BMA

Collaborative GP networks

A step-by-step guide to setting up a GP network

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Introduction

An increasing number of GP practices are considering entering into some kind of collaborative arrangement with other practices. GP networks go by many names: federations, networks, collaborations, joint ventures, alliances. These terms are often used interchangeably to describe multiple practices coming together for a common goal.

Whether this is driven by the desire to share costs and resources (for instance, workforce or facilities) or as a vehicle to bid for enhanced services contracts, providing general practice at scale is increasingly being viewed as the future of general practice.

This paper is designed to walk GPs through a list of key points for those practices actively establishing, or joining, a GP network, or those who are considering it. As individual GPs, practices and localities all have their own personalities and requirements, this paper should be regarded as food for thought rather than detailed guidance.

First, the big question

What do you want the network to do?

The first question for any burgeoning GP network to ask itself is *what do we want the network to do?* This question is fundamental and will help guide subsequent activity and planning.

The GPC recommends that nascent GP networks have clear goals in mind before proceeding any further.

Informal collaboration vs new legal entity?

The network's ambitions should guide this thinking.

For instance, if the network's ambition is to only deliver core services or provide a mechanism for staff development (e.g. training) functions, there may be no need to create a new formal structure (e.g. a legal entity). In this instance, there are more informal ways of developing collaborative support between practices that don't require the creation of a new legal entity.

If the network's aspiration is to share staff, bid for contracts and deliver a wider range of services, then it should strongly consider forming a new legal entity. Much of this guidance is aimed at groups who intend to establish legal entities.

Legal forms: Community Interest Company or another legal structure?

Once the network has agreement about what it would like to do, the next step is to think about what legal form the GP network should take. Let the goals and ambitions of the network determine the type of legal form adopted, not the other way around.

For instance, many emerging GP networks see community interest companies (CICs), or similar not-for-profit business structures, as the ideal legal form to adopt. Often this approach is based on a desire to ensure the network doesn't become a 'for profit' entity and retains its NHS values. Although these are legitimate reasons for considering forming as a CIC, these types of structures are regulated differently to other legal structures. Importantly, the asset lock that characterises CIC and other not-for-profit structures can introduce an inflexibility into the GP network that may not serve its long term interests.

On the other hand, although a 'for profit' company is a simpler corporate structure, these may not be the preferred model for commissioners.

Super-partnerships are another model for an emerging GP network to consider. These are typically a very stable structure but carry greater financial risk for constituent practices.

When considering what legal form to adopt, practices should understand the pros and cons of each legal model. GPC has produced separate guidance on the pros and cons of the different legal structures.[1]

Each network must obtain its own legal advice from advisors familiar with general practice and networks in order to determine which corporate structure is most suitable.

Due diligence

What services will the GP network provide?

If the GP network's aspiration is to bid for contracts and deliver services that go beyond the core GP contract, it should develop an agreed approach about which new services it is looking to provide, how and where it will obtain new contracts, and how it will deliver them.

In thinking about these questions, the GP network should ask itself the following questions:

– How ambitious are the members of the GP network?
– What are the strengths – and weaknesses – of the constituent practices?
– What facilities and resources will be available to the GP network?
– What is the demographic and/or health profile of the local patient population?
– What health services are commissioners likely to be procuring in the future?

How will resources be distributed?

Alongside questions about the types of services to be provided, GP networks should also have regard to how resources will be distributed across the GP network. The minutiae of these arrangements need not be finalised during early discussions.

Key questions to consider include:

– How will any surplus be utilised/distributed across the GP network?
– Will service level agreements with each practice be put in place?

Ensuring that there is a cohesive, sensible and mutually agreed approach to service delivery and reimbursement will help to insure against potential problems further down the line once the organisation is a legal entity ready to start tendering for contracts.

Who should join the network?

Every GMS and PMS practice in the locality should be invited to join the nascent GP network but it is likely that not all practices within a locality will join. This need not be a barrier. Practices who do not join initially can still work with the GP network. In the first instance this might be on an informal basis.

If there is a situation where some practices within the proposed group are content to only deliver core services and have little interest in expanding into new areas, it may still be

1 http://bma.org.uk/practical-support-at-work/gp-practices/gp-networks/legal-pros-and-cons

beneficial for them to join the proposed network. This will allow future flexibility should the situation change as the network develops, as well as increase the population that the network covers.

As practices come together, an important part of this process is for each practice to produce a profile. It should cover key practice indicators that include, but are not limited to, the following:

– Patients (list size, age, gender, deprivation)
– Premises (space, size, owner-occupier/leasehold, services delivered)
– Service delivery (opening hours, clinical sessions, non-GP services delivered)
– Practice Workforce (skills, interests, age of employees, succession planning)
– IT infrastructure
– Dispensing

Is there an optimal size for GP networks?

This question can be considered in three ways:

– Population coverage
– Number of practices involved
– The size and configuration of other NHS and local authority bodies in the area

Population coverage

There are few hard and fast rules about the ideal list size for the whole network, but in general there is more strength as a provider if the GP network covers a large population.

Any GP network patient with a patient population smaller than about 50,000 is unlikely to have a significant influence with commissioners, although this is not to say that such a GP network wouldn't be an effective vehicle in the provision of mutual support and coordination for its constituent practices.

Many GP networks will be made up of group of practices located within a single CCG area as this supplies the early relationship with commissioners, but this is by no means a necessity. A locality may have particular needs and the GP network may want to cover more than one small CCG area.

If there is already a network organisation operating within the area of your practice, it may in the first instance be preferable to explore the possibility of joining this, rather than setting up a competing organisation.

There is no doubt that smaller networks are more likely to waste time and energy competing with one another. This is rarely a positive development.

Number of practices

Similar to patient size, there is no ideal figure when it comes to the number of practices making up the GP network. From a transactional point of view, there is an argument for bringing on board more practices.

For instance, a GP network of 20 practices may not have significantly greater running costs than a GP network of 5 practices. On the other hand, the ability to engage and communicate with each constituent practice will become more difficult as the number of practices grows.

Leading the change: the project team

Who will develop the new network?

In the first instance, the practices involved in the GP network should establish a project team. The project team's role is to take the GP network from concept to reality and create the basis for a viable and legally competent entity and to communicate important information to all interested practices who can then decide whether or not to form/join the network.

There are no hard rules about the composition of the project team but it should be populated by GPs and practice managers from the constituent practices. The project team should also strongly consider bringing on a board a project manager, not just for their skills, but because they will be able to develop the GP network without being distracted by the 'business as usual' workload that is likely to face other members of the project team.

Whether or not a representative from each constituent practice sits on the project team is for the GP network to determine. For large GP networks, with many constituent practices, this might be unrealistic.

It is important that the project team is seen by all practices involved to be both capable and trustworthy and it is essential that the team develops a shared strategy and goal.

Whilst input should be welcomed from all the practices involved, it should be ensured that this remains constructive as it can be all too easy to fall into impatience and criticism, especially during the early stages of the project.

Deciding on governance arrangements

There should be a strong focus upon the development of shared values, beliefs and goals upon which the network will operate, as well as agreement on the preferred legal structure of the organisation.

The GP network's governance arrangements will outline the project team's roles and responsibilities, accountability and the procedures for selecting company directors and management.

Governance arrangements should also have regard to any potential conflicts of interest (particularly for GP networks that are coterminous with the CCG's coverage) and develop procedures and processes regarding the sharing of patient information.

The project team should seek the advice and input of other professionals. At a minimum this means obtaining:

- Accounting advice, especially with regard to pensions and VAT
- Legal advice, especially with regard to establishing legal structures, compliance and regulatory requirements

Developing a business plan

A business plan will help the GP network reach its ambitions. A business plan can be as simple or complex as the network desires, but should, at a minimum, describe:

- The network's aims and objectives
- Its desired outcomes (and time scale) and how these outcomes will be measured
- Financial implications and costings
- Services to be provided and by whom
- Risk assessment (conducting SWOT or PESTLE analysis may be helpful)

Stakeholder Engagement and Communication

As the GP network evolves and grows it is crucial to keep all the relevant stakeholders abreast of developments, milestones and achievement. The communications approach should take into account the stakeholder in question, but as a minimum, the GP network should put in place a strategy for communicating with:

– Constituent practices
– CCGs
– NHS England representatives
– LMCs
– Local Authority representatives
– Community hospitals, community, acute and mental health trusts
– Patient groups

Bring practices along on the journey

This requires timely and clear communication between the project team and each of the constituent practices (including all staff not just partnered GPs). The GP network should ensure that each of the constituent practices is aware of the project team's plans and proposals.

Communication across the new organisation is vital, especially in the early stages when the network has yet to achieve its full impact.

The project team should not confuse engagement with decision-making. Practices should be aware of the project team's plans but shouldn't have an expectation that they will be consulted on every decision the project team makes.

Engaging with commissioners, providers and planners

This involves meeting with the relevant external stakeholders, such as CCGs, public health/Local Authorities, NHS England area teams and acute trusts, to discuss possible areas of expansion for out of hospital care and to discover the likely timescales for future procurement.

This will allow the new network to plan its growth and development based upon the likely opportunities within its region.

These discussions will also help to inform the network's business plan.

Keep patients involved

The GP network should work with their patient liaison group to ensure that those who use the services know why their practices are working together and how it will – or won't – affect the care they receive.

Now that you're up and running

Who will run the network?

Once the organisation is up and running a management team will need to be appointed to oversee the day to day running of the organisation, as well as tendering for contracts and development of service provision.

The management team could be drawn from the initial project team or hired separately. Limited companies must also appoint a Board of Directors, who may also take on a management function.

Where can we access external help and resources?

LMCs are increasingly involved in developing new GP organisations and should be able to provide guidance and assistance. They may also have contacts with management, legal and accountancy expertise all of which are essential in ensuring that the project succeeds and results in a viable business organisation.

CCGs can help with initial finances as this is part of their role in developing the provider market, but provider organisations must be clearly separate entities from commissioning bodies in order to minimise potential conflicts of interest. There is a real risk to the future business, and to the CCG as a commissioner, if the new network is not very clearly established as a stand-alone body.

GPC has produced separate guidance on conflicts of interest.[2]

Avoid, or learn to manage, pitfalls and problems

For many GPs embarking on such a project will be a new experience and, consequently, there will inevitably be a learning curve. However, most major problems can be avoided with careful planning and clear lines of communication.

A few examples of potential difficulties which networks might encounter are listed below:

- Lack of engagement by practices
- Uncertain leadership
- Local rivalries leading to a lack of forward thinking
- Differing agendas among practices or even in the project team
- Criticism from those GPs outside the project team

Keep going

This may sound rather simple, but one vital element in this process is to maintain momentum.

The project team must make steady progress and the various elements need to support one another. It can take a period of time before the new organisation has the necessary structures and reputation to be fully able to utilise its potential as a provider.

Patience and perseverance will be required from all parties to ensure the successful completion of the project.

2 http://bma.org.uk/practical-support-at-work/commissioning/ensuring-transparency-and-probity