



Londonwide LMCs

The professional voice of London general practice

Securing the Future of General Practice in London

Guidance and checklist for general practices considering partnership models, GP provider companies, federations or practice mergers.

February 2015

Preface

General practice is under increasing pressure to work harder, faster and longer than ever before. The demands from government and patients are rising exponentially at a time of unprecedented change, with decreasing resources, no investment in premises, significant workforce recruitment and retention problems, and increased practice closures leading to removal of existing GMS and PMS contracts in favour of APMS. As the NHS continues to face severe financial challenges, discussions about system transformation have almost become the norm, underpinned by assumptions that the numerous systemic challenges facing the NHS can be met by delivering services at scale and pace, based on segmented care, with larger organisations delivering care along agreed pathways as a precursor to vertically integrated service provision. The clear message from many commentators is that in order to achieve the necessary system changes, the perceived current issues across general practice need to be “fixed”; the clear assumption being that the current model is not fit for purpose!

It is becoming increasingly clear that the current challenges facing general practice will not diminish. In order to survive, and thrive, general practice needs to rise to these challenges, while at the same time maintaining and building on the core values and principles that underpin general practice. Practices need to understand the new challenges, risks (and opportunities) they are facing, and how they can develop and adapt to maximise opportunities and minimise risks.

As part of our ‘Securing the Future of General Practice in London’ work we have produced publications, and held a number of conferences and meetings setting out options to help practices cope. We have supported groups of practices that have been highly innovative, and which have transformed into thriving primary care providers of a diverse number of services alongside core general practice, primarily by working with local GP colleagues. It is clear given the challenges facing general practice that GPs need to carefully consider how to work more collaboratively with local colleagues, to not only overcome some of the difficulties but to ensure that the future looks more appealing.

There is no “right” model for how practices should work together; there is no definitive structure. Before designing the structure of any new grouping of practices, it is critical to fully understand the problem. This document sets out the options to consider, and provides practical guidance on the steps to take to put in place collaborative working arrangements.

It is important however that GPs, and LMCs, do not focus only on structural changes. It is essential not to forget the controls both financial and strategic that NHS England London command over your CCG and therefore the importance of our ability to influence their thinking as everything they think or do will have an impact on you and local GPs. This is complex territory but we have been working hard behind the scenes to help steer their thinking and outputs in the direction of the values of general practice which we have shared with you as defined by our ‘Securing The Future Of General Practice In London’ work. It is unlikely that the pressure, and cases for change will decrease, and we will continue to feed back responses on behalf of London GPs to documents such as NHS England London’s ‘London Standards for General Practice’ which emerged following their ‘Case For Change’ consultation as part of NHS England (National)’s ‘Call To Action’ and ‘Transforming Primary Care’ agenda. We will continue to make the case for additional resources, explaining that if there was enough practice or network cash, staff and available time with patients, the “standards”, with the right support, could be deliverable over time.

I know that your practice and all practices are experiencing on a moment by moment basis the direct negative and excessively stressful impact of the horrendous upheaval, funding cuts and excessive bureaucracy which continue to be flung at GPs, practice teams and your patients from all parts of the system – national, regional and local. You will recall that last year we launched our ‘General Practice Cares’ campaign to highlight the overarching areas of concerns and to get our messages out to patients – i.e. voters. This has been followed by the launch of the RCGP’s ‘Put Patients First’ campaign, and the BMAs ‘Your GP Cares’ campaign, both of which were heavily influenced by our original. Since then we have seen the development of the East London ‘Save Our Surgeries’ campaign and Pulse magazine’s ‘Stop Practice Closures’ campaign in support of MPIG-hit and stressed out practices. We support all of these. We will continue to campaign on your behalf.

This excellent guidance has been written to give you clear advice about the possible structures and how they might help you achieve your goals and look forward to a sustainable future for your practice. I fully commend it to you.



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Introduction – Why Federate?

There is significant and increasing pressure from commissioners to commission wider and at scale from primary care providers, as part of a wider transformation agenda. The case for change for GPs working in larger collaborative ways has been set out in a number of publications; including Londonwide LMCs documents, all of which can be found at www.gpresilience.org.uk. Arrangements have been established in various parts of London, with different approaches taken depending on the purpose of such networks and local circumstances. There is no one size fits all although there are issues which need to be assessed, and steps taken in developing any collaborative arrangements. It is essential that any such arrangements preserve GP core contracts, maximise opportunities, and minimise risks for general practice.

Service pressures have been recognised by NHS England in the 'Call to Action – Improving General Practice Phase 1 Strategic Review Report' (March 2014). This report describes how NHS England wishes to see general practice operating at greater scale and work in collaboration with other providers to meet the needs of patients, carers and communities. The report also states that creating wider primary care at scale does not necessarily have to involve a change in organisational form. It can be achieved through practices coming together in networks, federations or super-partnerships which will be at the core of more integrated out-of-hospital service provision. Current thinking indicates that general practice will need to be an integral part of the new NHS, reflecting the following agendas:

- Transformation
- Integration
- Segmentation
- Re-organisation (ACOs, ICOS etc).

There is growing national recognition that general practitioner services are experiencing considerable workload pressures. Although the nature and extent of these can vary from one practice to another the principal pressures being experienced by most practices arise from:

- An increasing demand for general practitioner consultations and improved access.
- A growing and ageing population with many more people with two or more long-term conditions that would benefit from new general practitioner led approaches to complex care.
- An expectation that general practice will clinically lead new types of integrated out of hospital care services that will reduce reliance on the hospital sector for those with urgent but sub-acute care needs.

- Changes in general practice workforce demography and limitations in the number of GP trainees.
- The funding levels of general practice services linked to the national financial challenge.

General practitioner provider networks and federations are emerging in various shapes and forms across many areas of England to meet current service pressures in new ways. The range of services that can be offered through a collaboration of practices can be significantly extended. Such collaborative approaches offer a clear opportunity to realise the benefits of developing general practitioner services at the core of wider primary care at scale whilst preserving the local nature and configuration of general practice. As new organisational, commissioning and provider structures develop within the NHS it is important that general practice remains fit for purpose, and that core values and principles are maintained whether as part of the transformation, segmentation, or integration agenda.

Implications for general practice

Forming general practitioner provider networks or federations may provide opportunities to:

- Strengthen the capacity of practices to develop new types of out-of-hospital services.
- Improve the integration of services between General practitioner and other services provided through hospital specialist out-reach services, community health services and social services.
- Improve the quality and consistency of services at all practices.
- Strengthen peer review and clinical governance arrangements.
- Develop new localised clinical training and development programmes.
- Establish an organisation that can respond to future procurements and compete with NHS and independent health-care providers.
- Support efficiencies in the delivery of core general practitioner services.

Before setting up any collaborative working GPs need to consider the following:

Vision and purpose

The organisational and legal form of GP federations can vary in line with the purpose of the federation, the extent of the integration across practice services and the preferences of local general practitioners. It is essential that there is an agreed vision, purpose and objectives for any new organisation. A business plan is essential, setting out;

- Vision and priorities; objectives
- Current position

- Membership, governance and decision making
- Stakeholders
- Engagement
- Future development
- Opportunities, threats and risk-handling strategies
- Financial issues

Key questions to consider include whether the purpose is to:

- Achieve economies, share backroom functions?
- Improve primary medical services?
- Compete/bid for new services?
- Provide a model for future development; does this mean 'traditional' general practice, or being part of a new organisations e.g. ACO, ICO?

There may be risks, which need to be identified and addressed, and any development implemented in an appropriate way based on core values and principles (as per Securing the Future of General Practice in London).

This collaborative approach has been endorsed by both the BMA GPC in their document 'Collaborative GP Alliances and Federations – Guidance for GPs' (October 2013) and by the Royal College of General Practitioners in their strategy document 'The 2022 GP – A Vision for General Practice in the future NHS' (May 2013).

Identifying Suitable Organisational Structures

One of the most vital steps in federating is ensuring that the correct organisational structure is adopted for the type of service(s) that the group has in mind to undertake. Whilst there are a variety of structures to choose from, each has its own advantages and disadvantages. There are numerous options; Londowide LMCs does not recommend one over another.

There has been much debate about the right structure and whether one model may be better than another. However, it is clear that, when deciding a structure, the important factors to take into account are the size of the group, the type of work that it will be undertaking - both currently and in the future (future proofing the structure is therefore an important consideration) and risk. Adopting one type of structure only to discover that it is not adaptable enough going forward, or does not give the flexibility that its members require is both costly and time consuming. This is particularly so, when it may have to be abandoned and the whole exercise started again.

It is also vital to understand that every structure does not stand alone as there are numerous considerations and support documents that need to be addressed and put into place. These will be explored within this guidance.

Private Company Limited By Way of Shares

This model is currently one of the most popular among aspiring federations.

The main advantage is that it provides its members with limited liability. A company is regulated by Companies House and has statutory requirements which its members/directors must fulfil. It is generally the model adopted for profit-making and although this is an advantage in pure commercial terms, there are some that advocate that this model doesn't carry the same community feel or spirit attached to a community interest company or a social enterprise company. However, love it or hate it, a company is the vehicle that gives its members both the flexibility and protection that other models may not offer.

In terms of a federation adopting this model, the members, or in this case shareholders, of the company will usually be the practice partners. As GP practices are not considered legally to be individuals in their own right, a practice cannot hold shares. The shares are therefore held by each of the partners, or by one lead partner who may hold the shares on trust for the benefit of the others.

Creating a company will require articles of association. This is a document that sets out the details of the general management of the company and will include matters such as the election of the Board, quorum and voting rights, general meetings, service of notices, the right to declare dividends, termination and appointment of directors etc. The articles may be modified to suit the needs of a company and modified articles must be submitted to Companies House for approval.

If the company wishes to undertake work in a community interest company (CIC) then there are various ways to do this – there is nothing to prevent a private company from holding shares in a CIC, as long as the CIC ensured that the work conducted kept within the boundaries of its "mission statement". There is also no impediment for a company limited by way of shares to undertake work for a CIC by way of joint venture. Both companies would have to be permitted to do this under any memorandum of association.

The shareholders will be allocated shares in the company. The calculation and proposed allocation of shares is an exercise that should be conducted before the company is set up. In the case of practices, this is usually based on patient list size.

There is no longer a legal requirement to have a memorandum of association. This is the document that sets out what business the company intends to undertake. If a company decides to have a memorandum, it may only undertake such activity that the memorandum allows. Accordingly a lot of recently formed companies have chosen not to adopt a memorandum as it increases the flexibility of what the company is permitted to do.

The amount of share capital in the company will need to be confirmed and each of the shareholders will be liable to the company for any debts up to the amount they have invested. Suffice to say that one of the major advantages of this model is that no one will suffer unlimited liability in terms of their facing losing their personal assets in the event that the company becomes insolvent. This is very different from the usual partnership models that general practitioners usually adopt for the delivery of core services where liability of the partners is not only unlimited, but joint and several.

A limited company is considered to be a “person” or “individual” in its’ own right. It can be subject to legal action and can sue or be sued. It can also be a shareholder or a director in another company. The company therefore will exist beyond the life of its members and will continue whether shareholders leave, retire or die. This provides an element of security for other shareholders/members and for employees.

The Board of Directors run the company and are involved its day to day management and general business. They have ultimate control. However, this control can be diluted by any shareholders rights and/or obligations and these can be set out in a shareholders agreement. All directors are under a legal obligation to act in the interests of their company and their behaviour is regulated to a minimum required standard by the Companies Act.

There should be an awareness of any conflicts of interests between Directors sitting on a Board of a federation and also holding a position on the Board of a clinical commissioning group. It is not advisable that an individual holds a position on both entities where there is a potential or actual conflict of interest.

Every company should have a policy on conflicts and how to deal with these; every clinical commissioning group will have a section in their constitution that also deals with the management of conflicts.

The disadvantages of a limited company will inevitably be the complex accounting and bookkeeping rules as well as the fact they are regulated by the Companies Act. A private company cannot act like a public company and sell shares to the public to raise capital, although it can issue more shares to raise capital or call upon unpaid capital from shareholders. The costs of setting up a company are not usually onerous, but within the healthcare arena, the number of added steps, the size and complexity together with added documentation may give rise to more than the normal costs of set up.

Private Company Limited by Guarantee

Another form of company is one which is limited by way of guarantee. These share similar characteristics to companies limited by way of shares in that the member liability is limited. It also has articles of association and, if required, a memorandum of association. These types of company are usually non- profit making, but do not have to be. There are no shares or shareholders, simply members who usually guarantee to meet any company debts by contributing a fixed amount of money (usually the sum of £1 pound sterling). There is no mechanism to pay dividends and the company will make a surplus rather than a profit which it rolls back into the company for furtherance of company activity.

By way of example, the British Medical Association is a company limited by way of guarantee. Its members are members or prospective members of the medical profession and the company’s activities are concerned with furthering and supporting the profession. The company does generate revenue and any surplus is reinvested for the benefit of its members. A disadvantage is that whilst members obtain a number of benefits they receive no dividends or remuneration other than for services rendered by way of service on committees.

This type of model is usually best for charities or community based companies. Members meet and control the company via general meetings. This type of company still has directors that control and manage the company’s affairs and those directors are still subject to the director’s duties and obligations as mentioned above.

Community Interest Companies (CIC)

This is a new type of company which was introduced in 2005 and is regulated by the Community Interest Company Regulations 2005.

A CIC can be a company limited by way of shares or a company limited by way of guarantee. The company is governed by general company law but is regulated and registered not only by Companies House, but also by the CIC Regulator.

The main aspect of a CIC is that it is created mainly for the benefit of a particular defined community. This will be a distinct group of people or a defined section of the community. The whole purpose of the CIC is that it is chosen as a vehicle to trade for a particular social purpose to benefit the chosen “community”.

The manner in which a CIC is set up is not dissimilar to a company limited by way of shares or guarantee – in fact, the creators must choose which type of limited company model they require before undertaking the added process of converting it into a CIC. Effectively, this is done by issuing a Community Interest Statement (commonly referred to as the

mission statement) alongside the application to create the company. This statement must be signed by all directors and needs to describe in detail the company's objects and certify the reasons why it has been formed i.e. identify the specific community and state that it is formed to serve that community rather than for private gain/profit.

Once the Community Interest Statement (CIC) has been agreed and registered, the CIC cannot undertake any activity that may fall outside of this remit. Flexibility for diversifying services and work may be curtailed in the future.

Advantages of this type of model for healthcare are that it provides a good basis for reinvestment back into the chosen community (e.g. patients) and has a "not for profit" feel that federations would like to be perceived as being their purpose. The disadvantages, which must be considered carefully, are that it will not necessarily generate sufficient income for its members/shareholders and may not be flexible enough should the purpose or aim of the company change in the future.

All CICs are subject to an asset lock, and this will be set out in the articles. This means that all the assets and profits (subject to dividend rules), will be permanently retained within the company and must be used solely for the benefit of the chosen community.

If a CIC is limited by way of shares, then one of the main disadvantages (as compared to a straightforward company limited by way of shares) is that there is a cap on any issue of dividends. This is to ensure that the CIC maintains its not for profit purpose and, whilst this may not be an issue for many organisations, may be one of the considerations that prospective shareholders may need to take into account in deciding which model would most suit. It does mean that if the company does extremely well and there are substantial profits, the company will be restricted in any dividend issue. For the avoidance of doubt, the CIC can issue a dividend to shareholders, but the amount of dividend issued will be capped per annum.

Directors can receive remuneration for the work they undertake. The majority of "profit" would normally be expected to be reinvested back into the CIC for the benefit of the chosen community.

CIC may also benefit in forming partnership arrangements with publicly funded NHS Trusts and social service departments, as long as the provision of services fitted into the objectives of the CIC.

Private companies, particularly those limited by way of shares should be able to partake of the benefits of an NHS pension for employees under an NHS contract; however, this is best checked thoroughly with the NHS Pensions Agency.

Social Enterprise Company

This is the blanket term used to describe companies which are primarily set up for social or community services, where profits are reinvested back into the company for that benefit. The company will be expected to reinvest profits to further the community or social purpose. There are no added tax benefits to a Social Enterprise company and it is treated on the same way as a commercial organisation as far as the tax man is concerned.

Limited Liability Partnerships (LLP)

This new form of limited liability business model was introduced by the Limited Liability Partnerships Act 2000. Despite the name, it operates more like a corporate entity than a typical partnership and has been mainly adopted by large accountancy firms and law firms. The need for the introduction of LLPs was mainly because of the collapse of large accountancy firms due to negligence claims.

Under normal partnership rules – as with general practitioners, liability is joint and several. However, because of the low risk nature of core contract work and the fact that partners are usually small in number and usually based in the same premises, this model works particularly well.

However, that is not to say that federated groups of GPs cannot adopt the LLP model, particularly where there are large numbers covering several practices. The major disadvantage of an LLP is that it cannot be an employing authority for purposes of being recognised under the NHS pension scheme. It also cannot hold a core contract.

A LLP offers its members limited liability, although it is taxed like a general partnership. It exists until it is formally dissolved and requires to be registered at Companies House, just like a company. Registration requires the completion of an incorporation document and will require the names of at least two people who are "carrying on business with a view to profit". The incorporation document must also provide details of all the members of the LLP including their addresses and, also details of designated members – who will be responsible for all filings and administrative matters – similar to a company secretarial role. Every member of the LLP becomes the agent of the LLP and has the authority to act on behalf of the LLP and bind the LLP in all business. This can be problematic for federations.

Federated groups of GPs are large and the LLP model does not allow a separation between owners (e.g. there is no separate Board of Directors). The only way a member cannot bind the LLP is when the third party who that member has dealt with was aware of the members' lack of authority. This therefore may pose a higher risk to the LLP than, say, a limited company where there is an elected or appointed Board of Directors that makes decisions.

Cooperatives

These are also known as Industrial Provident Societies. They are set up to carry out a trade or business for community benefit. A cooperative is incorporated which means it has gone through the registration process of setting up as a company limited which makes it a separate entity in its own right.

Examples include agricultural and housing cooperatives, working men's clubs, women's institute, mutual investment companies and housing associations.

Registration of this structure is not with Companies House, but with the Financial Conduct Authority (FCA) who regulates the entity. The Companies Act 2006 still requires the name of an Industrial Provident Society to be included on the register of companies.

Advantages include limitation of liability of members. It is incorporated and regarded as a "person" able to hold property in its own name and take legal action in its own name.

The disadvantage if the organisation does not use model rules, is that registration can be lengthy and expensive. All annual accounts must be submitted to the FCA and the organisation must pay the FCA an annual fee.

There are no real advantages to setting up an Industrial Provident Society rather than, say, a Community Interest Company or a Company limited by way of shares or guarantee.

For the medical profession, federating should be simple and straightforward with the aim of ensuring that the federation achieves its objectives in the manner that they feel is manageable and understandable and caters for the needs of its members/shareholders and is flexible going forward.

The most popular models throughout the country have been companies limited by way of shares and community interest companies. Either one is very suitable to the needs of federating groups, but each federation in each locality must make informed decisions about structure based on its own specific needs.

Partnerships/Partnerships at Will

No guidance document on structure would be complete without a section on partnerships. This has been the main model adopted by GP practices throughout the UK and is one of the structures recognised as being eligible to hold a primary care core contract, its use, adaptability and problems has been the subject of much debate.

We will be issuing a separate document regarding GP partnerships in the new NHS, and do not therefore intend to cover partnership issues in any detail in this document. There are however a number of key considerations as you move towards more collaborative working arrangements.

Participating practices should have a current written partnership agreement clearly setting out the terms of how partners are to carry on the business, mainly to prevent disputes between partners in the future.

GP partnerships are set up mainly so that they can conduct business through holding a General Medical Services (GMS) or Personal Medical Services (PMS) contract (sometimes also an Alternative Personal Medical Services contract – APMS).

The core services contracts are the bread and butter work of GPs and, unlike many other trade partnerships, the regulations that govern the delivery of those services are highly complex. The obligations placed on GPs are extensive and exacting and the raft of subsidiary legislation that sits around the delivery of primary care service contracts is ever growing. With the introduction of the Health and Social Care Act 2012 (discussed later) the need for a written partnership agreement becomes imperative.

The beauty of a partnership is its flexibility and unregulated nature, the downside is that each partner will be liable for the entire debts and liabilities of the partnership - jointly or as an individual. Essentially, there is not limit on the liability of individual partners as afforded by limited liability corporate entities such as companies or LLPs.

It is perfectly possible to have super-partnerships and these larger models of partnerships having contractual arrangements between themselves have been adopted and have worked. Super-partnerships will be explained in detail in the follow up document, 'Medical Partnerships in the Modern World'.

Further Necessary Documentation

Shareholder Agreements

If the structure adopted is a company limited by way of shares, then a shareholders agreement is definitely worth considering. Where there are large numbers of shareholders, this document helps set out the rights and obligations of shareholders, including issues such as protecting minority shareholders, setting out the conditions for holding shares including options to re-purchase or sale, making clear when, and in what instances, shareholders have the right to vote on an issue, or vote on a particular decision. This is important where practices are concerned as there may be instances where decisions are not left to the Board. It is also important since the federation members are essentially GP practices/partners and there will have to be some conditions around who is eligible to hold shares. If a practice loses its core contract, or if one of the partners leaves, dies, or retires, it will be important to know the process for deciding what happens to the shares that practice or the partner

owns. There may need to be certain restrictions placed on sale or purchase and some mechanism whereby neighbouring practices shareholdings potentially increase as a result of list disbursement.

The advantage of having a separate shareholders agreement is that, unlike the articles of association of a company, it is a private contractual document between company and shareholders and is not subject to public scrutiny. It is also a good document to have in place to deal with the complex issues that may arise, and which are pertinent to GP federations.

LLP Agreements

As described above, LLPs are relatively easy to set up. The process requires a form to be submitted to Companies House setting out the details of the partners and designated partners, the name and the registered office. However, although this effectively creates the LLP (once registration is accepted formally) it would be unwise not to have a written LLP agreement.

There is no legal requirement to have a written agreement, and, if there is not one the provisions of the LLP Act 2000 will apply by default. Examples of default provisions will include:

- Members not receiving remuneration for acting on LLP business.
- A member cannot be expelled by a decision of the majority.
- All members share profits equally.

It is clear therefore, that the LLP may wish to impose different conditions and regulate the LLP and members in a different manner; a written agreement therefore becomes important. The agreement is not a public document and does not have to be lodged at Companies House. It is a private agreement between the members and the LLP.

A written agreement is similar to a traditional partnership agreement, where the partners wish to regulate their dealings with one another in a manner outside of the provisions of the Partnership Act 1890 and so will deal with matters such as dispute resolution, retirement, expulsion etc.

Trust Deeds

Most federation members consist of GPs within practices. Shareholders are usually partners in GP practices, but could also consist of salaried GPs. As a practice partnership is not a legal entity capable of holding property or shares as an individual, the partners usually become shareholders. Each practice shareholding is usually based on list size. The value of that shareholding and number of shares is then divided between existing partners in accordance with their practice profit share (or by such other means as the practice may determine).

Salaried GPs may also be allocated shares if the practice so desires or the federation decides not to exclude them from membership. The result is a high number of individual shareholdings, and shareholders.

One alternative method of allocation of shares is to have a lead partner in a practice who agrees to hold shares allocated to the practice as a trustee, on trust, on behalf of the beneficiaries, who will be either all the other partners and/or salaried GPs. This reduces the number of shareholders and for the federation, simplifies matters of process. Such arrangements need to be documented in a Trust Deed.

The practice will have to ensure that the trust deed is executed correctly and that there are processes in place within employment contracts (if trusts are held for employees as well partners) and partnership agreements to clarify what happens when individuals leave, die, retire or there is an increase in salaried GPs or partners.

Some of these fail safes will necessarily have to be in place in any event. A trust deed makes for more work in terms of documentation and will require changing when something changes in terms of individuals within the partnership.

Internal Documentation

Once the federation has established itself in a legal capacity, it should turn its attention to creating internal policy documents on issues not addressed within any formal documentation. Matters such as HR policies, allocation of work to practices/shareholders, remuneration and fees etc.

These policies should have the agreement of the members/shareholders.

The federation is established essentially to enable practices to respond collaboratively to the commissioning of new and additional primary care services including responses to formal procurements. The federation will need to have the necessary pooled resource and expertise of a large group of practices/healthcare providers, backroom resource, equipment and manpower.

Once a contract has been won as a result of a successful tender, there should be a clear indication of the process to be adopted to allocate that work fairly and equitably. There should also be a clear indication of how the providers within the federation are to be compensated. The federation is only as good as the practices within it, if a practice fails or underperforms or partners (shareholders) are suspended from the performers list, a federation should have systems in place to deal with this.

Insurance and CQC registration are dealt with in later sections, but all these issues should be dealt with within a set of internal processes and procedures so that the federation and its members are clear at the outset how certain issues that partnerships face from time to time are reconciled within the federation model.

Employing Staff and Related Considerations

Employing and sharing staff – terms and conditions

Federations, essentially being made up of people and expertise, may have an existing source to tap into and therefore may have no need to employ staff specifically for the federation. Where this is the case, existing practice staff may be utilised in part for federated work. However, there are two considerations that will need to be borne in mind:

Firstly, staff must be consulted on their existing terms, ensuring they are aware of, and agreeable to, any changes in work function, hours and pay. This should be reflected in changes to their existing contracts of employment, or as an addendum to their employment contracts where any work for the federation may be limited in time. There is also the question of who pays for the extra costs of working for the federation.

Secondly, any provision of non-medical staff to the federation may be regarded as a VATable supply and subject to a VAT charge to the federation. Clearly, this may place a financial burden on any newly formed federation and advice will need to be taken on the possibility and advantages of putting into place joint contracts of employment to avoid this.

Before using practice staff, it is strongly recommended that advice is taken on the employment implications of doing so. It should be ensured that any contracts of employment and staff consultations on increased workload are properly conducted.

Transfer of Undertaking (Protection of Employment) Regulations 2006 (“TUPE”)

TUPE occurs when a business merges with another business or part of a business or, more likely in this context, where a practice employee works solely for, (or a large proportion of work is conducted for) the federation.

In the event that the employee is supplied to the federation and the employing practice closes down, the employee will, unless the contract has been varied, automatically transfer to the federation on the practice terms and conditions of employment.

It is important to take advice on how a practice closure will affect staff that either have joint contracts of employment with the practice and the federation, or have been supplied to the federation by the practice. The easiest and most sensible way of doing this would be to take advice before the employee starts working for the federation. This ensures that the federation, the practice and the employee are clear about their rights and obligations in the event of any problems arising.

Employees will also want to ensure that any NHS pension benefits are not affected by working for the federation. This is another reason why it is important to choose the right structure for any federated model.

HR Policies

HR policies are essential when joint contracts of employment are in place. There will need to be clarity about which employers will have recourse if there is a dispute; how much of the employees work will be conducted for the federation; who conducts appraisals; disciplinary processes and grievances; and what happens if one employer gives a contrary instruction? All these matters should be clarified at the outset.

Insurance and Covering Risk

Care Quality Commission (CQC) registration

Each individual practice will have to have CQC registration to carry on core work. Joining a federation raises questions as to who will require to be registered. If the larger overarching federation is not actually providing the service, but, is rather acting as a conduit for responding to tenders and securing contracts on behalf of practices that are to deliver the service, then the federation may not have to obtain separate CQC registration itself. The practices that are to deliver the service however, will have to secure appropriate CQC registration and in doing so, they must notify CQC that they form part of a larger organisation.

This creates some issues that the federation must consider:

Firstly, when responding to a tender for the delivery of a particular regulated service, it is unlikely at that time all the practices earmarked for delivery will have obtained the specific CQC registration required, so any bid may not be able to make reference to appropriate CQC registration being in place at the time that the bid is submitted. This is clearly a disadvantage.

Secondly, obtaining appropriate CQC registration takes at least 8 weeks from the receipt of an acknowledgement from CQC of a submitted application. This does not take into account any extra time that may be added on for failures to meet criteria and correcting faults.

Naturally, no services can be delivered unless and until a certificate of registration is obtained. This is not a problem if practices already hold certificates for certain services above core work. This is also on the assumption that any contracts that are obtained, are sub-contracted out to individual practices on separate arrangements.

Whatever the scenario, the legal responsibility for the delivery of any contract for services will lay with the provider or overarching organisation – the federation. In response to a tender a federation will have to ensure it is clear about the locations where the services are to be delivered and the fact that CQC registration has been/or is likely to be obtained. The federation, since it intends to hold the contract, will have some responsibility to ensure that CQC compliance is maintained by the practices/individuals that it sub-contracts to. This will have to be added to any indemnity that the federation will need to have with any practice to which it sub-contracts.

This in itself raises issues of insurance for the federation and the practices. Practice insurance cover will necessarily have to be reviewed and premiums will inevitably be revised upwards. It is essential that individual practices contact their medical defence organisations to inform them of any changes in service to ensure that adequate cover is in place. The federation may have to factor this cost into any subcontract, however it is down to each federation how they wish to handle this issue from a cost perspective.

The issue of insurance is also an important consideration when dealing with the use of equipment/premises. If practices intend to utilise equipment and/or premises that they own or lease for the benefit of the federation, then, the question arises as to who pays for the on-going costs of maintenance, rent and insurance? This needs to be factored into the costs of any sub-contract.

Amendment of Practice Partnership Agreements

Current updates to core contracts

Every practice needs to have an updated partnership agreement. Failure to do so means that the partnership could be deemed to be Partnership at Will and therefore subject to the conditions as set out in the Partnership Act 1890. This means for example that partners may be deemed to have equal shares in the partnership, or, that a partner may be able to dissolve the partnership on notice.

Working for the federation – impact on core service

The creation of a federation and the increased obligations on practices and partners to undertake federation work/services will inevitably mean an impact on core services and the partnership agreement. Federations would be unwise to create a structure based on a loose set of partnerships which are unregulated by any agreement. If federations are relying on the strength and capabilities of shareholders (usually partners in practices) or members, then it is axiomatic that those partnerships need to be governed by a robust agreement. This ensures that any issues that arise are dealt with properly and do not impact on the federation, or at the very least are mitigated. Issues to anticipate could include: what happens when a partner is suspended and can no longer work for the federation; what happens if a partner wishes to leave; what happens to the delivery of core work when a partner may be delivering services to the federation?

These are just some of the questions that require resolution within a partnership agreement when a practice becomes part of a larger network.

Changes to Practices/Partners

In order to maintain and enhance general practice services it is essential that wherever possible existing contracts and NHS-contracted patient lists are preserved; GPs working collaboratively are in a strong position to both maintain existing, and also shape future contracts and services. More details will be available in our next publication, 'Medical Partnerships in the Modern World', however there are a number of areas which GP networks should consider as they develop, including:

- Merging practices
- Closing practices; dispersal of list
- Leaving partners

Remuneration

Fees, remuneration and expenses

No matter what structure or model is adopted for the federation, those working for the federation will usually expect to be paid for their time and provision of any services.

If there is a management committee, or a Board of Directors or a lead practice that takes on the day to day management of the federation, or makes decisions operationally, those individuals usually expect to be paid. This can be an agreed fee for services or, if employed, a salary. This is usually determined by the board or committee – or could be

determined by a separate remuneration committee which, depending on the size of the federation, may be fairer and indicate good governance.

Any federation should have an expenses policy for both directors/committee members and/or employees who work for the federation, making it clear what expenses may be claimed and under what circumstances.

Payment of dividends

The payment of dividends will be made as a result of a decision of a Board of Directors to shareholders. This is usually determined if there is enough profit after expenses and tax to be able to justify a distribution. It is not always the case that a dividend will be declared, as the board may well determine that the profit should be capitalised and reinvested back into the company. As mentioned above, declarations of dividends by a community interest company are capped, so it is worth giving some consideration to what the federation and its members want to gain out of the operations of the federation – if it is profit distribution to top up core income, this is curtailed via a CIC.

Any practice or group of practices who undertake work for the federation could be paid separately through a service level agreement. This will normally be similar to and contain obligations mirrored in the main contract that the federation may hold as a result of a successful bid for services. The federation may have to factor in indemnities and the costs of running the service and pay those over to the practice. Any practice should take into account any costs associated with obtaining any added insurance cover or premiums and the costs of buying in extra staff to deliver. The federation may need to consider the costs of bidding for the contract and any project management. Any surplus should be held by the federation and later potentially issued by way of dividend.

Joint Ventures/Mergers/ Collaborative Working with other Organisations

Having a federation does not prevent further collaborative working or joint ventures with other federations. In fact, where two or more federations or organisations come together in a joint working relationship, this may be beneficial in any bid by way of an increase in expertise, strength in numbers and may cover a larger proportion of the patient population in a given area. Any commissioner will therefore only have to issue one contract for services to cover a larger locality. Joint ventures are possible between companies, individuals and partnerships.

A joint venture agreement will be necessary to set out the purpose of the joint venture, the investment and profit share. The manner in which the venture operates should be clear, including any dissolution and/or dispute.

Joint ventures between companies are only possible where each company is permitted under its articles/memorandum to not only enter into a joint venture, but also to conduct the type of work that the joint venture intends to perform. So, for example, a CICs mission statement or statement of intent must allow the CIC to perform the type of services that the joint venture wishes to perform or else the CIC will be not be permitted to undertake the work.

Another option is for two or more companies to form a new corporate entity and each company become a shareholder in the new company. The new company could take the form of a CIC and be created for a specific community purpose. This is very workable where profit making companies wish to remain flexible in their business, but also wish to undertake work which is more community based and has a more public or community feel. Doing this by creating a separate CIC model would be ideal.

Some individuals are reluctant to create any form of legal corporate entity at all. Despite the risks in terms of limited liability, they prefer to remain in the familiar partnership model and conduct business/perform services as a group of individuals under a formal contractual arrangement. As long as the contractual arrangement is robust and set out in a written document, this can be effected between several groups of practices and usually requires a lead practice to take control over management decisions and coordinate the rest of the group. In fact, this model has been successfully used in several areas. The major disadvantage is there is no limited liability for any of the members and members will have to rely upon insurance cover and indemnities built into the agreement. From a purely legal perspective, this is not the prime model to minimise risk to any individual, or any individual practice. The rule of thumb is to ensure that core GMS/PMS work and partnerships are ring fenced and protected vis a vis any federated work.

Professional Advice – Current and On-going

It is hoped that this guidance gives individuals a flavour of the general principles that require consideration when creating and running a federation. The absolute need to take legal and other professional advice cannot be over stated. GPs are being forced into a more regulated and competitive environment. The sheer size of some federations begs the need for more regulated internal governance and protection of individuals. The increase in staff and functions requires careful thought and consideration with regard to HR policy and employment contracts. The level of risk that larger tendered contracts carry far outweighs the comfortable understanding of any core contracts, and any contract which is the subject of a bid should be reviewed and where possible negotiated. Any risks or potential risks in terms of finances, costs and potential expenses in increased premiums and staff should be factored into any bid price.

Directors must be aware of their statutory duties and how to conduct themselves in running a corporation. They need to be aware of conflicts and how to handle and be comfortable with governance issues.

In terms of finances, declaration of dividends, distribution of profit, reinvestment, tax and VAT, imperative to seek initial and on-going, accountancy advice.

Further information/support

- <http://www.gpresilience.org.uk>
- <http://www.lmc.org.uk>
- GPSupport@lmc.org.uk

Checklist

1. What is our vision, purpose?

- What type of entity is best for the federation?
- Consider whether you want to focus on distribution of profit or services to the community
- Do you wish to limit your functions to services of a particular nature to a specific community?
- Do you wish to minimise risk to members?
- Do you wish to protect core contracts?
- Who will be your members/shareholders?
- How many practices form part of your federation?
- What is the shareholding and how is it calculated?

2. Other documentation required?

- Consider whether you need a shareholders agreement
- Is there any other agreement you require to sit alongside your federation? Eg LLP agreement/trust deed?
- Do you require any internal policy documents? Eg HR policies? Board remuneration or governance documents?

3. Employing staff

- Will the federation employ staff?
- Will the federation share staff?
- Who will employ those staff – the practice? Jointly with the federation?
- Consider whether any consultations are required to discuss change in terms of employment, increased salary, working hours, reporting lines
- Insurance/CQC

4. Will further CQC registration be required?

- Who will apply?
- Will increased insurance be required for federation activity? Who will apply and who will bear costs?
- Have practices checked with the MDOs about increased activity/insurance cover?
- Use of equipment? Rental payments? Insurance? Breakdown?

5. Partnership agreements

- Have you advised practices to obtain an up to date agreement?
- Have you advised practices to modify agreement to accord with federation obligations?



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