



# Federation & GP Practices

## The Basics of Federation

*Factsheet No. 1*



**Andrew Lockhart-Mirams, Lockharts Solicitors**  
Series Editor: Moira Auchterlonie, Family Doctor Association

# The Basics of Federation

---

This is the first in a series of three factsheets outlining what to consider before forming a GP Federation. The factsheets are written by Andrew Lockhart-Miramis at Lockharts Solicitors. The Family Doctor Association commissioned these factsheets in response to requests from members. Full of tips for the unwary based on the collective experiences of other GP practices who have gone down the federation route. In this edition, Andrew shares his experiences of federating.

## Introduction

*'The traditional small business model of general practice is unsustainable.'* So said the BMA in March 2009. Four years later, the accuracy of this statement seems even more evident, with GP practices, whether small, medium or large, coming under increased administrative and financial pressures.

## Simple federated working: three stages

Whilst the third article in this series examines the mechanics of merging practices, we start here with the simple proposition that practices have to work together in order to obtain the benefits of the economies of scale that are available. This is achieved through federated working.

### 1. Sharing "back room" administration

Possibly the simplest example of federated working arises where two or three practices share a 'back room' administrative resource, such as bookkeeping. This does not involve one practice being the employer and then seconding the bookkeeper to another practice. Instead, practices simply agree that they will use the same bookkeeper at different times of the week, with each practice making a separate arrangement with the bookkeeper. This arrangement offers the advantage of advertising the position jointly. It also permits the practices to offer what is in effect a full-time working week, rather than part-time working arrangement, and is likely to attract a higher calibre of candidate as a result.

### 2. Staff sharing – slightly more complex

Staff sharing, in contrast, constitutes a slightly more complex example of federated working. Here, one practice employs, for example, a nurse, who is used by the practice but also 'hired' out to another practice. This allows a great deal more flexibility than having two separate contracts, as set out in our bookkeeper example above. However, it also requires a certain amount of management, particularly if things go wrong.

The main problem that can arise when sharing staff occurs where, for example, a nurse employed by 'practice A' is seconded to 'practice B' and is subject to a discriminatory act. This discriminatory act will be attributed to something said or done by a staff member at 'practice B'; the employment claim, however, will be made against the partners in the employer 'practice A'. In order to tackle this potential issue, 'practice B' will need to indemnify the partners in 'practice A' against employment related liabilities. The provision of such indemnities and the terms upon which staff are seconded must be properly recorded in written documentation. Where clinical staff members are seconded, care must also be taken with regard to clinical negligence cover.

## The Basics of Federation

---

### 3. Sharing premises and facilities—a lot more complex

The most complicated form of sharing is probably the sharing of premises and facilities. Often, two or more practices will occupy the same health centre, taking their own consulting suites, but sharing a nurse treatment room or, for example, a minor surgery facility. The terms on which this sharing takes place require very careful consideration, as do the proportions in which the costs of sharing are spread between the two practices. In very simple terms, a practice with 6000 patients might be expected to pay two thirds of the cost, as against a practice with only 3000 patients. There are, however, a number of variables, as the demographics within each practice might be very different. It may also be that, for other reasons, the smaller practice, for example, does not use 33.3% of the facility but say 43.3%. The costs of running a shared facility can be quite substantial and cost sharing mechanisms, however complicated, should therefore be properly recorded.

Issues may also arise where one of the two practices that are sharing premises and facilities wishes to withdraw from the arrangement. In this instance, the other practice(s) will not wish to be left carrying all of the costs. A cost sharing arrangement should therefore govern the procedure should this occur. Such an arrangement constitutes federating in simple terms and many groups of practices up and down the country are already involved in similar arrangements.

#### **Larger federated units and conflicts of interest?**

In addition to arrangements between two or three practices, there is an increasing trend towards the creation of larger federated units. This can give rise to difficulties where, say, seven or eight practices want to work together, but two or three of these practice are already joined together in another federation. Although the separate federation will in some cases be providing a different service, there is often a strong possibility of this extending into overlapping work. Where this is the case, a conflict of interest will arise.

Conflicts of interest have always existed, particularly in the regulation of companies, where directors may be on the boards of various companies and/or have interests in other businesses. In the NHS, however, conflicts have only really been identified since 2004, when the door to outside providers was opened. Proposals for clinical commissioning have brought matters to the fore. Many GPs have been quite gravely troubled, wanting, on the one hand, to participate in commissioning, whilst on the other, being aware that they might benefit if services were commissioned from their own practice.

#### **Federation conflicts; commissioning conflicts**

The first type of conflict, where a GP is involved in two federations, can simply be resolved by the GP in question electing which federation to be involved in. The commissioning conflict, however, is different. Although it is clear that GPs who stand to benefit can properly take part in assisting their CCG to identify the services that are needed in the locality, such a GP cannot then assist the CCG further in identifying and agreeing on the eventual provider of services. It might seem that this could totally negate the commissioning powers of the CCG, as the board might be comprised very largely of GPs who are members of practices who would participate in provision. However, this difficulty can be overcome by CCGs taking outside advice from other CCGs. Having reflected upon possible conflicts of interest and simple forms of federating, the second factsheet in this series will consider more formal federating arrangements.

# The Basics of Federation

## Simple Federations: Check List

Federating can offer practices:

- efficiency savings/economies of scale by sharing back office functions or procurement of practice services
- strengthening the capacity of practices
- survival to strengthen clinical governance
- development for training and education capacity
- critical size to enable tendering for new services
- opportunity to improve the quality and safety of services



## Questions to ask yourself at the start

1. Who can you work with?
2. What are the reasons for working together?
3. Who do you know that has had a go at federating to ask how it went?
4. What back office functions could you share easily?
5. What about your practice identity?
6. What is your CCG attitude to federations?

## Must do's

Seek appropriate advice  
Get on with it!

## Further resources

**Useful reading:** RCGP GP Federation Toolkit

**Ideas:** [www.family-doctor.org.uk](http://www.family-doctor.org.uk)

**Federation Agreements:** [www.lockharts.co.uk](http://www.lockharts.co.uk)

## About the Author

### Andrew Lockhart-Mirams

Andrew co-founded Lockharts in 1995 and has had 30 years of experience in primary care regulatory and contract work. For more than 20 years he acted for the General Practitioners Committee of the BMA on a wide range of regulatory and contractual issues affecting GPs, including the New GMS Contract in 2004. Andrew has a national reputation for his work in the development of PMS and APMS agreements. He has produced agreements for federations of practices, and shareholder agreements for provider companies wishing to provide to NHS bodies.



## The Family Doctor Association

We are the national voice of frontline GPs and their practices. An educational charity founded in 1985, our members are GPs and practices that offer their patients the benefits of continuity of care; the cornerstone of UK general practice. Charity registration 299871.

Membership benefits include high quality events and updates for GPs and practice teams, a shared FDA brand and logo for member practices, and common sense updates on the myriad of NHS changes.

**New Members Welcome | Practice & Individual Options | Contact** 📧 [moira@family-doctor.org.uk](mailto:moira@family-doctor.org.uk)