of its shareholders or members, and limited liability: beyond paying for their shares the shareholders or members have no further liability for the debts or obligations of the company.
- Offers a range of methods for raising finance. It can be financed by grants, loans (secured and unsecured) and by equity. Dividends are paid from generated surpluses and are not, therefore, a cost of the business (unlike interest on a loan). Shareholders are only rewarded if there are profits available for distribution.
- Eligible to hold a PMS, GMS, SPMS, and APMS contract under the NHS Act 2006, and provided that it meets the right ownership criteria can qualify as an Employing Authority for the purpose of accessing the NHS Pension Scheme under the NHS Pensions Scheme Regulations 1995 (the Regulations).

COMPANY LIMITED BY GUARANTEE (CLG)

Key features

- An incorporated entity, owned by members whose liability is limited by the guarantee that they give to the company (usually up to £1) rather than shares.
- Shares the same two tier governance structure as a [CLS](#).

Advantages and Disadvantages

- The classic not-for-profit vehicle – a relatively simple structure conferring the benefit of limited liability while making it difficult to dispute profits and so allowing any surpluses to be applied for the company’s purposes instead.
- This type of company can also be registered as a [Community Interest Company \(CIC\)](#) under the Companies (Audit, Investigation and Community Enterprise) Act 2004, or as a [charity](#), provided that a charitable purpose can be demonstrated (this may offer tax benefits but the entity will be subject to the Charity Commission’s highly regulated regime).
- A CLG which has a contract with a PCT to provide Out-of-Hours services, or which is sub-contracted by a GMS/PMS/SPMS practice or an approved APMS contractor to provide Out-of-Hours services, can be an Employing Authority for the purpose of accessing the NHS Pension Scheme.
- The fact that there are no shares means that it is difficult to realise income and capital value in the business. It is also not possible to raise funds through equity finance.

COMMUNITY INTEREST COMPANY (CIC)

Key Features

- Specifically designed for organisations wishing to further social objectives and reinvest profits for the public good. Used for organisations that do not require, or cannot obtain, charitable status, since a CIC cannot be registered with the Charity Commission.
- Must be set up in the form of either a [CLS](#) or a [CLG](#). The laws and characteristics relevant to the CLS or CLG model therefore apply to a CIC, depending on which form the CIC adopts.
- Must satisfy a community interest test (‘whether a reasonable person could consider the CIC activities to benefit the community’). An annual public report is required detailing activities undertaken to pursue the interest and involvement of stakeholders.
- Regulated by the CIC Regulator and the regulation is intended to be ‘light touch’. However, the CIC Regulator will respond to complaints from stakeholders and has considerable powers to act to protect the community interest.
- Prohibited from transferring its assets, other than for full consideration, except to another asset locked body (such as a CIC or a [charity](#) or where the transfer is made for the benefit of the community. For this reason a CIC’s constitutional documents will incorporate an asset lock as well as a cap on distribution of profits (see below).
- Can accept grants and take out secured and unsecured loans in the same way as any other type of company. A CIC set up in the form of a [CLS](#) will also be able to raise equity finance from external investors.
- A CIC set up in the form of a [CLS](#) is able to distribute dividends to members of (from April 2010) up to 20% of the paid up value of shares. There is a total cap on distribution of profits of 35% - in other words, at least 65% of profit must be reinvested in the company.

Advantages and Disadvantages

- The use of a CIC presents a number of benefits: [social enterprise](#) objectives incorporated in its constitution (income and asset lock); separate legal entity and limited liability to members; monitored by a regulator to ensure adherence to the community interest test; profit and not-for-profit options available; public recognition as a social enterprise.
- A CIC set up as a [CLS](#), can qualify as an Employing Authority for the purpose of accessing the NHS Pension Scheme, subject to putting in place the right contractual and ownership arrangements. Also, the ability to offer dividend payments allows a CIC set up as a CLS to attract external investors and reward shareholders financially.

INDUSTRIAL AND PROVIDENT SOCIETY (IPS)

Key features

- An incorporated entity which operates a business either as a co-operative or for the benefit of the community (Bencomm).
- Both types of IPS have a share capital, but it is usually not made up of equity shares like those in a [CLS](#) (which can appreciate or fall in value); rather they are par value shares, which can only be redeemed (if at all) at face value. The profits and losses of an IPS are thus the common property of the members. The share typically acts as a "membership ticket", and voting is on a "one member one vote" basis. Profit distribution is permitted.
- An IPS Bencomm may be classified as an 'Exempt Charity' under HM Revenue and Customs (HMRC) rules to give it broadly the same benefits as a registered [charity](#) (it cannot obtain charitable status through the Charity Commission).
- A Bencomm which is not an Exempt Charity may opt to incorporate an asset lock in its constitution similar to the statutory asset lock for [CICs](#).
- An IPS has a two tier governance structure, with a committee of management accountable to a wider membership.

Advantages and Disadvantages

- An IPS set up as a not-for-profit body corporate, which has a contract with a PCT to provide Out-of-Hours services, or which is sub-contracted by a GMS/PMS/SPMS practice or an approved APMS contractor to provide Out-of-Hours services, can be an Employing Authority.
- The IPS model can be inflexible and cumbersome to operate in practice. The existing piecemeal legislation is complex and its review and consolidation is currently underway.

Co-operative societies are run for the mutual benefit of their members, with any surplus usually ploughed back into the organisation to provide better services and facilities.

Bencomm societies are run for the benefit of the community and provide services for people other than their members. There need to be special reasons why the society should not be registered as a company. A Bencomm is likely to be more suitable for a social enterprise than a co-operative society where services are provided beyond the membership.

CHARITY

Key Features

- An organisation (including a [social enterprise](#)) must be set up for the public benefit and must have, and carry out, wholly charitable purposes and activities. It will not be possible to set up a healthcare charity which has the benefit of its employees as its charitable purpose.
- It is entitled to trade as the means of delivering its objects without being subject to corporation tax on profits from primary purpose trading.
- It can be set up as a [CLG](#), a Charitable Incorporated Organisation (CIO) or as an unincorporated organisation, usually an association of members or a trust.
- A [CLG](#) is the classic charitable vehicle – it is a relatively simple structure conferring the benefit of limited liability on members and allowing any surpluses to be applied for the company's purposes. Employees can be members of a charitable CLG. A charity established as a CLG will be subject to dual registration with Companies House and the Charity Commission and will be regulated under both company law and charity law.
- Apart from reimbursement of expenses, directors of a charitable CLG can only receive a financial benefit from the charity (including remuneration) with the consent of the Charity Commission. This means that CLG charities are required to separate the Board of Directors from the management team, creating an extra layer of governance.

Advantages and Disadvantages

- The main advantage of a Charity is its tax regime. This is off set by heavy regulation by the Charity Commission.
- A Charity which has a contract with a PCT to provide Out-of-Hours services, or which is sub-contracted by a GMS/PMS/SPMS practice or an approved APMS contractor to provide Out-of-Hours services, can be an Employing Authority.

A Charitable Incorporated Organisation (CIO) is a proposed new form of incorporated legal entity with charitable status. It will be regulated by the Charity Commission rather than Companies House, but a date has not yet been fixed for its introduction.

LIMITED LIABILITY PARTNERSHIP (LLP)

Key features

- The Limited Liability Partnerships Act 2000 was introduced to provide an element of protection from unlimited liability for the members of a partnership formed as an LLP, whilst allowing the LLP to be taxed in the same way as a partnership governed by the Partnership Act 1890.

- Where an LLP is used to carry on a trade or a profession (but not if it is used to make investments), it will be treated for most UK tax purposes in the same way as an ordinary partnership.
- Popular with professional partnerships, as members with a larger share of the profits bear a larger proportion of the overall tax liability but they all benefit from limited liability.
- In other respects a LLP is very similar to a [CLG](#). It is a body corporate (i.e. it is a legal personality separate from its members) with unlimited capacity. It is a single tier structure (i.e. the members are the equivalent of directors of a company and vice versa).
- Generally two or more persons, including corporate bodies, associated for carrying on a lawful business with a view to profit, are allowed to form an LLP.
- There are two categories of membership: ordinary and designated. Designated members have the same rights and duties towards the LLP as the ordinary members. These mutual rights and duties are governed by the LLP agreement and the general law. However, the law also places extra responsibilities on designated members. Every LLP must have at least two designated members at all times. If there are fewer than two designated members then every member is deemed to be a designated member.

Advantages and Disadvantages

- Retains the organisational flexibility of a partnership with which GPs are very familiar and is taxed as a partnership but members have the benefit of limited liability.
- LLPs are not eligible to hold a PMS or a GMS contract and as such will not be eligible to qualify as an Employing Authority for the purpose of the NHS Pension Scheme under the Regulations.

COMPANY FORMATION QUESTIONNAIRE

This questionnaire is intended to assist persons to decide what form, structure and governance may be suitable for the purpose of incorporation of a Federation or part of a Federation providing NHS-funded or co-funded services.

This questionnaire is for guidance only. It is not intended to be a statement of relevant law.

Issue to consider	Response
Company name and registered office	
<p>What will be the company's name?</p> <p><u>Note:</u> This information is required for initial registration of the company. Some words require regulatory approval.</p>	
<p>What will be the address of the company's registered office?</p> <p><u>Note:</u> This information is required for initial registration of the company.</p>	
Nature of business that the company will undertake	
<p>What will be the company's core function(s)?</p>	
What is the immediate and future business of the company?	
<p>What are the activities of the company?</p> <p><u>Example</u> Provision of health service Provision of education of healthcare practitioners Establishment of community involvement Development of new healthcare initiatives</p>	
<p>Will the company contract to provide NHS general or primary medical services?</p> <p><u>Note:</u> If yes, then consider if the company should be limited by shares.</p>	
Charity or social enterprise status (if applicable)	
<p>Will the company be a charity?</p> <p><u>Note:</u> If yes, then the company cannot be a CLS or CIC.</p>	
<p>If you intend to set up a charity, then how will its aims be for the public benefit</p> <p><u>Note:</u> The Charities Act 2006 requires all charities to have aims which are, demonstrably, for the public benefit. Two principles (with a number of sub-principles) must be met to show that an organisation's aims are for the public benefit: There must be an identifiable benefit or benefits Benefit must be to the public or a section of the</p>	

Issue to consider	Response
<i>public</i>	
<p>Will the company be a social enterprise?</p> <p><u>Note:</u> <i>A social enterprise reinvests profits for community benefit (as opposed to distributing profits to investors).</i></p>	
<p>If you intend to set up a social enterprise, then who will be the beneficiaries?</p> <p><u>Note:</u> <i>If you set up a CIC, then a short statement is required to identify the community or section of the community that a CIC will benefit.</i></p>	
<p>How will the activities of the company benefit the community?</p> <p><u>Note:</u> <i>Give brief details</i></p>	
Employment and pensions	
Will the company employ staff?	
<p>Will the company seek NHS employing authority status for staff pensions?</p> <p><u>Note:</u> <i>If yes, the owners of the company must be eligible under the NESA 2006.</i></p>	
<p>Will the company seek NHS direction status for staff pensions?</p> <p><u>Note:</u> <i>If yes, then consider if the company should be a CIC (or otherwise a charity or IPS).</i></p>	
Company ownership	
<p>Who will be the owners (owners) of the company?</p> <p><u>Note:</u> <i>The owners of a company own it either as shareholders or guarantors. Their liability is limited to the nominal value of their shares or guarantee.</i></p>	
<p>What are the names and home addresses of each of the first owners of the company?</p> <p><u>Note:</u> <i>This information is required for initial registration of the company.</i></p>	

Issue to consider	Response
What are the grounds for ownership qualification, disqualification and termination?	
Will there be any restrictions on owners of the company competing with it?	
Can an owner voluntarily resign from the company?	
Will there be mandatory grounds for transfer or cancellation of ownership?	
<p>Will the company be a small membership company?</p> <p><i>Note:</i> <i>The owners of a small membership company are also its directors.</i></p>	
<p>Will the company be a large membership company?</p> <p><i>Note:</i> <i>If the company is a large membership company, then only some of the owners would also be directors.</i></p>	
<p>Will there be separate classes of owners who have different rights?</p> <p><i>Note:</i> <i>For example, there may be separate classes for staff, service user and stakeholder owners.</i></p>	
If separate classes of owners have different rights, what will be the differentiated rights?	
<p>Will staff elect representative owners?</p> <p><i>Note:</i> <i>For example, if not all staff will be owners, then they may instead elect representative owners.</i></p>	
<p>Will beneficiaries or classes of beneficiaries elect owners of the company?</p> <p><i>Note:</i> <i>For example, if not all service users will be owners, then they may instead elect representative owners.</i></p>	
Will stakeholders, partners or other organisations have a right to be or to appoint or nominate	

Issue to consider	Response
<p>owners?</p> <p><u>Note:</u> For example, local NHS, local authority, voluntary sector or other bodies could be or nominate or appoint representative owners.</p>	
Investment, funding and profits	
<p>Will the owners contribute capital to the company?</p>	
<p>How will the company be funded?</p> <p><u>Note:</u> Examples of funding include grants, loans, other debt finance, equity investment and contract surplus. Equity investment would require a CLS.</p>	
<p>Will profit be distributed to the owners or a class of owners?</p> <p><u>Note:</u> If profit will be distributed, then the company must have shareholders. Any company may have an employee bonus scheme.</p>	
<p>Will owners agree to cap the amount of profit that can be distributed?</p> <p><u>Note 1:</u> Any company may agree to restrict the amount of profit that can be distributed.</p> <p><u>Note 2:</u> The CIC cap is: an overall cap of 35% of profits for each shareholder a cap of 20% of the paid up value of his or her shares.</p>	
<p>How will the company decide the amount of profit that can be distributed?</p>	
Assets	
<p>Will there be a lock on the company's assets?</p> <p><u>Note 1:</u> Any company may write into its articles a restriction on the transfer of its assets.</p> <p><u>Note 2:</u> A CIC must have a lock on its assets so that a transfer of assets can only be made: for full consideration (i.e. at market value), so that the CIC retains the value of the assets transferred; or</p>	

Issue to consider	Response
<p><i>to another asset-locked body (a CIC or charity, a permitted IPS or non-UK based equivalent) specified in the CIC's articles of association; or to another asset locked body with the consent of the Regulator; or otherwise for the benefit of the community.</i></p>	
<p>Will there be a specified beneficiary of an asset lock? <u>Note:</u> <i>A specified beneficiary of a CIC must be an asset locked body (a CIC or charity, a permitted IPS or non-UK based equivalent) specified in the CIC's articles of association.</i></p>	
Company governance (owners)	
<p>What functions and powers are reserved to the owners? <u>Note:</u> <i>Owners have a statutory power to remove directors without cause and to amend the articles.</i></p>	
<p>Will exceptional event powers be reserved to specified owner or owners? <u>Note:</u> <i>An owner may wish to reserve powers relating to removal and appointment of directors in the event of specified exceptional events.</i></p>	
<p>What are the requirements for owners' meetings and proceedings? <u>Note:</u> <i>Matters to be covered will include for example:</i> <i>Annual general meeting</i> <i>Number and frequency of other general meetings</i> <i>Calling a meeting</i> <i>Notice of meeting</i> <i>Quorum</i> <i>Voting</i> <i>Majority and other decisions</i></p>	
<p>Will an Annual General Meeting be required? <u>Note:</u> <i>An annual general meeting is not a statutory requirement.</i></p>	
<p>Will beneficiaries, stakeholders, partners or other</p>	

Issue to consider	Response
<p>organisations be invited to join a committee of the Board or an advisory group?</p> <p><u>Note:</u> <i>If beneficiaries, stakeholders, partners or other organisations are not owners, then it may be appropriate to invite them to join an advisory group.</i></p>	
The Board	
<p>Who will be the first directors of the company?</p> <p><u>Note:</u> <i>Please provide the full names, home address, nationality, date of birth and occupation of each director. This information is required for initial registration of the company.</i></p>	
<p>How will the directors be appointed?</p>	
<p>Will any owner or class of owners have the right to appoint directors?</p>	
<p>How many directors will there be?</p>	
<p>What will be a director's term of office?</p>	
<p>Who will be the chair?</p>	
<p>What are the criteria for directorship qualification, disqualification and termination?</p>	
<p>Will directors be remunerated?</p>	
<p>Who will determine directors' remuneration?</p>	
<p>What are the requirements for directors' meetings and proceedings?</p> <p><u>Note:</u> <i>Matters to be covered will include for example:</i> <i>Number and frequency of meetings</i> <i>Quorum</i> <i>Voting</i> <i>Chair's casting vote</i> <i>Majority and other decisions</i></p>	

Issue to consider	Response
Executive management of the company	
What are the arrangements for executive management? <i>Note:</i> <i>Usually the directors would undertake executive management.</i>	
Will there be an executive management committee to which the board will delegate?	
How many managers will there be?	
Who will be the senior manager?	
What are the criteria for manager qualification, disqualification and termination?	
What are the functions of the executive management committee?	
What are the requirements for executive management committee meetings and proceedings? <i>Note:</i> <i>Matters to be covered will include for example:</i> <i>Number and frequency of meetings</i> <i>Quorum</i> <i>Voting</i> <i>Chairman's casting vote</i> <i>Majority and other decisions</i>	

KEY CHARACTERISTICS OF LEGAL MODELS

Legal model / Determinant	CLS	CLG	CIC (CLS)	CIC (CLG)	IPS	Charity	LLP
Corporate characteristics							
Limited liability of members	✓	✓	✓	✓	✓	✓	✓
Issue of shares allowing members to participate in income and capital growth	✓	✗	✓	✗	✓	✗	✗
Two tier governance structure separating ownership and management	✓	✓	✓	✓	✓	✓	✗
Retention and reinvestment of profit / surpluses	✓	✓	✓	✓	✓	✓	✓
Income and asset locks	✓	✓	✓	✓	✓	✓	✓
Status							
Social enterprise status	✓	✓	✓	✓	✓	✓	✓
Charitable status	✗	✓/✗ ³	✗	✗	✓	✓	✗
NHS body	✗	✗	✗	✗	✗	✗	✗
NHS brand	✓	✓	✓	✓	✓	✓	✓

³ A CLG may or may not be a charity

Legal model / Determinant	CLS	CLG	CIC (CLS)	CIC (CLG)	IPS	Charity	LLP
Employee engagement							
Employee ownership	✓	✓	✓	✓	✓	✓	✓
Share ownership (direct or indirect)	✓	✗	✓	✗	✓	✗	✗
Rights to appoint directors to the Board	✓	✓	✓	✓	✓	✓	✗
Financial incentives via dividends and sale of shares	✓	✗	✓	✗	✓	✗	✗
Financial incentives via profit-related pay and bonus schemes	✓	✓	✓	✓	✓	✓	✓
Non-financial incentives	✓	✓	✓	✓	✓	✓	✓
Public engagement							
Public ownership	✓	✓	✓	✓	✓	✓	✓
Share ownership (direct)	✓	✗	✓	✗	✓	✗	✗
Rights to appoint directors to the Board	✓	✓	✓	✓	✓	✓	✗
Establishment of stakeholder groups	✓	✓	✓	✓	✓	✓	✓
Access to funding							
Debt finance	✓	✓	✓	✓	✓	✓	✓
Equity finance	✓	✗	✓	✗	✓	✗	✗
Ease of access to grant funding	✗	✓	✓	✓	✓	✓	? ⁴
Terms and conditions of employment							
Continuity of existing terms	✓	✓	✓	✓	✓	✓	✓
Automatic right to benefit from nationally negotiated reward schemes	✗	✗	✗	✗	✗	✗	✗
NHS Pension							
Automatic NHS Pension Scheme eligibility	✗	✗	✗	✗	✗	✗	✗
NHS Pension Scheme eligibility for GMS / PMS contracting subject to ownership	✓	✗	✓	✗	✗	✗	✗

⁴ This point has not been tested

Legal model / Determinant	CLS	CLG	CIC (CLS)	CIC (CLG)	IPS	Charity	LLP
NHS Pension Scheme eligibility for OOH contracting	✓/x ⁵	✓	✓/x ₃	✓	✓/x ₃	✓ ⁶	✓/x ₃
NHS Pension Scheme eligibility as a Direction Employer	✓	✓	✓	✓	✓	✓	✓
Assets							
Ownership of assets	✓	✓	✓	✓	✓	✓	✓
Use of assets under lease / licensing arrangements	✓	✓	✓	✓	✓	✓	✓
Corporate support							
Access to corporate support services	✓	✓	✓	✓	✓	✓	✓
NHS indemnity cover							
Access to Clinical Negligence Scheme for Trusts ⁷	✓/x	✓/x	✓/x	✓/x	✓/x	✓/x	✓/x
Access to Liability to Third Party Scheme	x	x	x	x	x	x	x

Please amend the following row in the table as set out below:

⁵ The company must be non-profit making

⁶ The charity must be incorporated

⁷ A PCT's Clinical Negligence Scheme for Trusts (CNST) cover can be extended to a new provider of services previously provided by the PCT. But otherwise, CNST cover is presently not available to non-NHS bodies.

General Resources

WHERE TO BEGIN – RESOURCES

General Business Models & Techniques

The [BusinessBalls site](#) offers plenty of advice, steps and tips for managing change. It describes the theory behind managing change and links to research into how to do it.

Resources include:

- theory and research underlying change management principles
- links to research supporting change and benefits
- templates
- workshop ideas
- case studies
- descriptive and illustrative stories of success.

<http://www.businessballs.com/>

Change Management

A useful toolkit produced by Leicestershire, Northamptonshire and Rutland Strategic Health Authority SHA:

The [Change Management Toolkit](#) is designed to help manage the process of change which we are all experiencing in the NHS. Some of the toolkit focuses on organisational change and some is personally focused. Some of the toolkit is written for general information; some of it requires some thought about values and priorities. It is intended to be a personal document, to complete as required and with personal results.

<http://www.fsdnetwork.com/documents/change%20management%20toolkit.pdf>

Project management

OGC Programmes and Projects Resource Toolkit

The OGC provides a number of project management resources including guides, websites, software, training and a range of other information to help organisations improve their management procedures.

http://www.ogc.gov.uk/ppm_resource_toolkit.asp

RCGP - Leadership Development Resources

http://www.rcgp.org.uk/professional_development/leadership_and_the_rcgp.aspx



LeAD is a free and engaging e-learning resource to help clinicians develop their understanding of how their role contributes to managing and leading health services.

<http://e-lfh.org.uk/projects/lead/index.html>

As GPs look at how best to organise the provision of their services, Nick Gleeson, head of Corporate Business at the Medical Defence Union, explains the clinical indemnity and medico-legal implications for GPs and companies

This article is intended to provide general information. Doctors are advised to seek specific advice applicable to their circumstances.

Clinical indemnity – who is responsible?

When deciding the most appropriate organisational form and structure, one of the key considerations is where responsibility will lie for clinical liability matters. GPs considering working with other practices and GP consortia need to address this same question.

Why do companies need corporate clinical indemnity cover?

The legal position for a limited liability company (or LLP) differs from that of a standard GP partnership. Unlike a partnership, a company or LLP is a separate legal entity. In a GP partnership, each partner is jointly and severally liable for the acts or omissions of all the partners while they are engaged in the partnership's affairs. Individual GP partners can be sued, but the partnership itself cannot as it does not exist as a legal entity.

The medical indemnity provided to a GP partner on an individual basis is there to help with allegations of clinical negligence and their vicarious liability, as employer, for the clinical negligence of staff under their direction. A company, as a separate entity to the GPs, may be sued separately to the GPs either in tort (for negligence) or in contract (for breach of contractual duty or failure to meet its agreed commitments). In order to protect the company (and, therefore, the shareholders' investment in it), the company will need a range of insurance covers. One of these is corporate clinical indemnity cover.

Traditionally, claims for clinical negligence have been made directly against individual healthcare professionals. Where a company employs the doctor or nurse practitioner and where the patient referral is organised through the company, it is likely that a claim may be made against the company itself instead of, or more likely, in addition to, the individual healthcare staff involved in treating the patient.

Will employers' clinical indemnity cover individual GPs?

GPs are advised to maintain their individual clinical indemnity regardless of the organisational structure for their business. This is because an employer's corporate clinical indemnity cover is a contractual agreement between the policy holder (the company) and indemnity provider - in effect, therefore, it only provides indemnity to the company for its vicarious liability for the acts of its doctors and not to the doctors in their own name. If the employer stopped trading, or simply stopped paying for the insurance, a claim might subsequently be brought against the doctor, who may have no personal cover in place.

It is important that GPs fully understand the extent of cover available from their employer's clinical indemnity arrangement. Specifically, they should ensure they have appropriate personal indemnity in place to cover potential claims arising after they leave an employer.

Just as importantly, at a time when patient complaints and GMC investigations continue to rise, GPs need the personal support provided by a medical defence organisation (MDO). The GMC requires this of all registered doctors, advising that they "must take out adequate insurance or professional indemnity cover for any part of your practice not covered by an employer's indemnity scheme, in your patients' interests, as well as your own".⁸ An MDO can provide a range of services, including legal assistance in the event of a fitness to practise investigation by the GMC, or a criminal prosecution arising out of the provision of clinical care, or advisory services on clinical practice issues. An employer's indemnity arrangements are unlikely to provide such personal support.

Does your new business partner have appropriate clinical indemnity?

As GP practices form new collaborative business structures, they are advised to ensure that all parties have appropriate clinical indemnity in place and fully understand the fundamental differences in the types of indemnity and their implications.

Insurance v discretion

Insurance provides a binding contractual obligation and certainty governed by the terms of the relevant policy. Discretionary indemnity for clinical negligence claims may provide assistance but it is important to remember that there is no guarantee that assistance will be provided. The GP only has the right to seek assistance, and to have that request reasonably considered, but not a legal right to receive it.

When entering into new business ventures, GPs should carefully consider the indemnity arrangements of their new business partners as they may potentially be exposed to clinical liabilities that they believe are insured but are in fact only covered on a discretionary basis.

Clinical indemnity benefits

Clinical indemnity benefits are usually offered on a broader "occurrence" basis or a narrower "claims made" basis.

The traditional not for profit mutual medical defence organisations, the MDU, MPS and MDDUS, offer their benefits to individual GPs on an occurrence basis. This means that a GP is covered if he or she was a member of the defence organisation at the time the incident occurred/treatment took place (not at the time when the claim is notified to the GP/indemnity organisation), regardless of whether the claim is reported after they have left or retired from membership.

Typically, employers' indemnity arrangements will be provided on a claims-made basis meaning they only provide indemnity for the period in which an agreement is actually in force. In order to continue

⁸ GMC, Good Medical Practice (2006), paragraph 34

to have cover for claims which stem from the period in which the agreement is in force, once the agreement has ended, the organisation would need to consider the payment of an additional premium for run-off cover to ensure that they are protected in the future against a retrospective claim, or seek such cover from their new provider.

GPs should carefully consider their clinical indemnity arrangements to ensure they are sufficient to support their current and future needs. GPs seeking to obtain their personal cover from insurance companies, as opposed to medical defence organisations, will need to ascertain what the provisions of the cover are if they change employer.

Insured indemnity solutions provide financial security to meet future claims

One feature of insured clinical indemnity solutions, such as that provided by commercial insurers, and for members of the MDU, is that their claims funds are monitored by the Financial Services Authority to ensure they are adequate. As a safety net if something does go wrong, individual GPs have access to the Policyholders' Protection Scheme which will look after their interests by paying most, if not all, of a claim. This financial safety net does not exist for discretionary indemnity arrangements.

Independent right of redress if something goes wrong

Insured clinical indemnity solutions offer an independent right of redress. If a GP has a complaint against the indemnity insurance company, he or she has the right to approach the independent Financial Services Ombudsman to have the case considered. The insurer is then bound by the Ombudsman's decision. Under discretionary indemnity arrangements, if a GP has a complaint which the indemnifier does not accept, the only right of redress is the courts.

Medico-legal issues of GPs working collectively to provide services

When GPs work collectively, unanticipated medico-legal consequences may arise. One of the principal areas of concern is likely to be confidentiality and the sharing of information. Although practices may be working within consortia, patients will nevertheless identify with their 'usual' practice. They may be surprised to learn that their data could be more widely available, being shared with other members of the consortium. It will be important that such issues are addressed in advance, so that if there is any intention to share patient information, this is subject to patients' express agreement.

Clinical governance issues may also come to the fore when practices begin working closely. There may be variation in policies and procedures that could lead to adverse incidents if not identified and resolved. For example, systems of recall for specific risk groups, or for monitoring patients on certain medications (e.g. warfarin) could differ within the consortium and consequently lead to confusion. Systems that are consistent across the constituent elements of the consortium will help to mitigate such risks.

The current NHS and Social Care Complaints procedure requires individuals within 'responsible bodies' (of which GP practices are an example) to designate a complaints manager and a responsible

person, to ensure compliance with the statutory arrangements. With practices joining consortia, it will be necessary to ensure that the statutory requirements of the complaints procedures are met.

A final example is that of professional responsibility and accountability. Joining forces with other practices may blur the normal chains of responsibility between healthcare professionals.

Consideration may need to be given to formalising organisational charts so that line management and accountability is clear to all.

It is vital that the needs of patients are at the forefront of any decisions that may affect the way care is delivered. Practices may wish to consult with patient representative groups to ensure that any changes are welcomed by both staff and patients.



The Good Governance Standard for Public Services

The Good Governance Standard for Public Services presents six core principles of governance that are common to all public service organisations. Each principle has supporting principles that provide more detailed guidance, along with practical advice on how to apply them. There is a set of probing questions for governors to assess how well they are living up to Standard, and another set for members of the public who want to find out how well their services are governed.

<http://secure.cipfa.org.uk/cgi-bin/cipfa.storefront/4c629de00a2d3c64273f3efdf407067c/Product/View/BU011>



NHS Healthy Board Principles Document

The National Leadership Council has published a new guide and online resource to support boards to deliver better services to patients. The Healthy NHS Board outlines ways to support good governance and approaches that are most likely to improve board effectiveness. The publication is aimed at boards of all NHS organisations.

Click [here](#) to download the guide

“What makes boards great”

Sonnenfield JA 2002 Harvard Business Review September 2002

http://www.eoeleadership.nhs.uk/downloadFile.php?doc_url=1262603769_mqfb_hbr_jeffrey_sonnenfeld_what_makes_boards_great.pdf



The Procurement Guide for Commissioners of NHS-Funded Services sets out expectations of commissioners on the use of procurement to improve services for patients, including: investment in new service models or significant additional capacity; upon expiry of existing contracts; or, where services fail to improve through contract management

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118218

This document sets out revised Principles and Rules for Cooperation and Competition (PRCC) in commissioning and provision of NHS services.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118220.pdf



National Association for Patient Participation (NAPP)

N.A.P.P. is the umbrella organisation for Patient Participation Groups (PPGs) within primary care. They are able to help with advice on getting a PPG started, as well as guidance on maintaining the Group and making it more effective.

<http://www.napp.org.uk/>

Growing patient participation



The Growing Patient Participation campaign is a joint initiative run by the National Association for Patient Participation, Royal College of General Practitioners, British Medical Association and NHS Alliance. The aim is to see more Patient Participation Groups (PPGs) set up across the country, and to strengthen existing PPGs.

<http://www.growingppgs.com/home/>

Whose NHS is it anyway? Sharing the Power with Patients and the Public



This report by the NHS Alliance was the result of a year-long debate with key stakeholders. It provides a set of recommendations for implementing effective PPI across the NHS. It addresses involvement both at an individual level, when a patient goes to see the doctor, and collective level, by involving local people in planning and designing their local NHS.”

[http://www.nationalvoices.org.uk/sites/default/files/Whose NHS is it anyway.pdf](http://www.nationalvoices.org.uk/sites/default/files/Whose_NHS_is_it_anyway.pdf)

March 2004 - How managers can help users to bring about change in the NHS



A research summary based on the main findings of two literature reviews by Crawford et al (2003) and Rose et al (2002). The first review looked at user involvement in change management across a range of sectors to identify factors that promote successful user involvement. The second review looked at literature about user and/or carer involvement in managing organisational change within mental health services.

Click to download the [research summary](#) and the [full study](#)

The General Practice Foundation is a new RCGP initiative which offers general practice nurses, managers and physician assistants the opportunity to be a part of the Royal College of General Practitioners. The Fora include:-

- Forum of **Practice Management** : Open to any manager working in Practice Management in General Medical Practice in the UK
- Forum of **Nursing in General Practice** : Open to any registered nurse working in General Medical Practice in the UK
- Forum of **Physician Assistants** : Open to anyone working as a Physician Assistant in General Medical Practice in the UK

<http://www.rcgp-foundation.org.uk/>

RCN - General practice nurse toolkit

Provides examples of good practice in relation to General Practice Nurses in the following areas: employment practice; education and professional development; competence; integration with the wider community health care workforce; career development; quality improvement and evaluating practice. The Toolkit explores each of the areas described above from a variety of perspectives including that of the employer. Each section includes tools to provide practical help towards improving practice.

http://www.rcn.org.uk/development/general_practice_nurse_toolkit

The Health Academy - Online and other resources to support continuing professional development of practice managers

<http://www.healthacademy.org.uk/>

The community pharmacy - a guide for general practitioners and practice staff

This guide aims to support general practitioners (GPs) and community pharmacists in developing more effective working relationships. This guide has been developed jointly by NHS Employers, the British Medical Association's General Practitioners Committee (GPC) and the Pharmaceutical Services Negotiating Committee (PSNC).

http://www.psn.org.uk/news.php/734/gp_and_pharmacist_guides_launched

The General Practitioners Committee (GPC) of the British Medical Association (BMA) and the National Pharmacy Association (NPA) have produced a workbook entitled 'Improving communication between community pharmacy and general practice' to help facilitate local dialogue between the two professional groups, helping to improve patient care.

http://www.bma.org.uk/health_promotion_ethics/drugs_prescribing/improvecomm0308.jsp

Teams without walls (RCGP, RCP, RCPCH)

This report advocates 'an integrated model of care, where professionals from primary and secondary care work together in teams, across traditional health boundaries, to manage patients using care pathways designed by local clinicians'.

http://www.rcgp.org.uk/PDF/CIRC_Teams%20without%20walls%20REV%20March%202008.pdf

RCGP Quality Network & Quality Practice Award

The RCGP Quality Network exists to support GPs and practice teams in improving the quality of care and the standard of services. The Quality Practice Award (QPA) is a criterion-based quality accreditation process undertaken by Primary Health Care Teams across the United Kingdom. The RCGP Quality Practice Award provides a comprehensive framework for improvement at practice level including delivering patient centred care; management of illness; clinical records; meeting needs of special patient groups; developing the practice as a learning organisation.

http://www.rcgp.org.uk/practising_as_a_gp/team_quality.aspx



Seven steps to patient safety for primary care

This best practice guide alerts primary care organisations and teams to the seven steps through which they can work in order to safeguard their patients.

<http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59804>

Clinical governance a practical guide for primary care teams

(Martin Rowland & Richard Baker, National Primary Care Research & Development Centre)

This guide has been written mainly for doctors, practice nurses, managers and receptionists. It provides practical advice that will help primary care teams get clinical governance off the ground in their practices.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006014

RCN - General practice nurse toolkit

The toolkit provides examples of good practice in relation to General Practice Nurses including quality improvement. The Toolkit explores this from a variety of perspectives including that of the employer. Each section includes tools to provide practical help towards improving practice.

http://www.rcn.org.uk/development/general_practice_nurse_toolkit

How to change practice: understand, identify and overcome barriers to change

[Link to full-text here, Portable Document File / PDF](#)

This guide aims to support the NHS and the wider public health community in understanding, identifying and overcoming barriers to changing and improving services. Set out in three parts, the guide:

- discusses the types of barriers to change encountered in healthcare, highlighting how awareness and knowledge of what needs to change, and why, are important first steps in enabling change to occur
- offers practical suggestions on how to identify the barriers to change faced by organisations

- provides evidence-based advice on what methods work to overcome these barriers, and highlights potential levers to help do this

DEVELOPING AND REDESIGNING SERVICES – RESOURCES

Guidance on developing business cases

The OGC provides guidance on developing business cases including a [template business case](http://www.ogc.gov.uk/documents/BusinessCaseTemplate-MinimalContent.pdf).
<http://www.ogc.gov.uk/documents/BusinessCaseTemplate-MinimalContent.pdf>

http://www.ogc.gov.uk/documentation_and_templates_business_case.asp

The Care Quality Commission

The Care Quality Commission sets out the registration requirements and processes for undertaking regulated activities that require registration under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009.

Regulated activities include:

- personal care
- accommodation with nursing or personal care
- accommodation for persons who require treatment for substance misuse
- accommodation and nursing or personal care in the further education sector
- treatment of disease, disorder or injury
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- surgical procedures
- diagnostic and screening procedures
- management of supply of blood and blood-derived products
- transport services, triage and medical advice provided remotely
- maternity and midwifery services
- termination of pregnancies
- services in slimming clinics
- nursing care
- family planning services

<http://www.cqc.org.uk/guidanceforprofessionals/independenthealthcare/registration/currentregistration/formsandguidance.cfm>

TRAINING & EDUCATION – RESOURCES

RCGP

The RCGP provides access to a wide range of e-learning and other resources for GPs and other professionals

http://www.rcgp.org.uk/practising_as_a_gp.aspx

BMJ Masterclasses

BMJ Masterclasses help clinicians to use the latest evidence and recent guidelines in practice and meet their CPD/CME requirements. They provide GPs and with updates on the latest evidence and current issues. They use case studies and practical demonstrations to encourage sharing of best practice and interactions with peers and experts.

<http://masterclasses.bmj.com/>

The Open University

The Open University offers a range of remote learning courses for health staff of all disciplines.

<http://www3.open.ac.uk/study/postgraduate/health-and-social-care/courses/index.htm>

PUBLIC HEALTH – RESOURCES

NHS EVIDENCE - NATIONAL LIBRARY FOR PUBLIC HEALTH

Provides access to the public health evidence base by providing access to guidelines, strategies, policies, systematic reviews, and news and events of note to the wider public health workforce.

<http://www.library.nhs.uk/publichealth/>

NICE - Guidance on Public Health

NICE's public health guidance makes recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health. The guidance may focus on a particular topic (such as smoking), a particular population (such as schoolchildren) or a particular setting (such as the workplace).

<http://guidance.nice.org.uk/PHG>

SHARING BACK OFFICE FUNCTIONS – RESOURCES

LMC BUYING GROUPS FEDERATION

The LMC Buying Groups Federation is a voluntary association of Local Medical Committee sponsored Buying Groups who have agreed to work together to negotiate the best possible discounts on goods and services that GP practice members regularly buy.

<http://www.lmcbuyinggroups.co.uk/>

WORKING WITH AN EXTERNAL PARTNER – RESOURCES



Building high-quality commissioning examines how external support is being used by primary care trusts and strategic health authorities and whether it is helping them to develop more effective commissioning. There was evidence that in many cases external organisations had succeeded in improving commissioning processes and could provide support in key areas such as data analysis and commercial skills.

However, it was also clear that external support is not always used effectively. This report provides guidance for commissioners, policy-makers and providers of support on how to avoid those pitfalls and ensure best value from external support. The recommendations made will be relevant to GP Federations and GP Consortia as well as to PCTs.

<http://www.kingsfund.org.uk/publications/building.html>

Supporting Materials

OVERVIEW & INTRODUCTORY SECTIONS

Learning from the research evidence – references

Survey findings

Legal form – table A

Legal form – company formation questionnaire

Legal form – more details about legal forms

CASE STUDIES:

Brent GP Federation – governance case study

BrentGovA = Brent GP Federation Governance agreement

BrentGovB = competency standard

BrentGovC = TOR for PBC Executive

Principia – governance case study

PrinGovA = Articles of Association

PrinGovB = person specification for the community directors

IPSCOM – governance case study

IpsGov = June 2010 newsletter

GAT-NET – governance case study

GatgovA = board chair role description

GatgovB = description for clinical lead

GatgovC = key responsibilities for board members

Optimus – improving quality case study

Optimusquality = list of policies

Brent GP Federation – training & education case study

BrenttrainA = ‘A practice-based format for discussing GP referrals’

BrenttrainB = about the Kilburn Cluster

Croydon Federation of general practices – developing and redesigning services

Croydevel = legal accountability agreement

LADMS – developing and redesigning services

Ladmsdevel = board structure

Salford Health Matters – public health case study

SalfA = organisational chart

SalfB = annual report 09/10

SalfC = company profile

SalfD = business plan 2009-12

Badger – sharing back office functions

BadgersharingA = associate application form

BadgersharingB = staff feedback forms

Salford Health Matters – sharing back office functions

SalfA = organisational chart

SalfB = annual report 09/10

SalfC = company profile

Pathfinder – working with an external partner

PathpartnerA = slide on Redesign Scope setting out the 5 projects

PathpartnerB = box about Care Management Programme