LMC Discussion Paper on GP Federations in Somerset

Summary
GP Federations are an important building block in the arrangement of primary care in Somerset. They need to be constituted in a way that minimises organisational costs whilst keepings provider and commissioning activities separate.

Background

Although GP practices are technically in competition with one another, joint working in geographical localities is long established in Somerset, largely arising from shared out of hours arrangements and the appearance of GP co-operatives in the 1990s.

The evolution of the NHS means there are now four areas in which practices could work together

- Within their core GMS or PMS contracts
- As providers of extended, supplementary or intermediate services contracts
- As commissioners of NHS secondary care
- As providers of non-NHS services.

History of GP Federations

Where practices choose to work together, it is obviously important that the structure within which they choose to do so should reflect the reasons for their joint working. However, it is sensible for the constitution to be flexible enough to accommodate other potential shared projects if possible.

The original network of Federations evolved as potential provider groups, largely based on the configuration of previous out of hours co-ops, and spurred, in some places, by the need to prepare a bid to provide extended hours Darzi centres demanded of all PCTs by the last government. This gradually coalesced into a network of variously sized localities, covering all the practices in the county, who mostly adopted a loose constitution based on a club or co-operative structure, sometimes with a limited company available as a vehicle for tendering for potential provider work.

Clinical Commissioning Localities

At the same time, it was becoming clear that the county wide practice based commissioning structure of Wyvern Health needed to be supported and informed by commissioning localities. Although there were initially some boundary differences, inevitably the two groups merged, functionally at least. The Transition Group, made up of PCT, Wyvern, and LMC members, recommended in January 2011 that the Interim Clinical Commissioning Group for Somerset should copy the successful countywide configuration of Wyvern, and that the commissioning localities should become formal subsets of the CCG. The election of the GP members of the iCCG was based on this structure.

Progress in 2011

Although some federations, notably Bridgwater, have taken on significant commissioning responsibilities, there has been no formal agreement on how each locality should be structured. Most are still loose associations of practices that choose to work together on a particular set of projects. But as provider opportunities have not

materialized due to pressure on the NHS budget, the majority of federation activity has related to commissioning.

Constraints on Federation Development

1. **Conflicts of Interest**
   Although it is inevitable that the same group of active and interested GPs in any locality will be at meetings about both provider and commissioner work there is clearly scope for conflicts of interest. However, GPs have always had this dual role, and the LMC believes that this can be overcome by having two parallel but separate superstructures that allow the two strands to be discussed at county level.[1]

2. **GP and Practice Manager Capacity**
   The 2011/12 QOF QP requirement for discussion between practices about prescribing and commissioned services provides a modest financial incentive to participation, but the inexorable rise in the demands of practices GPS or PMS contracts means that practice GP and PM time is under great pressure. The additional funds released from PCTs for GP commissioning development cover administration costs and a little commissioning work but not much more. Until federations are seen to have an essential role most GPs will have little interest in them.

3. **Implications of Formal Structures**
   Any development beyond a loose association brings with it a deadweight of bureaucratic requirement that risks crippling small and low budget organisations. For example, if the federation makes a provider bid in its own right, it would probably need to be registered with the CQC, if it handles funds directly it might become VAT liable, and even as a commissioner it would need full clinical and information governance protocols and the rest of the structures of an NHS body – including, for example the capacity to respond to Freedom of Information requests.

Development of Federations in 2012

Co-operative work with the CCG, starting with a joint survey of individual GP and practice manager views about federations, will allow us to design the form of federations on the functions that are determined by member practice wishes and the commissioning needs of the CCG.

It may be that some central guidance on possible substructures for larger CCGs will be issued by the Department, but given their declared "hands off" approach this seems unlikely. In the absence of any specific requirements for the organisation of commissioning localities, the LMC suggest that federations should consider carefully before changing their current "mutual" arrangements. We also know that the final CCG will have fewer GP members than are on the present board, and that it is unlikely to be possible for the direct link between localities and board membership to be retained although the main operational committee of the current CCG, the Clinical Operating Group (COG) may be able to carry federation membership into the final organisation.

Although, as with CCGs, there is no "perfect size" for a federation and geography and access to services dictates some variation across the county, the difference in patient

populations from 30,000 to over 110,000 between Somerset federations is noteworthy and may merit consideration.

The allocation by the CCG of a lead manager to work with the GP delegate to develop each federation is very welcome but cannot replace active involvement by constituent GP practice members.

Federation Constitutions

Rather than try to design a form of words that allows a federation to have both provider and commissioner function, we suggest that there should be, on paper, *two* organisations, one GP provider federation and a separate GP commissioning one. Practices would be members of both federations (although there will be no contract requirement to join the provider federation) and although there would need to be separate formal procedures, the same practice representatives could attend both meetings, and, if so agreed, the same individuals could be elected to equivalent officer posts. Federation business can then be allocated to the appropriate section of each meeting, but because so much of what practices do has elements of both commissioning and provision it will be possible for the same people to discuss matters that cross the boundary.

Conclusions

1. Somerset practice federations are an essential component of primary care organisation if the county is to maintain its position as an innovator in commissioning development.

2. Federations should continue to operate as co-operative associations of practices until their precise role is more clearly defined.

3. Significant further federation development will require sufficient and guaranteed funding.

4. Practices may wish to review their current federation structure to ensure that it is of the most appropriate size for the future.

5. Federation constitutions should recognise the inevitability of conflicts of interest and the likely need for practices to work together in a number of different ways in the future. Separate constitutions for provider and commissioning parts of the federation should help make this easier.

6. The LMC will continue to work with the CCG to encourage federation development.

1. LMC Discussion Paper on the Commissioner/Provider Split in Primary Care (Nov2010)