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Collaborative GP Alliances and Federations

Guidance for GPs

BMA

Collaborative GP Alliances and Federations – Guidance for GPs

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IMPORTANT

This guidance mainly applies to practices in England, but the principles of collaborative alliances and federations can also be applied across the UK. The General Practitioners Committee (GPC) does not endorse or support any specific model, but is merely highlighting the different ways that GPs can and do organise themselves.

Please note it is not part of the BMA service to provide commercial/management advice to practices or GPs.

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Further information is available to BMA members through the BMA and to LMCs via GPC.

A broad description of collaborative alliances and federations

Alliances and federations are broad terms used to describe collective arrangements between two or more parties. They are often established to maximise effective working in the pursuit of one or more common aims.

Definitions[1]

Collaborative – 'produced by or involving two or more parties working together'

Alliance – 'a union or association formed for mutual benefit', or 'a relationship based on similarity of interests, nature or qualities'

Federation – 'an organisation or group within which smaller divisions have some degree of internal autonomy', or 'the action of forming organisations into a single group with centralised control'

The chosen collaborative model can vary significantly depending on the circumstances, and there is no one-size-fits-all approach. The following options are not exhaustive and GP practices could adopt more than one arrangement for different purposes:

- Simple alliances / Formal and informal joint ventures
- Joint premises
- Partnership mergers
- GP cooperatives

The above arrangements may fall under one or more of the following legal structures:

- Traditional GP partnership agreement
- Private companies limited by shares
- Community interest companies and social enterprises
- Charity or charitable incorporated organisation
- Limited liability partnerships (LLPs)
- Private companies limited by guarantee

[1] oxforddictionaries.com

Context and challenges

The Health and Social Care Act 2012, which came into effect on 1 April 2013, brought about the advent of clinical commissioning groups (CCGs) and new procurement and competitive tendering rules[2] . Whilst presenting traditional General Practice with considerable challenges, this also gives rise to some significant opportunities.

The demands from the UK governments, including the 2013/14 contract imposition in England, have not only increased the workload of already over stretched practices but have also reduced investment in the GMS contract.

In England, many practices, already operating at the limit of their resources, will soon find themselves under additional pressure to adapt to equitable funding[3] changes.

Add to this the uncertainty surrounding the future responsibility for unscheduled care, and this combination of stresses on the profession is leading up to a recruitment and retention crisis in General Practice.

Significant financial[4] and patient demand pressures on all sectors of the NHS have resulted in an urgent need for efficiency gains and greater integration between primary, secondary and tertiary care services. GPs need to be the leaders of this integration, and GP practices are best placed to continue providing high quality primary care services for NHS patients.

The imminent plans for equitable funding are likely to be a key facilitator for change. A fairer funding landscape has the potential to reduce geographical variation in services. Equally, practices that face reductions to their core contract funding will need to evolve and consider economies of scale simply to maintain levels of access and their range of patient services.

Opportunities for diversification and entrepreneurial behaviour, particularly in accessing different sources of income, can be utilised as a means for survival.

Practices should be preparing for the future in terms of the political context too. This brings with it the risk of large private healthcare corporations bidding to deliver a greater range of primary care services.

Monitor's recent consultation, *A fair playing field for the benefit of NHS patients*, addressed the extent to which all potential providers of NHS care have a fair opportunity to offer their services to patients. 'If the playing field were fair' Monitor says, 'there would be nothing to prevent providers with the best services from accessing patients, regardless of the type of provider'.

Finally, the difficulties health services are facing are well reflected in NHS England's *Call to Action*, which was published 'against a backdrop of flat funding which, if services continue to be delivered in the same way as now, will result in a funding gap which could grow to £30bn between 2013/14 to 2020/21'.

The document sets out the need to help the NHS meet future demand and tackle the funding gap through 'honest and realistic debate' between staff, public and politicians.

[2] Competition and choice – www.bma.org.uk/working-for-change/the-changing-nhs/competition-and-choice
[3] Equitable funding proposals will be implemented across the UK from April 2014
[4] NHS to make efficiency savings of £15-20 billion between 2011-14; challenge set by Sir David Nicholson, Chief Executive, NHS England, in 2009.

What should GPs be doing to prepare for the future?

The sooner practices begin to prepare for changes in primary care, the more chance they will have of protecting themselves against new emerging threats and making the most of any opportunities that may present themselves.

The majority of GP partners will be used to the relative autonomy that traditional general practice structures afford them. This has meant that GPs have been able to respond quickly to change.

Some may worry that the development of collaborative alliances or federations will lead to some or all of this control being lost. Bigger partnerships involving more GPs or shareholders could lead to the feeling that power is diminishing.

The General Practitioners Committee believes that it is still possible to ensure that the traditions, values and history of UK general practice are used to drive improvements that benefit patients, practices and the wider NHS. The importance of planning change, gaining commitment and exploring the feelings of partners, staff and patients, however, cannot be underestimated.

GP partners should be asking themselves:

- Do partners and practice staff frequently allocate time to consider the future?
- Has the practice considered its long-term viability and sustainability?
- Do partners regularly review quality and regulation?
- Have discussions around the implications of the health reforms and the 2013/14 contract changes / imposition started within the practice and with patients?
- Has the practice considered threats, such as:
  - pressures to deliver more despite shrinking resource
  - increasing consultation times for an ageing patient population with (often multiple) complex conditions
  - the likelihood of reduced access for patients with less serious ailments
  - potential staff redundancies?
- Has the practice sought advice from peers (other local GPs or Local Medical Committee officers) or professional consultancy experts who have experience of establishing collaborative alliances and federative structures?

Why form collaborative alliances or federations?

Some GPs have already asked the questions – why should practices consider forming alliances or federations? Are all practices really faced with the prospect of forming larger organisations in order to survive? Have we not already seen countless NHS re-organisations come and go, maintained excellent healthcare for our patients and survived to tell the tale?

Depending on geographical location and local patient need, the nature of the structure practices may choose to adopt can and will vary. Some will implement more formal organisational structures, whilst others may determine that patients will gain the most benefit

from smaller scale, flexible alliances or ventures that can be adapted as the needs of their local patients change over time.

Practice considerations will vary depending on whether they are urban or rural. Bringing a group of local practices into one purpose built premises may not necessarily be suitable for rural patients scattered across remote parts of the UK. If they feel unable or less willing to travel to see their GP, the risk for those patients requiring more expensive future treatments will inevitably rise.

This does not necessarily mean rural practices cannot collaborate to improve certain services. Indeed, existing GP out of hours cooperatives already successfully cover considerable rural areas.

Practices have had experience of establishing and maintaining a variety of collaborative alliances for a considerable number of years, so this will not be new to GPs. Nevertheless, the NHS has rarely been under so much pressure to make the most of finite resources. As always, the role GP practices have in maintaining high quality healthcare across all sectors will be vitally important.

Case study: Derbyshire Health United (DHU)

- Operates as a not-for-profit social enterprise
- Providers of out of hours, walk-in and urgent care services
- Servicing contracted CCGs and over 300 GPs
- Covering 1,000,000+ patients
- Operating four walk-in centres
- Call handling and triage expertise across wide areas of the East Midlands
- Offers offender healthcare for police and prison services
- Has developed the RightCare© scheme to ensure seamless patient care out of hours
- Any surplus funds generated are reinvested in staff and facilities so that patient services benefit

Essential components for a successful collaboration

Before any formal arrangements are set in motion, GPs should consider the reasons for establishing collaborative alliances and what partners hope to gain.

Protecting and maintain the essentials of general practice as much as possible during any scheme of collaboration or when working in bigger arrangements is an extremely important consideration.

Continuity of care, the connection between GPs, practice staff and their local community, involvement of GPs in decision making and stakeholder participation in the way practices are organised as businesses should be the fundamental basis of any proposal for improving the delivery of primary care services.

The following list, which is based on the testimony of a practice manager following a successful merger[5], offers some important factors GPs and their staff should think about:

- Benefits to patients
- Indentifying candidate practices
- Commonality and compatibility
- Openness and honesty
- Analysing strengths, weaknesses, opportunities and threats
- Relationship between partners and practice managers
- Future proofing the general practice workforce
- Joint partnership agreement – including adherence and retirement
- Affiliation
- Corporate governance / management principles
- Profit sharing principles
- Sharing of financial results and clinical protocols
- Staff integration[6]
- Premises arrangements – do they necessarily need to change?
- Continuing professional development (CPD)
- Job evaluation process (e.g. Agenda for Change) and
- Shared quality framework (e.g. the Royal College of General Practitioners (RCGP) Quality Practice Award)

[5] *Practice Mergers,* First Practice Management – http://www.firstpracticemanagement.co.uk/index.php/knowledge_base/practice_administration/practice_mergers/

[6] See the GPC's *Guidance to practices on how to employ shared staff*

The Amherst H. Wilder Foundation has also published a free online tool, *The Wilder Collaborations Factors Inventory*[7], to assess how collaborative groups are doing. GPs are encouraged to access the tool as it offers a range of practical questions that can be applied when considering, planning and implementing collaborative alliances and federative structures.

Structural options available to practices

Simple alliances / Formal and informal joint ventures

Two or more practices may agree simple collaborative alliances to deliver one or more specific community or enhanced services for local patients. This can enable better use of combined resources, such as staffing and premises space, in order to increase access to a wider range of patients.

Advantages

- Can help to improve the quality of one or more patient services
- Staff sharing can bring about significant cost savings
- Better patient access
- Arrangements can be flexible between practices

Disadvantages

- Limited to specific services
- Vulnerable to being beaten by large private healthcare providers if bidding for enhanced services
- The limited scope of the arrangement can mean it has a short life span
- Joint contracts of employment can be problematic from an employment law perspective, but may have a VAT benefit.

Joint Premises

Usually involves the building of purpose-built premises and a number of local practices moving into one healthcare centre, whilst remaining autonomous. Already a well used model that generates economies of scale as practices can share certain members of staff and recurring premises costs.

Advantages

- Recurring premises costs can be shared amongst each practice
- Certain staff can be shared by each practice in the premises
- Close proximity of practices will make simple alliances or joint ventures easier to arrange and manage
- Staff sharing could enable consistent quality frameworks and policies to be adopted by all practices

[7] Mattessich, P., Murray-Close, M., & Monsey, B. (2001). Wilder Collaboration Factors Inventory. St. Paul, MN: Wilder Research

Disadvantages

- If the landlord changes, recurring premises costs can escalate if there is an attempt to increase rent / service charges and amend lease terms
- A reduction in the number of local surgeries could have a negative impact for patients who have to travel further
- Some GPs within the shared premises can feel their autonomy is eroding if pressured into ventures

Merger

Mergers have previously involved two or more neighbouring practices that are confronted with similar limitations. A desire for larger, better equipped premises is one driver for this, as is the opportunity to increase the patient list size and practice income. The benefit of sharing staff is also a significant factor.

A partnership agreement between the partners of the practices will usually be sufficient for a merger to take place, but this may eventually be replaced by another structure, e.g. a company limited by guarantee or a company limited by shares.

Advantages

- Merging parties do not have to have equal viability
- This model can be applied to multiple practices, e.g. the Midlands Medical Partnership
- Merged practices can hold GMS, PMS and APMS contracts
- Equitable funding changes should make merging easier
- Can offer significant benefits through economies of scale
- Enables rationalisation of quality frameworks and policies
- Can establish joint ventures with other GP or NHS organisations

Disadvantages

- Poor planning and preparation can lead to future splits following disintegration of relationships
- Joining a larger GP organisation can led to an initial decline in income due to profit sharing arrangements
- Involves a considerable amount of effort and motivation to establish large organisations
- Individual GPs may have less influence in decision making within a very large partnership
- Risk of losing local connections and continuity with patients if staff become remote or too centralised

Case study: Midlands Medical Partnership

- One partnership of 33 GP partners
- Holds four GMS contracts, with each partner holding each of the four contracts
- Four separate GP practices, three of which are training practices
- Operating across 10 surgeries
- Providing NHS primary care services to over 60,000 patients
- Has seven salaried GPs plus trainees
- Employs 150 members of practice staff, including SGPs and Nurses
- Core purpose is 'to work within a culture of quality to constantly improve the care and service we give our patients'
- The vision behind the creation of the partnership is to 'improve and develop all that is excellent about traditional GP services, whilst working in a larger, more corporate business structure in order to operate more effectively in the new NHS'
- Practices and patients benefit from the resources of a larger organisation
- Pooled resourcing enables improvements to the range and quality of patient services
- Shared learning is facilitated more easily across the formal structures of the organisation
- Has formed a limited liability partnership (LLP) with the local OOH service (Badger) in order to run a walk-in centre as a joint venture.

GP co-operatives

Another existing example of GPs forming collaborative alliances in order to deliver patient services on a wider scale. These have historically been commissioned by primary care organisations to arrange services for local patients. A number of out of hours (OOH) services have been arranged in this way since the introduction of the GMS contract in 2004, e.g. Badger Group.

Advantages

- Additional and enhanced services organised by GPs with substantial expertise and experience
- GP-led services are likely to find recruitment of peers easier
- Can hold APMS contracts
- Alliances or joint ventures could be established with other GP organisations through limited liability partnerships

Disadvantages

- Cooperatives cannot hold GMS or PMS contracts
- Contracts with commissioners are likely to be relatively short term – from one to five years
- Vulnerable to competition from healthcare corporations entering low priced contract bids

Case study: BADGER Group

- Based on the Birmingham and District General Practitioner Emergency Room co-operative of GPs, a company limited by guarantee
- Providing out of hours primary medical services for over 17 years (established in 1996)
- Providing services for patients of contracted CCGs and 230+ opted-in GPs
- Covering over 1.3 million patients for out of hours care
- Over 500 clinical and non clinical staff
- Delivers GP-led primary care services in other settings, including Urgent Care and Walk-in Centres, prisons, hospices, hospitals and for the Ministry of Defence
- Provides a GP-led NHS walk-in centre in Birmingham and an emergency and urgent care centre in Walsall
- Call centre operation expertise
- Has established joint venture companies with other GP groups including Midlands Medical Partnership

Benefits to patients, the integration of the extended primary care team and the NHS

The Royal College of General Practitioners (RCGP) believes primary healthcare delivered by collaborative alliances or federations, organised to ensure patients receive high quality care from highly skilled GPs and NHS staff, will enable integrated working to become a reality for the NHS[8].

Whilst the Health and Social Care Act 2012 will undoubtedly introduce a greater degree of competition in the provision of healthcare services, practices that form collaborative or federative structures should be in a stronger position to bid for and win contracts commissioned by CCGs and Local Authorities. This will also enable patients to benefit from:

- the existing patient-doctor relationship
- an existing understanding of local patient need
- local GPs' experience of delivering high quality primary care services
- better access to consultations provided in different sites
- services closer to home and in reassuring settings
- patient participation in the running of collaborative structures
- a wider range of tailored services and continuity of care
- an opportunity to build a more extensive community team involving community nursing, secondary care specialists and social care.

Whilst considering the merits of collaborative or federative structures, GPs should also bear in mind any possible disadvantages. These could include:

- loss of autonomy
- risk of small group of partners and large numbers of salaried GPs
- reduced choice for patients that want to have different types of practices to choose from and
- loss of local accountability.

[8] Field, S., Gerada, C., Baker, M., Pringle, M., & Aswani, K. (2008). Primary Care Federations: Putting patients first.

Developing Services

The GPC acknowledges that single practices can and have developed additional specialised services already. However, working in collaboration enables practices to do this in a more comprehensive way, utilising the skills of more clinicians and ensuring a good range of services are available within a defined community.

Before considering the pros and cons of forming alliances or federations, practices should enquire as to which services will soon be procured by local commissioners. This will go some way to determining whether patients will benefit from practices working together in a particular area.

If practices agree that there is logic in working together, the advantages of forming collaborative alliances or federations are three-fold.

Firstly, practices are the navigators and coordinators of NHS care for their patients. As GPs already know, a great benefit of collaborative working is the opportunity to develop a wider range of community services, whilst at the same time making more effective use of resource.

Secondly, better use of resources, including through the use of cost sharing agreements[9], and the potential to increase access to a wider patient population mean practices are well placed to generate additional income and improve their profitability.

Finally, collective strength can enable practices to offer commissioners services that cater for larger patient cohorts, across considerably bigger geographical areas.

Collective strength could be important, since the introduction of additional providers into the NHS healthcare market[10] suggests competition for enhanced services will be considerable.

The generation of economies of scale is likely to be an important factor in competing with large private organisations when bidding for contracts. Being prepared to bid for and win contracts to deliver enhanced services may become vital in boosting practice income and maintaining viability in the future.

[9] Cost Sharing Agreements (Cost Share Group Exemption - Group 16, Schedule 9 of the VAT Act 1994) – the exemption applies when two or more organisations (whether businesses or otherwise) with exempt and/or non-business activities join together on a co-operative basis to form a separate, independent entity, a cost sharing group (CSG), to supply themselves with certain services at cost and exempt from VAT.

[10] Brought about by any qualified provider (AQP) arrangements introduced by the Health and Social Care Act 2012

Legal structures[11]

GP partnership
The traditional general practice model, partnerships are formed where a group of self-employed individuals wish to come together to do business with a view to making profit, whilst sharing liability.

Advantages

- Subject to low regulation (compared with other structures)
- Flexibility

Disadvantages

- Partnerships require the highest degree of trust
- Partners are jointly and severally liable for their own and each other's actions
- A stable partnership is reliant on a good written agreement (partnership deed)
- Partnerships have no access to capital markets through selling shares

Private companies limited by shares

These companies are formed when a group of private individuals wish to form a for-profit business, using their own contributions as capital while protecting their personal interests.

Advantages

- Limited liability company
- Private companies are flexible – subject to less exacting regulations
- Easy to set up
- Access to debt and equity finance
- NHS Pension Scheme eligibility for GMS/PMS contracting (subject to ownership)

Disadvantages

- Must be floated by members' own capital (or their debt)
- Requirements to publish information at Companies House

[11] For detailed guidance on the nature of the different legal structures, see the BMA's *Business structures for doctors* guidance

Case study: AT Medics

- A GP Led organisation spread across 8 CCG areas
- Run as a private company limited by shares with 13 shareholders
- Fully managed service running Primary Care Centres
- 15 primary care sites
- Covering over 70,000 patients
- 6 GP Directors
- Employs over 130 staff members
- Established a vision in early 2003 – 'a primary care company across London, with quality of provision as its ethos'
- Corporate structure that enables CPD and career progression
- Provides core GMS services as well as a diverse portfolio of enhanced services
- Works with commissioners to solve problems within the primary care market
- Works in some of the most deprived areas in London, increasing access and provision successfully
- Has worked in poorly performing practices and improved performance and efficiency in short timescales
- Responsible for all aspects of the contract and governance arrangements from mobilisation, transitional service provision and clinical and non-clinical service delivery, as well as ongoing clinical supervision, CPD and staff training across all sites

Community interest companies (CICs) and social enterprises

CICs are formed when organisations want to reinvest their profits into the business or the community. The 'asset lock' of CICs ensures that the assets generated are used for the benefit of the community.

The control of CICs is dependent on whether the CIC is a private company limited by shares or by guarantee.

Advantages

- Flexibility and limited liability of members
- More lightly regulated than a charity
- Not-for-profit objectives are clear
- CICs have access to equity (in the case of a company limited by shares) and debt markets
- Social enterprises receive public recognition
- Should be able to convert to a charitable incorporated organisation from 2014
- Can qualify as an Employing Authority for the purposes of accessing the NHS Pension Scheme.

Disadvantages

- Does not share the tax advantages of charities
- Not suitable for profit-making
- Must file an annual community interest report

Case study: Suffolk GP Federation

- Currently 40 practices, but in the process of expanding to 75
- Currently 360,000 patients, but expanding to 590,000
- Not-for-profit community interest company
- Owned by GP practices, mainly GP Board but with a senior management team
- Five core values – patient-centred and continuity of care; exceptional care for all, particularly those from deprived and marginalised communities); highest clinical quality and the best patient experience; team working and collaboration; and, nurturing talent and fostering innovation
- Members remain independent organisations, whilst collaborating in the further development of local primary care
- Facilitates practices to work together to jointly address issues which cannot easily be resolved by individual practices
- Offers skills and expertise that an individual practice would find uneconomic to employ, e.g. improving services for patients, bidding for contracts and sharing best practice
- Facilitates practices working together in an open, democratic and transparent way to create mutual benefits
- Addresses issues by collaboration
- Provides a management infrastructure that practices could not otherwise afford to implement
- Inclusive of all Suffolk practices regardless of size or type – work is allocated by the Federation fairly across all practices

Charity or charitable incorporated organisation (CIO)[12]

The Charities Act 2006 details charitable purposes, which includes the advancement of health or the saving of lives[13]. A CIO is a new legal form for a charity. Charities have also been established as a specific arm of a larger organisational structure, such as in children's hospitals. Nuffield Health is an example of a healthcare charity.

Advantages

- It only has to register with the Charity Commission and not Companies House and is only created once it is registered by the Commission.
- These organisations can enter into contracts in their own right
- The trustees will normally have limited or no liability for the debts of the CIO.

Disadvantages

- Not suitable for profit-making
- No access to equity finance
- Must file accounts and an annual report to the Charity Commission
- No eligibility for NHS Pension Scheme for GMS/PMS contracting

[12] Charity Commission, *What is a CIO?* – http://www.charitycommission.gov.uk/FAQS/Registering_a_charity/FAQs_about_CIOs/ID260.aspx
[13] The Charities Act 2006, paragraph 2(2)(d) - http://www.legislation.gov.uk/ukpga/2006/50/pdfs/ukpga_20060050_en.pdf

Limited Liability Partnership

An LLP is a body corporate – a separate legal entity distinct from its members. It can form a legal relationship in its own right and will continue in existence despite any change in membership.

LLPs share some similarities with limited liability companies, since one partner does not inevitably bind another partner.

Advantages

- Limited liability
- Flexibility

Disadvantages

- LLPs are more complicated and costly to set up and run
- Reporting requirements include annual returns
- There may be tax implications if limited companies form an LLP
- As the regulations currently stand, GMS practices would be prevented from forming LLPs
- No access to equity finance

Companies limited by guarantee

This structure is used when there are no funds required for the running of the business, or where the necessary funds come from an alternative source such as endowments, donations or subscriptions.

Companies limited by guarantee will be run by all the members as directors or by an appointed executive board.

Advantages

- Minimises the risk and liability of members
- Has formal democratic controls by its members enshrined in its articles
- Eligible for charitable status where this is appropriate
- It is possible to set up a subsidiary company to hold capital and conduct non-charitable trading

Disadvantages

- Not appropriate for a profit making business
- Not appropriate for businesses that need capital

Additional case studies

Case study: The Hurley Group

- Exclusively led by practising GPs
- Four GP partners, 21 Lead GPs, team of Directors and a GP/Nurse led Medical Directorate
- 16 practices in some of London's most deprived areas
- 90,000+ patients
- Over 280 members of staff
- Three walk-in centres
- Four urgent care centres
- Over 500,000 consultations every year
- 5 core beliefs – quality, GP-led, patient-centred care, innovation and nurturing talent
- With an aim to provide superior healthcare for all
- Community services include x-rays, ultra sound and on-site pharmacies
- Patients 'get to see the same team of doctors and nurses every time you visit'
- Wide ranging services mean GPs can access specialist advice from across the 16 practices

Case study: New Zealand's independent practitioner associations (IPAs) – Nuffield Trust Research Report[14]

- Many GPs and primary care clinicians in New Zealand have worked collaboratively in IPAs for the last two decades
- Networks of primary care providers developed in the early 1990s, from the grassroots of general practice
- Hold budgets, but on a smaller scale than CCGs
- Functions include standard setting and scrutiny of primary care practice, taking on contracts for delivering new intermediate and extended primary care services; acting as collective budget holders for some local health services; and, improving the quality of primary care
- Now part of an infrastructure aspiring to create new integrated health organisations and networks
- Taken a variety of organisational forms, governance structures and sizes
- Weathered a succession of shifts in government policy
- IPAs demonstrate the potential of GP-owned provider networks to deliver benefits for member practices
- They can become sophisticated primary care development and management organisations at the heart of integrated healthcare networks
- As IPAs have expanded, the retention of strong links to front line practices and practitioners has been critical to their success
- New Zealand's experience suggests it is the provision, rather than the commissioning, of care that the majority of GPs are most likely to engage with new organisations
- New primary care provider organisations may be the most enduring legacy of CCGs
- CCGs therefore stand to gain from exploring how to stimulate new general practice provider networks, capitalising on New Zealand's experience of IPAs.

[14] Thorlby, R., Smith, J., Mays, N., & Barnett, P. (2012). *Primary Care for the 21st Century: learning from New Zealand's independent practitioner associations*. Nuffield Trust.

Other research, policy and information

Royal College of General Practitioners (RCGP), The King's Fund, the Nuffield Trust and Hempsons
Primary care federations: Putting patients first – a plan for primary care in the 21st century
Primary care federations toolkit

Nuffield Trust
Securing the future of General Practice – new models of primary care
Transforming General Practice – GP providers thinking big
Primary care for the 21st century: learning from New Zealand's independent practitioner associations
Developing a federation (presentation)

The King's Fund
Developing GP federations: will clinical commissioning stand in the way?

First Practice Management
Practice Mergers

Primary Care Commissioning (PCC)
All Together Now?
Evolve or Die: A Stark Warning for General Practice
Benefits and Challenges of Federation

Family Doctors Association
Federation & GP Practices

Association of Independent Specialist Medical Accountants (AISMA)
How will commissioning affect my income?
Making collaboration work
Preparing for a practice merger
Surviving the changes to enhanced services

HM Revenue & Customs
Revenue & Customs Brief 23/12: Guidance on Cost Share Group Exemption - Group 16, Schedule 9 of the VAT Act 1994

Pulse Online
'How we established a 40-practice federation to compete for bigger contracts'