

FEATURE

BRIEFING

Rise of the federation: how GPs are meeting the challenge of competition

Many GPs are finding that size does matter when it comes to winning contracts and delivering modern services. **Nigel Hawkes** reports

Nigel Hawkes *freelance journalist*

London, UK

General practice has often been told it needs to change. But exactly how is less clear. Everybody seems ready to define and redefine the problem, but fewer are willing to say how to solve it.

Take NHS England's *Improving General Practice—a Call to Action*, published late last year.¹ Any GP reading this would struggle to discover what action was actually being called for, as the document describes ends but not means. It was followed by a very similar call to action for London, where the problems are seen as the most acute. One chapter was headed, "More needs to be done." Yes, but what? What can GPs convinced by the arguments actually do?

The current answer is that GPs cannot deliver modern services without a bigger footprint. Merging with other practices is unattractive, so the alternative is to form networks or federations, shedding some independence in order to gain weight. This idea was first proposed in 2007 by the Royal College of General Practitioners (RCGP)² to counter one of the few reports that did include a plan: Lord Darzi's polyclinic vision for London.³ "We caution against the development of 'super surgeries' or disease-focused 'polyclinics,' which simply co-locate individuals without an underpinning philosophy or vision," said the college, though its real fear may have been that general practices would be swept aside by private companies bidding for polyclinic contracts.

What is the driver?

Maureen Baker, chair of the RCGP, says the call for federations was inspired by the desire to preserve "so much that's good about primary care" while enabling change. "We wanted to keep practices as the basic unit of care instead of corralling doctors into new city centre premises, and to offer more by working at scale," she says. "Federations can share back-office costs, or cooperate to improve access to services such as dermatology that a few GPs may specialise in."

Time has moved on, and Simon Rudland, a GP and non-executive director of a 61 practice federation in Suffolk, says that "fear of the future" was the driver for its formation two years ago. "We saw a very bleak future for general practice, with reduced income and increased competition from other providers," he says. "Smaller practices were particularly vulnerable—they're too small and often too badly run to survive." Tim Reed, who chairs the federation, says that competition introduced by the Health and Social Care Act 2012 means that clinical commissioning groups (CCGs) will tender for local enhanced services traditionally delivered by GPs, with no presumption that general practices will be preferred providers.

Phil Yates, chair of GP Care, a 100 practice federation in Bristol and the surrounding area founded in early 2007 as Labour's reforms started opening up commissioning, echoes the sentiments. "We felt that as a very disparate group we didn't have much chance of winning contracts," he says. "We feared that people would come in with no interest in the local community, take services, and that general practice here would become unviable."

Is it official policy?

That's not entirely clear. "As far as NHS London is concerned, it's policy with a small p" says Clare Gerada, who is chair of London's Primary Care Clinical Board. Her view was backed at the launch of the London Call to Action by NHS England's regional director for London, Ann Rainsberry, who said: "The vast majority of practices in London want to do this [form federations]. As a commissioner, if you end up a few years hence where every Londoner can access this apart from a small part of London, then I think our job will be to take action."

Nationally the picture is more ambiguous. While financial and clinical pressures do point in the same direction, NHS England has never formally declared federation to be its policy, though

it has called for “wider primary care, provided at scale,” which may mean the same thing.⁴ But even in the absence of a clear steer, many practices have already formed federations or are in the process of doing so.

How many practices are already involved?

No figures are held, but the current best guess is that about a fifth of practices across England are in some form of provider organisation—a partnership, federation, or a private company. Some are small, including just a handful of practices, while others such as Cumbria involve an entire health economy. And while general practice generally consists of small operations, some are much bigger (including Gerada’s Hurley Group, at more than 72 000 patients) or are part of national chains such as Virgin Care or The Practice.

What is the legal structure?

No single model predominates. The Suffolk federation was set up as a community interest company because “it felt right,” Rudland says. “We didn’t want to set up a company to make profits—it’s not about creating profits for the members.”

But solicitor Nicky Collins of the law firm Browne Jacobson, who has set up two federations in Manchester and is working on two more, says she favours private limited companies with shares. “It’s simple and inexpensive,” she says. “The company is just a vehicle for holding a contract. In future you might want to sell, and it’s easier to do that if it’s got shares.” Yates says that GP Care started as a limited liability partnership but found that structure unsuitable and became a limited company with each of its 700 GPs as shareholders. Its articles of association mean, he says, that it behaves more like a community interest company. Baker says the form should follow function: “Doctors should decide why they are forming a federation and let its form follow. Some may not need to have a legal identity, though if they are taking on contracts they need one.”

What is important, Collins stresses, is the willingness of practices to delegate authority to the board. “Bigger federations are going to be better placed to get contracts, but it’s largely down to how well they’re run. If you’ve got 25 practices linked together but no effective delegation to the board, it’s never going to work.”

What counts most: size or geography?

Federations need size to take on contracts and smooth out the risks. But is size enough? If it is, national chains such as The Practice or Virgin Care are well placed. But Gerada believes that federations also have to be geographical. “If not, you just have a health maintenance organisation that can pick and choose and leave people out,” she says. “Once you have capitated budgets for secondary care, and no checks and balances, you end up picking patients. That’s always been my worry. If federations are geographical, they have to include all the patients in that area and it becomes a lot more coherent.” Baker agrees, though she can envisage non-geographical federations of practices interested in, for example, the health of the homeless or of practices serving universities.

Sam Everington, an East London GP who now chairs the local CCG and is a huge supporter of GP federations, says: “It’s not always possible to have geographical federations, but it is best. Otherwise the risk is that federating doesn’t help to eliminate variance—you just get like minded practices linking up, and some are left out. Here, nobody has been left out—we linked

36 practices into eight local networks, and the CCG contracts with them.”

In theory, he says, big practices such as the Hurley Group have the capacity and can deliver a good medical service, but he feels they lack the personal sense of ownership that practices belonging to a federation retain. “You need maximum flexibility combined with closeness to the community and a personal sense of ownership, and big, salaried practices can’t provide that,” he says.

Does it work?

“Contracts are not easy to come by,” says Yates. “If I’m honest, I’d say we anticipated we would win community care contracts in Bristol, where we’re based. But that market has been slow to develop and we’ve looked wider. We now provide services in Gloucestershire, such as ultrasound.”

His experience is matched by the Suffolk federation, which has no contracts from its own CCGs but one from neighbouring North East Essex for diabetes care, worth £10m (€12m; \$17m) over five years. Collins says that it is these “out of area” contract wins that are driving much of the current activity in federation building. “I always thought that competition would come from the private sector, but it’s not,” she says. “It’s when GP providers from out of the area take services that people respond.”

Some of the best outcomes have come from the East London networks, where regular monthly meetings help GPs compare their methods and results with others. “MMR vaccination rates are 94%—the highest in London,” says Everington. “Flu vaccination rates in over 65s are also the best in London. And blood pressure and cholesterol control is the best in the country. For diabetic patients we’re getting early evidence of a reduction in admissions.”

How do you set one up?

Set-up costs come from the practices participating—30 pence per registered patient in the Suffolk federation, for example. The RCGP commissioned the King’s Fund, keen proponents of federation, to provide a toolkit of guidance.⁵ Yates says the environment for setting up is now more demanding than when GP Care was launched in 2007. “Some organisations trying to set up now are at risk of not making it,” he warns.

Isn’t there a conflict of interest?

With GPs now running commissioning and GP provider companies bidding for contracts, is there a possibility of a conflict of interest? “Yes, there’s clearly a potential problem but it can be handled,” says Baker. Both Rudland and Yates believe the fear is exaggerated and is inhibiting progress. “Anyone can bid: the contracts are out there, it’s an open bidding process,” says Rudland. “The real problem at the moment is not conflicts of interest but a fear of them, which is inhibiting innovation.” Yates agrees, saying the conflict of interest question is always raised, “even before an income stream ever arises.” He says there is no overlapping membership at CCG and provider board level and the commissioning support units provide a third party to ensure probity.

Do the federations have a voice?

There’s no central organisation yet for general practice federations. But it may not be long. Yates says he has talked to the National Association for Primary Care about setting up a national network, and Baker wants the RCGP to provide a

register of federations. That would provide some much needed clarity as well as mutual aid.

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1 NHS England. Improving general practice—a call to action. 2013. www.england.nhs.uk/ourwork/qual-clin-lead/calloaction/igp-cta/.