PRIMARY CARE NETWORK AND COLLABORATIVE WORKING

OPTIONS APPRAISAL

Options appraisal for organisational and contracting forms for joint working within a Primary Care Network

The information contained in this paper is for information purposes only and no liability can be accepted for the application of the advice contained herein to any particular scenario. Professional advice should be obtained before applying this information to any particular circumstances.

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1. BACKGROUND AND INTRODUCTION

1.1. This paper has been prepared to provide NHS England with an overview of:

1.1.1. the main organisational and contracting forms of Primary Care Networks (PCNs),

1.1.2. the current state of PCNs and their envisaged development; and

1.1.3. the pros and cons associated with the different models.

1.2. Capsticks Solicitors LLP set out the legal considerations including key commercial and employment issues and BHP Chartered Accountants (BHP) set out the financial considerations of each option.

1.3. The legal considerations are set out in blue font and the financial considerations are set out in green font.

2. OVERVIEW OF CONTRACTING MODELS AND KEY CONSIDERATIONS

2.1. The following two options for a Primary Care Network are set out in this paper:

- Loose Network/Cluster (including consideration of the prime contractor model).
- Super Partnership.

2.2. The following structures which can work in collaboration with a Primary Care Network are set out in this paper:

- Corporate Federation (considering a company limited by shares).
- Limited Liability Partnership.

2.3. Section 5 sets out contracting models.

2.4. The collaborative options are set out in section 6.

2.5. Much discussion has been had about Primary Care Networks being eligible to be Cost Sharing Groups in order to benefit from a VAT exemption. A brief overview about a cost sharing group is set out in section 3. It must be recognised that this is a very specific area of law and finance and the ability for a PCN to be a Cost Sharing Group will very much turn on the facts.

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3. Cost Sharing Group

3.1. VAT cost sharing allows two or more organisations capable of forming a cost sharing group (CSG) to be exempt from VAT when supplying services to the members of the CSG if certain conditions are met.

3.2. Organisations that carry out relevant VAT-exempt or non-business (that is, non-economic) activities which includes health and welfare, and are therefore unable to recover fully the VAT they incur on purchases, may take advantage of the cost sharing exemption. This is on the proviso that they fulfil the various conditions by working together to pool their services. By doing this, members of a CSG achieve cost savings and economies of scale.

3.3. A CSG is a legally separate entity to its members and may take any legal form it is therefore itself responsible for its VAT affairs. The models we have identified in section 4, if structured correctly, could be considered a CSG.

If (for example) a PCN employs staff to provide services to its members, and those services would be standard-rated for VAT (eg management, admin, payroll) then VAT at 20% would be added to the salary costs (plus any margin) when these are recharged to its members, increasing irrecoverable VAT in those practices. If the (stringent) conditions for a CSG can be met, this additional cost can be avoided.

For more detail, see HMRC Revenue and Customs Brief 3(2018) and VAT Information Sheet 02/18.

4. Current state and development of PCNs

4.1. Primary care networks are to be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000 patients.

4.2. The intention is for practices to come together in these hubs and work collaboratively, to achieve economies of scale, move care into the community setting and decrease the fragmentation of care by providing holistic care to patients.

4.3. The new GP Contract 2019/20 (for both GMS and PMS providers) will mandate practices to join a PCN.

4.4. It is envisaged that multidisciplinary teams will be aligned with new PCNs.

4.5. Once established, a PCN Contract will be commissioned to the PCN as a Directed Enhanced Service (DES). Detail of the DES will be available in February/March.

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As this is a practice based contract, the practices (as a loose cluster) will be required to form part of the Network.

4.6. Each PCN will also need to sign up to a Network Agreement. A form of the Network Agreement is expected to be available in February/March.

4.7. A more formal structure such as a company or an LLP could form part of a PCN but it is unlikely to be the PCN in its own right.

4.8. The PCN Contract also requires a practice within the Network to be the nominated payee of the DES monies. In the alternative a third party could be the nominated payee.

4.9. A PCN will require a clinical director. The role of the clinical director and who he or she is employed by can be set out in the Network Agreement.

4.10. In this paper we therefore explore the models which can be a PCN and those which can support a Network.

4.11. Across England there are already a number of practices working together or collaborating in some form. Some will be doing so informally and some through a more formal structure such as a company. They will naturally fall into a PCN.

4.12. Where practices are collaborating together for the first time they are likely to work with a looser arrangement and as the collaboration matures and certainly when service provision is involved their PCN is likely include a more formal structure.

4.13. Several models can work in conjunction with each other. The models set out below are not mutually exclusive options.

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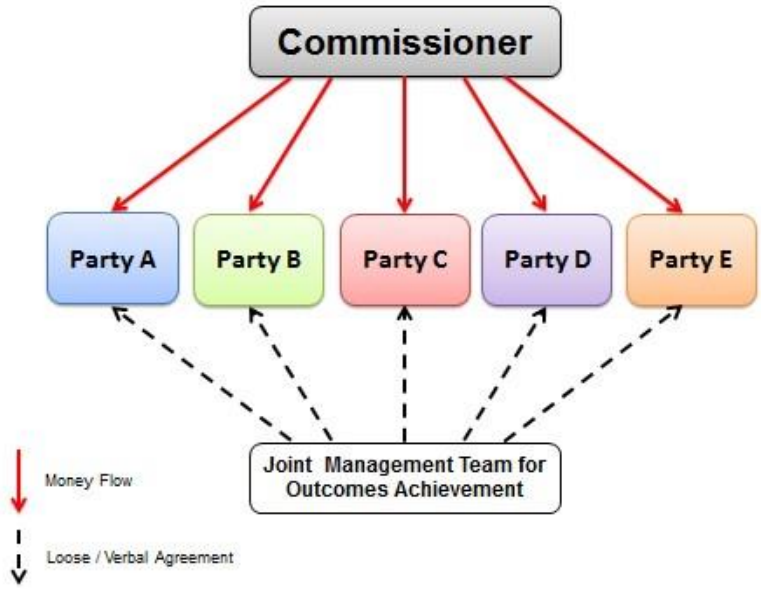
5. DESCRIPTION OF CONTRACTING MODELS

OPTION 1 – LOOSE NETWORK/CLUSTER BETWEEN THE PRACTICES	
What does it look like?	
How does it work?	• The practices agree pursuant to the Network Agreement to operate collaboratively. • A group comprising some of the interested parties ("Joint Management Team") is formed which meets regularly. • Practices can use this to model to discuss, assess, consider patient needs in their cluster, develop care pathways, share staff and resources, determine policy and regulatory issues.
Key Features	• This model enables practices to work together without forming a new entity. The practices retain full autonomy of their businesses and the arrangement with the commissioner affecting their core NHS contract continues. The arrangement between the practices is to collaborate and work together on an ad hoc basis. • This loose form of integration would be achieved through the formation of a Joint Management Team, whose membership comprises representatives from each practice and which would be tasked with achieving commonality across the practices.

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	• This arrangement would not facilitate the implementation of an integrated service delivery model but is a starter to build trust and confidence and achieve a vision before a more complex model is considered. • Practices' core business remains unaffected. • No impact on GMS Contracts/PMS Agreements. • No impact on NHS pensions. • No separate CQC registration is required. • One practice can be the nominated payee.
Strengths of this model	• The contractual levers in the Network Agreement could place obligations on the practices to achieve desired outcomes. • Representation on the Joint Management Team would not need to be limited to practices. Given the flexibility and informal nature of this model, other care sectors could participate in the group discussions and there does not need to be a limit or restriction on this. • The structure is easily amended given its informal basis and may not require a revision of existing arrangements.
Weaknesses of this model	• The Network Agreement needs to have contractual levers in place to bind the practices together in the delivery of the DES. This will result in shared contractual obligations between the practices to improve outcomes/achieve an integrated delivery model. This means that achieving common agreement to changes to each practices' resources if necessary is likely to be challenging. • This model could lead to fragmentation between practices where their incentives in relation to joint working are not aligned. • There is likely to be range of performance levels demonstrated by the practices. A practice's weaker performance will impact all other practices. • Implementing a single care plan across a discipline requires operational cross-disciplinary management to ensure these are in

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	place and are of high quality. Without an operational cross-provider management team in place, it would be challenging to implement coordinated care plans to deliver whole system outcomes. • The practices would only be very loosely coordinated and there would be a risk that the arrangements would not be adhered to or that there would not be a facility to deal with any default by any party (this will depend on the obligations set out in the Network Agreement). • As the risk and liability of the individual practices increases this model will need to coordinate with other models of service delivery. • The safeguards in place as risk and liability grow are inadequate.
Employment considerations	• Under the cluster model, the employment of all practice employees will remain with the individual practices. • Where practices wish to enable staff to work out of other practices within the cluster, the following options should be considered: **Place of work clauses/mobility clauses** • Each contract of employment/statement of terms will set out an employee's principal place of work; usually at the practice by whom they are employed. Where an employee is required to work at another practice within the cluster, flexibility within the contract is required to change the place of work. • The current contracts of employment at all the practices within the cluster should be assessed in order to establish whether they contain sufficient flexibility to accommodate the movement of staff. For example, some contracts contain express mobility clauses which give an employer the freedom to request that an employee provides services at a location other than the place of work, or alternatively no work place is given and the employee can be required to work at any location. • There is no legal requirement that the place of work clause or any mobility clause must be reasonable, but employers must exercise

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	such clauses so as to avoid undermining the mutual term of trust and confidence which is implied into all contracts of employment. This would involve, for example, providing employees with sufficient notice of a move and taking into account any personal circumstances that might impact on the ability to work elsewhere. • The absence of an express mobility clause does not automatically prevent an employer from moving staff to another practice. In every contract of employment there is an implied duty on the employee to be adaptable and a move to another practice may fall within this duty if it is within a reasonable travelling distance of the employee's home or current place of work. Where the move is deemed to fall outside the implied term of adaptability, a unilateral move could amount to a breach of contract which could allow the employee to treat him/herself as constructively dismissed. Therefore, advice should be taken before adopting this approach. • Where the current contracts of employment do not contain sufficient flexibility, or the duty of adaptability cannot reasonably be relied on, any change to the place of work will involve a variation to the terms and conditions of employment. Variations can be achieved in a number of ways, the most straightforward of which is by agreement. This can be achieved through collective agreement or individual agreement. If agreement is not possible, as a last resort dismissal and re-engagement can be used. A fair process must be followed when implementing a change. • Whichever approach is used, the practices involved should enter into a workforce sharing agreement which sets out the obligations and liabilities of all the organisations involved in the sharing of staff. In order to provide access at another practice, a licence to attend should be granted, which gives the right to work out of the premises and sets out the services the individual is permitted to provide. **Secondments** • Secondment agreements are a popular method of allowing the employment of an individual to remain with an employing practice

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	whilst they carry out work elsewhere. The employee will continue to be paid by their employer and will usually return to the employer at the end of the secondment. • Secondments tend to be thought of as full time assignments to another organisation but practices may wish to use secondments which are of a part-time nature. The employee would need to agree to the secondment and to vary their terms and conditions of employment to enable it. • It is usual to enter into a tripartite secondment agreement between the employer, host and the employee by which certain terms of the employment contract are varied, such as place of work. • Practices should be aware that there is a risk that long-term secondments, particularly on a full time basis, could be found to actually have been TUPE transfers (TUPE can be found to apply as a matter of fact and law even where the parties did not intend it) and so further advice should be sought if the secondment is of this nature. **TUPE transfers** • Where 'services' are transferring from one practice to another within a cluster, the parties could proceed on the basis of an automatic transfer of employees under TUPE. • It should be noted that in the case of a TUPE transfer, mobility clauses will remain an issue in respect of any requirement for staff to work out of alternative premises. • Where TUPE applies the new employer is likely to request an indemnity for all acts and omissions in relation to the period of employment prior to the date of the TUPE transfer, which is a reasonable position to adopt. For further details, please see Option 4. **Legal considerations for workforce sharing** • **Data protection** – in order to move staff between practices, it will be necessary to share their data. Practices will need to explain the lawful basis for processing the personal data of individuals who are moving between practices. This should be set out in specific

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document, called a privacy notice (or 'fair processing notice'). Consideration should also be given to whether a data sharing agreement is necessary, although this could form part of an overarching workforce sharing agreement.

- **Working Time Regulations** – the 48 hour working week obligation includes hours worked for other organisations, not just the individual's employer. In a workforce sharing scenario, it will be important to take all reasonable steps to ensure that the limit is complied with (and otherwise takes steps to protect the health and safety of employees where the limit is exceeded).

- **Right to work checks** – It is important to note that it is a criminal offence to allow someone to work where they don't have the right to do so. Liability for that offence cannot be transferred to another party. Right to work checks must be undertaken by, or on behalf of, the employer prior to employment commencing. Where employment remains with a practice, any workforce sharing agreement should contain a warranty that each member of staff who is moving will have the right to work in the UK and that the employing practice has the appropriate evidence of this.

  Practices would also need to check that a move to another organisation did not invalidate any right to work already granted.

- **DBS checks** - CQC guidance states that where individuals take up a new position and they are currently working in services regulated by CQC, that individual can satisfy the expectation that they will have an appropriate DBS check if they can provide evidence of a check, at the right level for their role, that is less than three months old at the point of application. As with right to work checks, the workforce sharing agreement should contain a warranty that a DBS check has been obtained by the employing organisation.

- **Documentation** – In respect of all of these options it is vital to have clear contractual documentation setting out the position as between practices and between each practice and the employee. If practices are considering using these options in the future, it is worthwhile ensuring that in the meantime any new contractual documentation issued to new staff is drafted in such a way as to enable practices to make these changes more easily, for example by including mobility clauses.

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	Joint employment • An alternative model is that of joint employment. This is where two or more practices jointly employee individuals. One practice will act as paymaster and pay the staff member's salary, NIC and pension contributions but the employee will work for both employers, with the arrangements set out in a tripartite contract of employment. • This model is less common than workforce sharing arrangements as set out above. However, it is sometimes considered because of the implications in terms of VAT (see below). • In order for an employee to be considered to be jointly employed, their contract of employment must make it clear that they have more than one employer. Thus, an employee will not be jointly employed if their contract of employment is with a single practice, even if that practice states that the employee is required to work for another organisation. Existing staff would therefore be required to enter new contracts of employment. • It is also essential that the management of the employee reflects the joint nature of the arrangement and the work they do, meaning that each employer must manage the employee according to their own policies and procedures in respect of the work they do at that practice. • As with the issues above, the employee will be entitled to access the NHS Pension Scheme in respect of the work they do for each practice, provided that practice holds the primary medical services contract.
Finance considerations	**General** • This loose arrangement would generally have no impact on individual practices, whose financial and tax affairs would continue as before. In particular, where a practice, or third party, is the nominated payee for DES monies, then that payee is receiving those funds on behalf of the ultimate recipients. It is therefore not income (either for income tax or VAT purposes) of that payee. **VAT** • General: The provision of healthcare to patients by GP practices is an exempt activity for VAT purposes. However, the supply of any staff (medical or back office) where the practice charges for the

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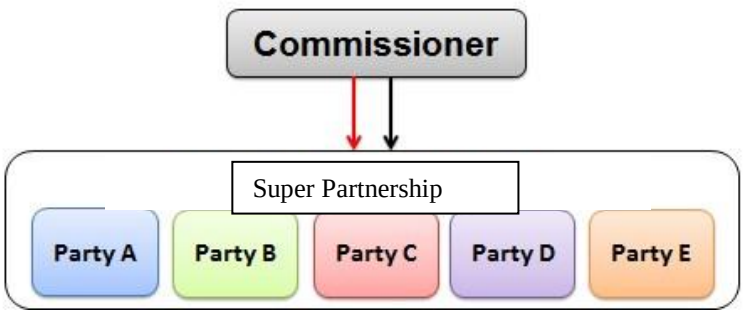
	supply, will be taxable at the current standard rate of 20% where the practice is, or is required to be, VAT-registered. Where practices are moving staff, or are providing services to each other, and payments are made for the cost of that, tax advice should be sought, prior to implementation. • Accordingly, individual practices should monitor their taxable income for VAT purposes, as, if this exceeds the VAT registration threshold (£85,000 for 2018/19) in any twelve-month period, it becomes necessary to notify HMRC of liability to be registered for VAT, and to charge VAT on such income, once registered. VAT-taxable income may include, for example, medico-legal work, medical boards/tribunals, passport/driving licence application countersignature, shotgun certificates, drug company reports, blue/orange badge reports (note: this list is not exhaustive), as well as the provision of staff or other services to which this report relates. **Joint employment** • Where there is joint employment, the reimbursement of salary costs from one joint employer to the other is treated as a disbursement for VAT purposes and is not subject to VAT. Again, advice should be sought.

Option 2 – SUPER PARTNERSHIP	
What does it look like?	

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Key Features	• A Super Partnership is formed by a number of individual practices merging into a single unit, covering multiple sites and will operate in much the same way as a regular partnership but on a larger scale. • A Super Partnership is likely to hold contracts centrally, and profits and risk are shared in accordance with agreed terms. • A Super Partnership can hold PMS Agreements and GMS Contracts and access the NHS Pension Scheme as an employing authority. • A Super Partnership will be registered with the CQC as a partnership. • A Super Partnership would need to enter into a Network Agreement. • A Super Partnership would need to nominate a clinical director.
Strengths of this model	• The participants would have direct interests in the underlying assets of the venture and contracts with third parties. • This is a familiar model for practices. • There can be effective senior representation across all the practices in a decision-making body so there is joint, equitable and active strategic management. • A shared budget can incentivise all practices to contribute. A joint venture management structure encourages a collaborative approach and a requirement for 'buy in' to quality/productivity by all practices. • The Super Partnership could also be a party to an alliance agreement (also referred to as a contractual joint venture) with other care sectors. • Flexible model in terms of structuring, ownership and management. Not regulated in the same manner as a corporate vehicle.

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Weaknesses of this model	• Each partner will have joint and several liability for the debts and obligations of the partnership and jointly and severally liable for the wrongful acts and omissions of his or her co-partners. • There is an absence of a legal vehicle with its own externally recognisable management structure and an indefinite life in which the assets and liabilities of the business can be vested and which can raise finance (including creating fixed and floating security) for the joint venture operations. • The practices will need to have an effective decision making mechanism to enable them to take decisions against each other where in the interests of the overall performance of the services. • As the Super Partnership grows in size a more corporate structure is advisable otherwise management of the Super Partnership becomes cumbersome. Even where a more corporate structure is put in place, unlimited liability will still remain.
Employment considerations	• Where practices merge to form a super partnership, this is likely to be a relevant transfer under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) either because responsibility for services will transfer from the employing practice to the super partnership or because there is the transfer of a business undertaking from the practice to the super partnership. • The terms and conditions of the employees will transfer to the super partnership together with all the rights, powers, duties and liabilities under or in connection with the transferring terms and conditions. Employees who object to the transfer will not become employees of the super partnership. Instead, their contracts of employment terminate by operation of law on the transfer date. • Changes to terms and conditions following a TUPE transfer are only permissible if the reason for the change is an 'economic, technical or organisational reason' (ETO) involving changes in workforce numbers or functions. This will cover rationalisation of staff (for example the consolidation of back office staff) and

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	changes to terms such as hours or place of work if there is underlying restructuring or redundancies. • One significant issue to consider when practices merge is that the employees carrying out similar roles are likely to be employed on varying terms and conditions as set by the original employing practices. This could have an impact on workforce morale and equal pay challenges are also possible. The super partnership should be able to rely on the TUPE transfer as a defence to any such claims but such differences would likely need to be addressed in the medium to long term in order to avoid successful equal pay claims. • Another particular risk is that employees could challenge any substantial changes in their working conditions to their material detriment arising from the TUPE transfer. The most obvious example would be the requirement to work in a different location that is not practically feasible for them. Again, the issue of mobility clauses will be relevant in terms of the ability to require staff to move between practices. In the absence of a mobility clause, this could result in automatically unfair dismissal claims against the employee's existing employer, or redundancy payment claims against the super partnership. • A TUPE transfer gives rise to some important information and consultation obligations which must be met in circumstances where TUPE applies. These obligations must be met by both the practices and the Super Partnership. • TUPE sets out basic issues which must be covered in the consultation process: a. the fact that the transfer is going to take place b. when the transfer is going to take place c. the reasons for the transfer d. the legal, economic and social implications of the transfer for the affected employees e. the measures which the practice will take in relation to the affected employees (or the fact that no measures will be taken)

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	f. the measures which the super partnership will take in relation to the affected employees (or the fact that no measures will be taken) i.e. what changes does the new employer contemplate making • TUPE does not specify when consultation must begin but for reasons of good industrial relations, consultation about the transfer must begin as soon as possible, before the transfer date. During the course of consultation, the practices shall consider representations made by the representatives, reply to these representations and if the employer rejects them, explain the reasons for this. In terms of the methods of consultation, the practice may wish to consider the advantages of both written consultation (clear, concise, accurate) and face-to-face consultation (direct, short chain of communication). If the information and consultation obligations are ignored, each affected employee can obtain a protective award of up to 13 weeks' pay from their employer in the employment tribunal. • Given the significant issues which arise in the context of TUPE, we recommend seeking legal advice as this will vary depending on the facts in each practice merger scenario.
Finance considerations	**Profitability** • On merger, practice profits are typically pooled and divided between partners in the new profit-sharing arrangements of the super partnership. The profit share of each individual partner will change and there will be winners and loser. • The arrangements for sharing profits vary between practices, for example they may be based purely on clinical sessions or calculated on a points-based system. Profit sharing plans for the merged practice should be agreed in advance and this will include consideration of items of income and expenditure which may be allocated specifically to individual partners, for example, student training income or professional subscriptions. • The level of partners' profits will, of course, affect the level of their drawings from the practice

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Partners' current accounts (investment in working capital)

- Working capital is typically funded by partners in profit sharing ratio and, on merger, individual partners will need to either introduce or withdraw funds depending on the relative levels of their current accounts.
- As a general rule of thumb, practices will maintain working capital at a level equivalent to one month's expenditure but this varies between practices and may be higher where practices pay the partners' personal tax liabilities.

Partners' capital accounts (investment in fixtures, fittings and surgery premises)

Investment in fixtures and fittings

- As for working capital, fixtures and fittings are typically funded in profit sharing ratio and partners will be required to either introduce or withdraw funds on merger. Consideration should be given to how the fixtures and fittings are valued in the accounts of the constituent practices.

Surgery premises

- Surgery premises are key to the financial position of the merged practice. Consideration should be given to future ownership of the properties in the merged practice and the terms of leased premises, including the potential cost of dilapidations.
- Changes in premises ownership will require professional valuations and appropriate loan funding will need to be arranged. Consideration should be given to the possibility of redemption penalties on fixed term loans and agreement reached as to who will suffer the cost of any penalties.
- The constituent practices may prefer to retain their own properties, allowing the super-partnership to occupy these. Such an arrangement would give rise to complex considerations for capital gains tax (including risks to the availability of entrepreneur's relief on a subsequent disposal), VAT and SDLT, so it would be

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	particularly important that a careful analysis be carried out before proceeding on this basis. This could also cause practical problems, increasing over time, as property ownership diverges from practice ownership. • It is most important that the partnership agreement sets out the arrangements for buying out a retiring partner's share of property and the expectations of a new partner proposing to join. **Tax** • **Income Tax.** All practices are treated as continuing, and so the commencement/cessation rules would not apply to continuing partners. However, almost inevitably, some of the member practices will have an effective change of accounting date, resulting in the creation, or use, of overlap relief, for income tax purposes and also for NHS superannuation contribution purposes. A change of year-end to 31 March, for example, will accelerate liabilities to income tax and NHS superannuation contributions, an effect which will, in general, be greater, the longer the partner has been in practice, and the more profits have increased during that time. • **Capital gains tax**. Individual partners will be treated as disposing of percentage interests in their respective practice premises, potentially giving rise to capital gains tax charges. It is likely that charges will be able to be mitigated by the use of rollover relief claims (since each partner will likewise be buying into other properties). • However, unless a particular partner is significantly reducing their commitment, it is unlikely that entrepreneur's relief would apply to such a gain, meaning that any gain remaining chargeable would most likely be taxable at 20%, rather than at 10% (and subject to the availability of annual exemption (£11,700 for 2018/19) and any capital losses available). • **SDLT**. It is likely that no SDLT would arise on the merger, due to the operation of the partnership rules within the SDLT code. However, if any of the merging practices is a sole practitioner, then the benefit of these rules is not available.

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	• **VAT.** This is potentially extremely complex, depending upon whether some practices are VAT-registered, and whether this is because of owning a property, on which the option to tax has been exercised or because they are dispensing practices. • Even if several of the practices are already VAT-registered, the 'new' partnership will have a single VAT registration. • If none of the practices was already required to be registered, it could be that the cumulation of taxable supplies made by the combined partnership will require it to be registered going forward. • Accordingly, the prospective super-partnership should consider the VAT taxable turnover of individual practices, as, if this cumulatively exceeds the VAT registration threshold (£85,000 for 2018/19) it becomes necessary to notify liability to be registered for VAT, and thus to charge VAT on such income, once registered. VAT-taxable income would include, for example, medico-legal work, medical boards/tribunals, passport/driving licence application countersignature, shotgun certificates, drug company reports, blue/orange badge reports (note: this list is not exhaustive), as well as the provision of staff or other services to which this report relates (although, if 'within' such a super-partnership, these would not constitute supplies for VAT purposes).

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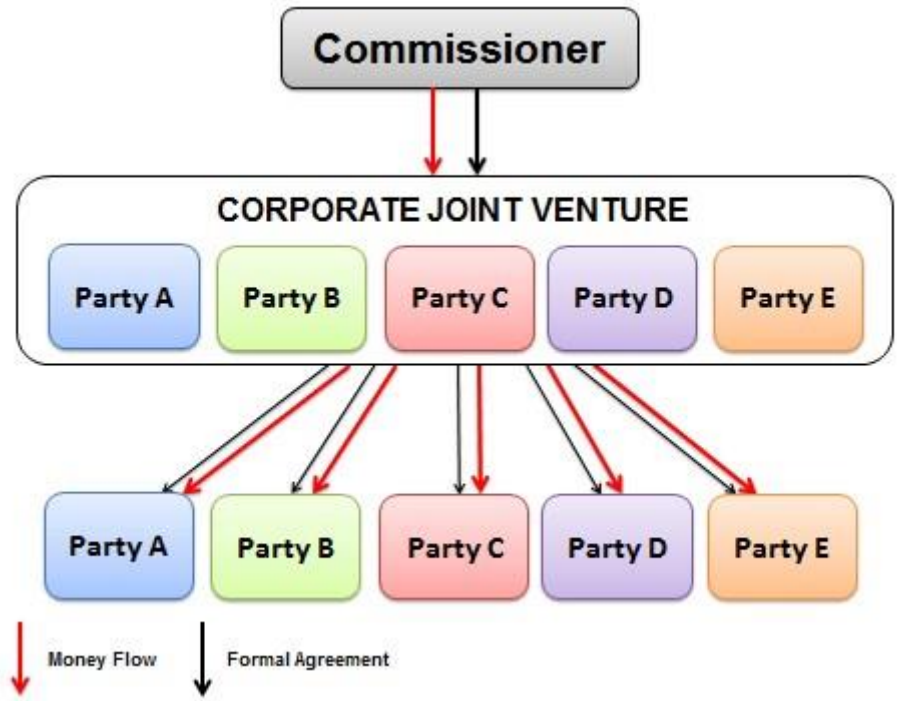
6. COLLABORATIVE WORKING

OPTION 1 - CORPORATE FEDERATION (Company Limited by Shares)	
What does it look like?	
Key Features	• A federation is an arrangement which uses a separate corporate vehicle in which all providers involved in the care pathway/bundle usually have representation in the corporate entity and agree on terms of collaboration for delivery of services. • Managed by directors, it is owned and controlled by shareholders. It is subject to its governance documents - the Memorandum and Articles of Association. • Liability of the shareholders is limited to the nominal value of the shares they hold. Shares can be divided into different classes with different rights. • The commissioner can contract directly with the federation. • The federation can pass down service delivery to its member practices or provide services itself or a combination of both. Service delivery by its practices would usually be via a subcontracting arrangement with the federation. • It is usual for practices' core businesses to be kept separate

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	from the federation.
	• If structured correctly, a federation can hold both GMS Contracts and PMS Agreements and access the NHS pension scheme as an employing authority.
	• If involved in the provision of services, the federation would need to be CQC registered.
	• A federation can be a nominated payee.
	• A federation can work with a PCN.
	• A federation could employ a clinical director.
	• A federation can also take the form of a Community Interest Company (Limited by Shares) (CIC) which has the same features as a company limited by shares but with the additional features of a social enterprise. The key features, strengths and weaknesses set out here in Option 1 of Par 6 would equally apply to a CIC save that it has the following main additional features:
	  • Dividend cap;
	  • Interest cap;
	  • Asset lock; and
	  • Community interest focus.

Strengths of this model	• Relatively low costs to set up. • It can hold tangible and intangible assets and enter into contracts in its own right (such as with commissioners and providers). • Shares can be issued at prices and conditions agreed in advance – this allows for different classes of shares with different rights. This can be a helpful and straightforward way of structuring representation of different practices. • Potential for greater consistency in provision through proper supply chain management across a broader spectrum of services, enhancement of integrated care through a mechanism which relies upon increased collaboration (i.e. in a very formal legal model) between providers of services. There can be effective senior representation across all the practices in a decision-making body so there is joint, equitable and active strategic management. • A shared budget can incentivise all practices to contribute. A joint venture management structure encourages a collaborative

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	approach and a requirement for 'buy in' to quality/productivity by all practices. • The corporate entity would be a separate entity and accordingly would contract in its own name and have its own liability meaning the practices owning the corporate entity are not personally liable for the financial risk. • The federation could also be a party to an alliance agreement (also referred to as a contractual joint venture) with other care sectors. • The contractual relationship with the PCN needs to be carefully considered. • If the federation is the nominated payee into which the DES monies flow it needs to be made clear under what conditions such monies are being held.
Weaknesses of this model	• Practices will need to have an effective decision making mechanism to enable them to take decisions against each other where in the interests of the overall performance of the services. • Regulated by corporate legislation which imposes additional administration requirements. Compliance with law/regulation (e.g. the preparation or audited accounts; filing returns with Companies House – therefore open to public viewing) which will add an additional administrative and cost burden. As a separate legal entity it will be subject to separate regulatory oversight which may include for example, NHS Improvement, CQC, Information Commissioners, etc. • The directors will have a legal duty to act in the best interests of the company. This may create conflicts of interest for representatives of participants/shareholders (to whom they owe similar obligations) that are on the company's board. Careful management would be required. • Incorporation of practices' core business and core NHS Contracts require consent and commissioners are required to consider their procurement obligations.
Employment	• Employment may remain with each of the individual practices

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considerations	under the Federation model, in which case the points set out at Option 1 should be considered where workforce sharing of existing staff is envisaged. • Alternatively, the Federation as a separate legal entity may be used to employ individuals who could then be required under their terms and conditions to provide services at one or more of the practices within the Federation. Where those staff are already employed by one or more practices within the network, consideration will need to be given to how the staff will be transferred into the Federation, usually under TUPE, and whether mobility clauses can be used (as set out above) to require movement between practices. • The benefit of this model over a cluster is that liability for such an employee will sit with the Federation as a separate entity, rather than resting with one practice. The Federation will be liable for the payment of salary and benefits to the individual and the place of work clause and job description can be widely drafted so as to include all practices, therefore avoiding the need for secondments, licences to attend and workforce sharing agreements. • It would be for the practices to decide under the governance documents how the costs of Federation employees will be funded. There would be VAT implications in adopting this model and advice should be taken. • If the Federation does not hold the primary medical services contract because they rest with the individual practices, it will not be an Independent provider for the purpose of the NHS Pension Scheme. Staff directly employed by the Federation would then not be entitled to access that scheme and an alternative pension scheme would have to be offered. This may well make it difficult to attract staff.
Finance considerations	**Corporation tax** • The company would be liable to corporation tax on its taxable profits (current tax rate 19%), such companies have no special tax status (not being charities), so, even if members regard them as 'not for profit', they remain liable for tax on profits they make.

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	• Assuming that such a company is profitable, the members may wish to consider how those profits may be extracted. • It is likely that a number of representatives from member practices will be delegated to run the company and its activities. It would be normal for those individuals to be remunerated by salary (via PAYE/NIC). • Profits can then be considered for distribution by way of dividend to member practices (although experience suggests that, generally, profits are accumulated, so as to fund further service provision). Any such dividends will be taxable on individual members (current rates 7.5%, 32.5%, 38.1%, depending upon income levels of individual partners. • Nominated payee. Where a practice, or third party, is the nominated payee for DES monies, then that payee is receiving those funds on behalf of the ultimate recipients. It is therefore not income (either for income tax or VAT purposes) of that payee. **VAT** • If the company is contracted to provide services within the VAT exemption for healthcare, then the subcontracting of the provision of these services to a member will also be VAT-exempt. Again, the distinction in VAT treatment between a supply of healthcare services and a supply of staff or other services must be recognised. • Alternatively, the members could potentially subcontract certain services to the company. Analysis of the VAT consequences of any such proposal should be carried out before implementation. **Succession** • Typically, each member practice will have a number of shares in the company, related in some way to list size, so that a bigger practice will hold a larger proportion of the shares than a smaller one. The arrangements will need to recognise that list sizes will vary and/or that practices may wish to leave or join the arrangement. There will need to be a mechanism for dealing with issue/transfer/cancellation of shares, including the value at which

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	such transactions are to take place. There will be tax and commercial implications associated with such transactions, and it is advisable that these are considered before such a situation arises. Any gain made on a disposal of shares would generally be chargeable to capital gains tax (current rate 20%, or 10% if entrepreneur's relief available)

OPTION 2 – LIMITED LIABILITY PARTNERSHIP	
Key Features	• Limited Liability Partnerships ("LLP") are established under the Limited Liability Partnership Act 2000. An LLP is a body corporate with a legal personality separate from that of its owners (known as members). • This is a hybrid model between a company and a partnership. • An LLP is liable for its own debts. The business liabilities and debts are the responsibility of the LLP, and not the individual members. The members of the LLP have financial exposure only to the extent of their capital investment (if any) in the LLP. • It is possible to have different classes of membership interest (and voting rights) so in that respect they are equivalent to companies. • The default position is that there is no separation between the ownership and management of an LLP, as every member has a right to participate in its management. • An LLP could be a nominated payee. • An LLP can work with a PCN. • An LLP could employ a clinical director. • An LLP could be a party to the Network Agreement.
Strengths of this model	• LLPs have unlimited capacity which means they can do anything that an actual person can do in its own name.

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	• The members can regulate their rights and duties by agreement between them. • As a separate legal personality, an LLP can hold its own assets and grant charges over them. It can enter into contracts in its own right and can sue and be sued in relation to those contracts. • A change of members does not affect the underlying assets of the LLP and the LLP also continues to exist following the change of membership.
Weaknesses of this model	• Members of an LLP act as its agents and owe fiduciary duties to the LLP. • LLPs are made subject to the various provisions of the Companies Act and the Insolvency Act so that they are, to a large extent, in the same position as limited companies, particularly in relation to disclosure requirements. • LLPs must file accounts with Companies House, which will then be public documents. • LLPs are legal entities but non tax payers (called fiscal transparency); the partners (called members) are liable for tax on their share of the profits of the LLP. • An LLP cannot hold GMS Contracts or PMS Agreements or access the NHS Pension Scheme as an employing authority. Given this, its role in an alliance model or contractual model is limited and unlikely to develop. It is also unlikely to be used as a model for service delivery.
Employment considerations	Similar to a Federation, a limited liability partnership can enter into employment contracts in its own right. However, LLPs cannot hold GMS Contracts or PMS Agreements and cannot access the NHS Pension Scheme as an employing authority. Accordingly, we do not recommend their use in the context of joint working within a primary care network.
Finance considerations	**Tax on income** As noted above, LLPs are transparent for tax purposes, so any profits are taxable on, and at the marginal tax rates of, the individual members. **VAT** An LLP is a corporate entity, and so has its own identity for VAT purposes

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	(as does an ordinary partnership). Further tax analysis is not given, since this model is considered not to be suitable for the non-tax reasons given above.

Capsticks Solicitors LLP and BHP Chartered Accountants

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