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**GUIDANCE ON STRUCTURING YOUR
PRIMARY CARE NETWORK**

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STRUCTURING YOUR PCN

A PCN can be structured in a number of different ways, a choice that will affect:

- the relationship between participating GP practices
- the flow of funding under the Network Agreement
- consequential liabilities
- employment of additional staff
- VAT implications.

We summarise below the three models that we consider will usually be the most practical for the initial PCN set-up for 2019/20.

LEAD PRACTICE MODEL

Under this model, the GP practices participating in the PCN allocate the performance of most PCN activity to one network practice (the 'Lead Practice'). Since Core PCN Funding is paid to a single practice, the Lead Practice is likely also to be the nominated payee. The Lead Practice employs the additional PCN workforce and provides other PCN requirements including extended hours access (although PCN decisions are taken by the network practices jointly).

This model is straightforward for employment matters. Staff employed by the Lead Practice will benefit from the simplicity of a single employer and similar terms and conditions and policies. They will have access to the NHS Pension Scheme. If required, other practices within the PCN can indemnify the Lead Practice and share in liabilities such as for additional employment costs or litigation claims.

There is a risk that the additional staff employed by the Lead Practice and working across the other practices in the PCN could be seen by HMRC to be a supply of staff and subject to VAT. This risk is lower if only Core PCN Funding is used to pay additional staff costs. It can also be mitigated by ensuring the additional staff contracts of employment with the Lead Practice provide for staff to work across all network practices (and are not sub-contracted or seconded to other practices). Further, it should be recorded in the Schedules to the Network Agreement that all PCN funds are held by the Lead Practice on trust for the benefit of the PCN to be used for the provision of medical care services.

Under this model, it is possible that the other network practices may be less engaged in the success of the PCN, and even for 2019/20 it may be difficult for a single Lead Practice to



cover all PCN activity – an issue that will become more acute as PCN activity increases from 2020/21. Those issues are mitigated by a Hybrid model discussed below.

HYBRID MODEL

This model is similar to the Lead Practice model, except that different elements of PCN activity are allocated to different network practices (for example, Practice A provides 25% of the extended hours access and employs the clinical pharmacist, Practice B employs the social prescribing link worker, etc.). The Core PCN funding is then distributed according to the allocation of activity. This model therefore provides for active participation by some or all network practices, although naturally care must be taken to ensure that all PCN activity has been accounted for and suitably allocated.

The considerations set out above under the Lead Practice model for VAT apply equally to the Hybrid model. In addition, it provides a viable template for the scaling-up of PCN activity in 2020/21.

For employment, staff employed in the Hybrid model will benefit from the simplicity of similar terms and conditions and policies but it will be important to ensure that all practices use similar documents. They will have access to the NHS Pension Scheme. If required, other practices within the PCN can indemnify each other and share in liabilities such as for additional employment costs or litigation claims.

Both Lead Practice and Hybrid models raise the issue of how different liabilities will be apportioned, but that question can be addressed in the Network Agreement to ensure that this is fair and does not prejudice those network practices taking direct responsibility for provision of PCN activities.

FEDERATION MODEL (GP FEDERATION OR OTHER ORGANISATION)

This involves the network practices delegating the performance of the PCN activity to a third party (whether a GP Federation formed as a limited liability vehicle owned by some or all the network practices, or another entity such as a community services provider). That entity (which will therefore act as a sub-contractor to the network practices) employs the additional staff and performs the PCN activity.

For employment, the staff would be employed directly by the limited liability vehicle as opposed to the practices. Staff employed will benefit from the simplicity of a single employer and similar terms and conditions and policies. The possible problem of access to the NHS Pension Scheme for some third party employers is not ideal when it comes to potential future expansion and employment of further staff. The pension position of staff employed by a third party/Federation employer is currently under review by NHSE.



The potential VAT issue is the same - whether there is deemed to be a taxable supply of staff. This is the riskiest option, but could be mitigated by ensuring the Federation oversaw and delivered the medical care services of the PCN, as well as including a clause in the sub-contract to the Federation providing for all PCN funds to be held on trust by the Federation for the benefit of the PCN to be used for the provision of medical care services.

Since the DES Network Specification is part of each practice's GP contract, prior commissioner consent and other sub-contracting controls must be complied with.

This model introduces a further tier of relationships, contracts and administration, and practices will need to engage fully with the sub-contractor to ensure its accountability and that the PCN operates with cohesion.

In principle, a Federation model could be combined with either the Lead Practice model or the Hybrid model above, by having certain activity performed directly by one or more practices and other activity performed by the sub-contractor.

OTHER MODELS

Other options suggested by the BMA include the Flat Practice model and the Super Practice model. The Flat Practice model ensures equal and joint participation by network practices, but is based on the workforce having joint employment contracts with the practices. Although possible, this raises several complexities, for example in relation to responsibilities and duties and reporting lines, and for that reason, it is not always the most practical model: 'buy-in' and sharing of risk can be addressed by other means.

As for the Super Practice model, please note that the DES Network Specification is part of the GP contract, and so a combined entity cannot be formed to hold a separate 'PCN contract', since that entity would also need to hold the GP contracts with registered patient lists. Therefore, although this model is suitable for existing super practices, it does not seem likely that currently independent practices would wish to merge purely for this purpose, and certainly, that would not be viable before the PCN go-live date in 2019.



Primary Care Networks

Guidance Note 1: Completing the Mandatory Network Agreement with its Schedules

This short note supplements the fuller guidance published by NHS England in the Network Agreement itself and elsewhere. For that reason, we don't replicate detail already covered, but make a number of practical suggestions aimed in particular at networks that are under pressure to complete the Network Agreement for the 30 June deadline and so are looking to complete a minimum viable Network Agreement for 2019/20.

WHO SIGNS UP TO THE NETWORK AGREEMENT?

The introduction to the Network Agreement states that its signatories are the Core Network Practices and “*may include any other organisations that form part of this primary care network*”. Although PCNs may wish other stakeholders to sign up to the Network Agreement as it develops (and an already developed network may wish to include other stakeholders from the outset) it is sufficient at this early stage that only Core Network Practices (i.e. those network practices that themselves hold a primary medical services contract with the DES Network Specification) are parties to it. Some collaboration arrangements with other stakeholders may take less contractual forms and can be referred to if necessary without making those stakeholders parties to the Network Agreement. A PCN may decide to invite other stakeholders to formally join the Network Agreement in due course, as collaboration with other providers is expected to develop towards 2020/21.

WHAT IS NEEDED BY 30 JUNE?

Although the PCN must confirm by 30 June that there is a signed and completed version of the Network Agreement, practices can treat this as an initial step to get the PCN up and running and access the various funding streams. Practices are likely to need to refine or modify the operation of the PCN on the back of practical experience, and it is perfectly possible to vary the Network Agreement itself in due course, either to adjust the operation of the PCN or to add in further detail. Although the clauses of the Network Agreement cannot be varied, the main operative content is in the schedules, which can be varied by network practices as needed.



WHICH SECTIONS MUST BE COMPLETED?

To have a viable Network Agreement for 30 June, the following elements must have been populated:

The **signature page** (p.3), signed by all network practices (*note: there is no need to circulate the same actual single signature page to each practice – if easier, each practice can sign a separate copy of this page, and those signature pages can then be appended*).

Schedule 1 (Network Specifics) Some of this information can be taken directly from the earlier registration form (or the registration form could simply be appended). Networks will need however to have at least a basic governance process recorded here for decisions to be taken on behalf of the PCN. We suggest that any meeting should require the attendance of the Clinical Director in order to be considered quorate; that meetings should be minuted; and that each network practice ensures that its representative is authorised to act on its behalf in PCN decisions. Decisions could either be required to be unanimous, by simple majority, or through weighted votes by list size. Our template wording covers the above, which can be adapted for local circumstances and preferences.

Schedule 2 (Additional Terms) Our view is that sections 1 to 10 of this schedule need not be populated – these are adequately covered as a basic starting point by what is already contained in the Network Agreement and so a PCN can make a viable start without further content here. However, PCNs will need to agree some principles in section 11 (Additional rights and obligations) to allocate certain risks (e.g. employment risks) between network practices. We suggest some principles in our separate Guidance Note 3 – Governance, Accountability, Liabilities & Internal Arrangements.

Schedule 3 (Activities) For 2019/20 this must, as a minimum, record how the PCN will cover the extended hours access requirements under the Network DES Specification. Additional workforce roles can be covered in Schedule 5. As other network activity develops (including for 2020/21 and beyond), that can be added here.

Schedule 4 (Financial Arrangements) All Core PCN Funding (apart from the Network Participation Payment) is paid to the nominated payee on behalf of the PCN. This schedule therefore needs to contain a workable description of how that will be handled and allocated – most likely to be a straight pass through of funding according to which network practices carry out relevant activity, and provision for how the 30% shortfall on the Clinical Pharmacist's employment costs will be met.

Schedule 5 (Workforce) This should record which practices will employ or engage the additional roles (Clinical Pharmacist, Social Prescribing Link worker), or if these are being sourced through a sub-contractor.



Schedule 6 (Insolvency) This can be left as is (just taking out the drafting note and square brackets).

Schedule 7 (Arrangements with organisations outside the network) Organisations outside the network are not parties to the Network Agreement, and so any content here would be merely for reference. Therefore, this schedule can be left unpopulated where a new PCN is being established and where network practices are taking on all the PCN activity among themselves. An already established PCN may wish to reference existing arrangements here, and where the PCN is using a third party to perform activities (i.e. as a sub-contractor), it could append a copy of the sub-contract here. Collaborative protocols can be added as the PCN develops.

VARYING THE NETWORK AGREEMENT

We have already mentioned that the schedules to the Network Agreement can readily be varied as and when that becomes necessary, including for expanded requirements from 2020/21. That would not require a great deal of formality for network practices, but only some form of written agreement between them to adopt an updated version.

CONCLUSION

Practices that are struggling to complete the Network Agreement for 30 June should focus on ensuring that it covers three basic points: who is going to do what? (i.e. how the responsibilities set out in the DES Network Specification will be allocated); how is the PCN funding to be distributed? and how will decisions be made? That will give a basic framework for the PCN to come together and begin its activities, which can then be added to, varied or refined as necessary during the coming year and beyond.



Primary Care Networks

Guidance Note 2: Employment & Pensions

WHAT IS THE ISSUE?

The issue is to ensure there is a workable, straight forward structure for employing 'Additional Roles' staff which does not attract VAT liability. For this reason, this note should be read in conjunction with Guidance Note 5 – VAT & Funding Implications. A summary of the employment position for each model, along with our recommendations, is to be found in the note 'Guidance on Structuring your Primary Care Network'. Our recommendation is that if appropriate contractual wording places a duty on staff to work throughout the practices in the PCN, the Lead Practice or the Hybrid models are likely to be the most straightforward. Certainly at an initial stage, these models will provide a completely functional employment structure to a PCN which could, in due course, when there is more clarity from NHSE on pension and other matters, be altered to a Federation model. For now though, in employment and HR terms, a Federation model is quite workable subject to the pension point set out below.

LEAD PRACTICE

Under the Lead Practice model one practice in the PCN (the 'Lead Practice') will employ the additional staff. The advantage of this is that there will be a single employer which will bring simplicity and clarity to both the employment arrangements and the HR policies. The Lead Practice will hold an NHS contract and will be able to allow access to the NHS Pension Scheme to its staff.

The contract of employment will have to be carefully drafted to ensure there is no express or implied suggestion that staff are being seconded or sub-contracted by the Lead Practice to the other practices in the PCN. Rather, their contracts of employment should require them to work in all practices across the PCN.

We suggest indemnities are entered into between the practices in which each one agrees to share equally (or based on list size) in any legal fees, awards and settlements should there be an employment dispute. (Whilst the indemnity could also cover any additional sums, such as a redundancy, it would not need to cover ongoing wages costs such as sick pay, maternity pay or the payment of a locum. These should all come out of the funding method decided on for



employment costs). The alternative is that the indemnity only bites the practice which is shown to be at fault but we do not think this is practical, particularly in terms of PCN cohesion.

Our template wording to be included in the schedules to the Network Agreement covers the above.

For the relationship to PCN funding, we refer again to Guidance Note 5 – VAT & Funding Implications.

HYBRID

In a Hybrid model, one practice receives the funding from NHSE on behalf of all members of the PCN but different practices within the PCN employ the additional staff e.g. Practice A employs the Clinical Pharmacist, whilst Practice B employs the Social Prescribing Link Worker. The benefits of a clear, simple employment structure within the PCN can be maintained if each practice employs their staff members on a similar format. In terms of VAT it will again be necessary to ensure the contracts of employment require the additional staff to work across all practices within a PCN. Staff will have access to the NHS Pension Scheme because their employer will hold an NHS contract. As with the Lead Practice model, it may be desirable to include an indemnity between the practices as to what should happen in the case of additional employment costs or litigation.

Our template wording to be included in the schedules to the Network Agreement covers the above.

FLAT PRACTICE

In a Flat Practice model the additional staff required for the PCN to operate are engaged under joint contracts of employment with each of the practices in the PCN. Since the employers are the practices, staff will have access to the NHS Pension Scheme. VAT issues will not arise because of the joint employment status. Joint employers though can cause practical problems. It can lead to confusion in terms of duties, responsibilities, reporting lines and processes. Responsibility for grievances for example can become very complicated. Further, if in the future changes are required, all employers would have to work together on this.

FEDERATION

Under the Federation model a separate organisation receives all the funding from NHSE and employs additional staff. The staff will then need to work across all of the practices and the PCN. The model anticipates the use of an existing GP Federation but there could be the establishment



of a limited liability vehicle, such as a limited liability partnership. Unless the organisation holds an NHS contract, staff will not be able to benefit from the NHS Pension Scheme. For the Clinical Director this might not be an issue (see Guidance Note 6 - Clinical Director) and at an early stage, the Clinical Pharmacist and Social Prescribing Link Worker might not expect access to the NHS Pension Scheme. An adequate defined contribution scheme could be implemented. In due course though, to have an organisation at the core of the PCN that does not have access to the NHS Pension Scheme for its staff is not ideal. This issue is currently under review by NHSE.

The benefit of the Federation model is again simplicity. All staff, all terms and conditions and all handbook policies will be the same. Liability for staff will be with the Federation. There may be some commitment on liability between the practices and the Federation but this can be agreed if wanted. VAT might be a problem and we refer again to Guidance Note 5 – VAT & Funding Implications.

SUPER PRACTICE

This is a single practice which can develop a PCN as the sole employer of the additional staff. This would benefit from simplicity of terms and conditions, HR policies, the NHS Pension Scheme and no VAT liability. Few Super Practices will yet be in existence, but in due course this is something that could be developed for the governance of the PCN.

In all models the 30% further funding in the 70/30 split between NHSE and the PCN will need to be considered (apart from the Social Prescriber). The source of employment funding is the choice of the PCN but it is likely in the initial stage at least, that some funding may be taken from the Core PCN Funding. We refer to Guidance Note 5 – VAT & Funding Implications.



Primary Care Networks

Guidance Note 3: Governance, Accountability, Liabilities & Internal Arrangements

In this note, we look at the question of the accountability of network practices for the performance of network activity, and suggest some ways to ensure a fair distribution of any risks. We use “GP contract” to describe any primary medical services contract (GMS, PMS or APMS) that covers essential services.

WHAT ARE THE ISSUES?

As discussed in Guidance Note 4 – Contracts, Sub-Contracts & Service Delivery, each network practice is primarily liable, under its own GP contract, to its commissioner for the delivery of network activity. However, because network practices will be relying on other network practices (at least) to deliver part of that activity, each practice is reliant on others for some of its own obligations under its individual GP contract. In addition, a practice taking on such activity (e.g. employing the Clinical Pharmacist) could face costs that it would be unfair for it to face alone. In fact, in any case where a practice is ‘carrying the can’ for the network as a whole, it would be fair to arrange for all practices in the network to share those risks. We look at:

- each network’s contract obligations to its commissioner under the GP contract
- risk of commissioners withholding network funding
- risks with other third parties (e.g. sub-contractors of network activity)
- clinical risk.

Allocation of employment risk is dealt with in Guidance Note 2 – Employment & Pensions.

This is in the context of initial PCN funding for 2019/20, and so different approaches may be warranted as funding and network activity develop in future years.

GP CONTRACT

In principle, each practice is separately responsible to its commissioner under the GP contract for the delivery of the DES Network Specification, even though that is necessarily a joint endeavour. Where a practice has properly participated in a PCN and issues arise that



are clearly attributable to the actions of other practices, we would not expect the commissioner to view that as a breach of the GP contract by the first practice. This is because the GP contract does not establish joint liability among the participating practices and because (given the ambition to support PCNs) a collaborative approach is likely to be more productive. Ultimately, any disputes between a practice and the commissioner concerning the operation of the PCN would be subject to the dispute resolution procedure in the GP contract.

COMMISSIONER WITHHOLDING FUNDS

The DES Network Specification provides that commissioners can withhold funds in certain situations (e.g. failure to submit workforce information or other returns, or to deliver required extended hours access). This should be rare, and we expect commissioners to act reasonably where any information deficiencies are attributable to teething problems or other administrative delays in this initial period. However, the Network Agreement needs to address what would happen should a commissioner actually withhold funds, for example, by:

- requiring any practice that has not complied with a requirement (e.g. reporting) to do so promptly
- where a withholding is clearly attributable to the disregard of a practice of its obligations, to require that practice to reimburse any other practices for any funding lost (this will be particularly relevant where that other practice is committed to network expenditure, for example, it is employing the additional workforce).

RISKS WITH THIRD PARTIES

Where a PCN entrusts network activity to a sub-contractor (whether a Federation, community trust or other provider), then there are the following key risks: contractual disputes (including around payment) with the sub-contractor; poor performance and sub-contractor insolvency; and changes to the DES Network Specification.

These are common issues for any sub-contracting arrangement, and can be addressed by a suitable sub-contract that allows for termination or variation in response to changing DES Network Specification requirements or sub-contractor default or insolvency, and which imposes suitable service levels and reporting requirements on the sub-contractor. If the PCN suffers any losses resulting from sub-contracting that cannot be clawed back from the sub-contractor, it will generally be appropriate for those losses to be borne across all practices, rather than solely by the practice nominated to hold the sub-contract. It would even be possible for all practices to be parties to the sub-contract, as joint purchasers of the sub-contracted service.



CLINICAL RISK

Similar considerations apply to PCN activity as to any patient-facing services under the GP contract. Where that activity is performed by practices themselves, the position has been simplified very recently by the introduction by NHS Resolve of the automatically applicable state-backed indemnity scheme for general practice. That scheme also applies to activities ancillary to general practice, and to sub-contractors of primary medical services and such ancillary services. Therefore, the introduction of the DES Network Specification does not create additional issues for clinical negligence, but any PCN should of course: carry out appropriate due diligence on any sub-contractor of any patient-facing services; monitor sub-contractor performance; and ensure that any sub-contractor is required to avoid any actions that could jeopardise the application of this indemnity (such as admitting liability without NHS Resolve prior agreement). A PCN may decide that additional insurances are required for some network roles to cover for example advice and representation, and it may be decided that those costs should be shared across the network.

GOVERNANCE

In order to give practices visibility of any risks, a PCN board and a clear reporting structure should be set out in the Network Agreement, to give early notice of any clinical issues, potential commissioner disputes (including withholding of network funding), disputes with sub-contractors, and any issues affecting the continued operation of a practice.



Primary Care Networks

Guidance Note 4: Contracts, Sub-Contracts & Service Delivery

This note gives a quick overview of how contract structures will fit together for PCNs and some considerations on service delivery, and supplements guidance produced by other stakeholders. In this note, we use “GP contract” to describe any primary medical services contract (GMS, PMS or APMS) that covers essential services.

DO WE NEED TO PUT TOGETHER ANY CONTRACTS?

It is important to understand that the basic contractual obligation on a network practice to participate in a PCN and deliver PCN activity does not come from the Network Agreement: those are obligations on a practice to its commissioner under the GP contract containing the DES Network Specification, and so that requirement is on similar footing to any other activity under that contract (including any other DES specifications).

By contrast, the Network Agreement is a form of collaboration agreement between practices as to how they will together deliver the PCN activity that each practice is committed to deliver under its GP contract.

Therefore, if all PCN activity is being carried out by the practices themselves, no additional contracts are needed (beyond the employment contracts of new workforce), since the Network Agreement will describe how the various PCN roles and responsibilities will be allocated between network practices, thereby allowing each practice to meet its individual requirements to the commissioner under its GP contract.

WHAT ABOUT USING A SUB-CONTRACTOR?

In principle, practices can ‘outsource’ the provision of all or part of the PCN activity to one or more bodies that are not network practices. That would be a sub-contracting of some obligations under the GP contract. This is possible, but some points should be noted:

- unless suitable sub-contractors are already identified and standing by (with necessary CQC registration etc.), this is not likely to be practicable for the start of the 2019/20 PCN activity – and a suitable form of sub-contract would also be needed
- the GP contract (in whichever form) has controls on sub-contracting (including prior commissioner consent) that would need to be considered and complied with



- the network practices remain responsible (under their GP contracts) for the provision of the PCN activity
- it appears (from the DES Network Specification) that for the additional 2019/20 PCN roles (Clinical Pharmacist, Social Prescribing Link Worker) the payment to the PCN is of actual employment costs (at 70% and 100%). Therefore (in addition to managing the 30% shortfall) the PCN would need to control the level of payment to a sub-contractor as against the reimbursement available for the relevant activity.

CAN ANOTHER ENTITY HOLD THE 'PCN CONTRACT' FOR THE NETWORK PRACTICES?

As noted above, there is no 'PCN contract' as such, but only separate obligations included within each network practice's GP contract (which contains the DES Network Specification). Therefore, practices cannot come together and establish a new legal entity to hold the 'PCN contract', since that entity would need itself to hold a GP contract (registered list, essential services), which is precisely what the network practices themselves do. This is very different, therefore, from the common scenario of a CCG tendering for an integrated secondary care service, in response to which a consortium (e.g. a foundation trust, primary care practice and social enterprise) may form a distinct jointly owned legal entity in order for that legal entity to hold the contract with the CCG.

WHAT ABOUT NETWORK MEMBERS (OTHER THAN A GP FEDERATION) THAT ARE NOT NETWORK PRACTICES?

In Guidance Note 1- Completing the Mandatory Network Agreement and its Schedules, we suggest that it is sufficient at this early stage that the parties to that agreement are just the network practices themselves. Any other stakeholders will not be bound (as the network practices are) by the DES Network Specification under the GP contract. As far as relationships with such third parties are concerned:

- where these are sub-contractors providing any PCN activity (i.e. a part of the DES Network Specification), there will need to be a sub-contract in place with that party (held either with all network practices jointly, or by one practice acting on behalf of all of them), but that would be a separate contract and it would be difficult and complex to mix sub-contract obligations into the Network Agreement – the sub-contract itself is best kept separate
- where there is no contractual arrangement between the PCN and a third-party stakeholder, then other co-operative working arrangements can be recorded in a memorandum or similar form, but that would not require those other stakeholders to be parties to the Network Agreement
- if the network practices at any point consider that more formal co-working arrangements are needed with other stakeholders, then in principle the network practices could enter



into other contracts to document those arrangements or, according to circumstances, invite those other stakeholders to join the Network Agreement as non-core members.

Therefore, although the ways in which other parties interact with PCNs is likely to develop over time, we suggest at this early stage there is no need to go beyond the network practices being included in the Network Agreement.

SERVICE DELIVERY

GP practices will, of course, wish to deliver all PCN activity to the same high standards that they apply to their essential services and any other enhanced services. Where the PCN activity is allocated between network practices, each practice is already (under its GP contract) required to deliver all services (including under the DES Network Specification) to relevant standards. As such, on a basic level, the Network Agreement need not add to that, although practices may wish that agreement to provide for proportionate reporting of activity and outcomes.

Where PCN activity is entrusted to a sub-contractor, the sub-contract must require appropriate standards of service delivery, and it is important that it should allow the PCN suitable rights and remedies for sub-standard performance (since the performance of the sub-contractor is taken as the performance of the network practices themselves under the GP contract). This should include a right to terminate the sub-contract if required by the commissioner under the GP contract, and it could include the requirement for the sub-contractor to address issues and provide an appropriate remediation plan for less serious issues. Again, the sub-contract should provide sufficient reporting obligations on the sub-contractor for network practices to be able to verify performance and activity.



Primary Care Networks

Guidance Note 5 – VAT & Funding Implications

This Guidance Note 5 explains the VAT and funding implications for each PCN model proposed by NHSE, and how to mitigate the risk of a VAT liability. We have also incorporated guidance in relation to one additional PCN model - the 'Hybrid model' - which is a hybrid between the Flat and Lead Practice models. Our 'Guidance on Structuring your Primary Care Network' sets out our recommended approach taking into account all of the benefits and risks of each model, including VAT.

WHAT IS THE ISSUE?

The fundamental issue as regards VAT, is whether the structure adopted could give rise to a supply of services on which VAT would be chargeable and then irrecoverable.

Whilst charges for a supply of services of medical care by a person enrolled in a relevant register are exempt from VAT, a supply of staff is a taxable supply. For this reason, whatever the role of the employee, there is still a risk VAT might apply.

FLAT PRACTICE

In a Flat Practice model the additional staff required for the PCN to operate are engaged under joint contracts of employment with each of the practices in the PCN. One practice within the PCN will be the nominated payee to receive the Core PCN Funding, which will be distributed for PCN activities to the practices accordingly.

As the staff are jointly employed, any payment made to those staff by any of the practices in the PCN cannot be regarded by HMRC as consideration for a supply of services from a VAT point of view, it is simply a payment of wages to an employee.

This model is therefore the joint safest with the Super Practice model from a VAT point of view.

LEAD PRACTICE

Under the Lead Practice model, one practice in the PCN (the 'Lead Practice') will employ the additional staff required. In order for the PCN to operate, the additional staff will be required to work across all practices in the PCN.

It is envisaged that the Lead Practice will receive the Core PCN Funding and may use this to pay the additional staff wages. Payment of staff wages can be sourced as the PCN wishes but it may also include practices' Network Participation Payments and other practice income. Our template schedules to the Network Agreement provide for these different options.



Any payments made by the other practices in the PCN to the Lead Practice for payment of additional staff, particularly admin staff, could be considered by HMRC to be payments for a supply of staff, which would attract VAT. If the additional staff are paid out of Core PCN Funding only (and the contracts of employment require them to work across all practices) there is a lower risk of VAT applying.

If staff were seconded or sub-contracted by the Lead Practice to the other practices in the PCN, this could be viewed as such a supply of staff, which could give rise to VAT. It would therefore be better if the contracts of employment for the additional staff required them to work across all practices within a PCN.

The Lead Practice will be the recipient of the Core PCN Funding, and also of any contributions to the PCN required from the other practices. To mitigate the risks of a VAT charge arising, the schedules to the Network Agreement should make clear that the Core PCN Funding, and any contributions from the practices to the PCN, received by the Lead Practice, are held on trust for the benefit of the PCN to be used for the provision of medical care services to patients of the network practices. The Lead Practice should avoid sending invoices to network practices for any contributions to the PCN (as HMRC tends to equate invoices with a supply of services), and instead send requests for payment if it is necessary to document any transfer of funds from an accounting point of view.

In summary, if a PCN adopts the Lead Practice model, in order to mitigate the risks of a VAT charge arising, the PCN should:

- include wording in the additional staff contracts of employment requiring them to work across all practices in the PCN
- include wording in the schedules to the Network Agreement recording that the Core PCN Funding received by the Lead Practice and any contributions from the other practices are held on trust for the benefit of the PCN to be used for the provision of medical care services to patients of the network practices.

Whilst the use of only the Core PCN Funding for additional staff costs should significantly reduce the VAT risk, this should not be relied upon and, particularly when the PCN expands, may not always be practical.

Our template wording to be included in the schedules to the Network Agreement for PCNs adopting the Lead Practice model covers the above.

FEDERATION

Under the Federation model, a separate organisation (quite possibly a GP Federation) receives the Core PCN Funding and employs the additional staff. The staff will then need to work across all of the practices in the PCN. Under this mechanism, any contributions made to the



organisation by the practices in the PCN are likely to be regarded by HMRC as consideration for a supply of services.

If the organisation does not hold a contract with NHSE for medical services, it seems likely that HMRC would be more sceptical that it is supplying medical services (outside the scope of VAT). That said, in VAT law there is nothing to prevent this to the extent it is providing medical services by people enrolled in the relevant registers.

Welfare services are also exempt when they are provided by a state regulated private welfare institution. This would include a GP practice, but might not necessarily include a federation or limited liability vehicle.

In order to avoid the supplies from a federation to the practices being regarded as a supply of staff then the Federation would need to oversee and deliver the medical services of the PCN.

The risk of a VAT liability could be mitigated by ensuring the wording of the sub-contract between the network practices and the Federation provides for all PCN funds to be held on trust by the Federation for the benefit of the PCN to be used for the provision of medical care services to the network practices. However, from a VAT point of view, this could be the highest risk option.

Our template wording for PCNs adopting the Federation model covers the above.

If the organisation could be set up as a Limited Liability Partnership (LLP) with the various practices as members, then the contributions could be regarded as partner capital (as opposed to taxable flows of money) from the LLP's member practices and outside the scope of VAT.

HYBRID

In a Hybrid model, one practice receives the Core PCN Funding on behalf of all network practices, but different practices within the PCN employ the additional staff, e.g. Practice A employs the Clinical Pharmacist, whilst Practice B employs the Social Prescribing Link Worker.

As with the Lead Practice model above, payment of staff wages may be sourced as decided on by the PCN but could come from the Core PCN Funding held by the nominated payee (distributed by the nominated payee to the practice employing the additional staff member) and/or practices' individual Network Participation Payments. The easiest approach would be to meet staff costs with the Core PCN Funding.

From a VAT point of view, the issue remains the same, i.e. whether Practice A's contribution is consideration for the supply of staff employed by Practice B and vice versa.



Our recommendations in the section headed 'Lead Practice' above apply to the Hybrid model i.e. in order to mitigate the risks of a VAT charge arising, the PCN should:

- include wording in the additional staff contracts of employment requiring them to work across all practices in the PCN
- include wording in the schedules to the Network Agreement recording that the Core PCN Funding received by the nominated payee, and any contributions from the other practices, are held on trust for the benefit of the PCN to be used for the provision of medical care services to patients of the network practices.

Our template wording to be included in the schedules to the Network Agreement for PCNs adopting the Hybrid model covers the above.

SUPER PRACTICE

This is a single practice which can develop a PCN and as the sole employer of the additional staff no VAT issues should arise. From a VAT point of view it is therefore the joint safest alongside a Flat Practice model.

ALTERNATIVE STAFFING ARRANGEMENTS

We understand that some PCNs are considering engaging a third party body e.g. a local County Council, to provide the services of the Social Prescribing Link Worker to all practices in the PCN. In these circumstances, the same considerations above apply i.e. whether the payment to the County Council would be considered to be for a supply of staff and subject to VAT. There is a risk that HMRC would deem the payment to be for a supply of staff subject to VAT. However, to mitigate this risk, we recommend that the contract between the network practices and the County Council (or other third party) makes clear that the payment to the County Council is for the Social Prescribing Link Worker to provide medical care services to the network practices.



Primary Care Networks

Guidance Note 6: Clinical Director

WHAT IS THE ISSUE?

The Clinical Director will provide leadership to the PCN. They will work and liaise with other PCN Clinical Directors, the practices within the PCN and LMCs. All Clinical Directors have already been appointed.

The core issue is who should engage the Clinical Director and whether that engagement should be one of employment or self-employment. The question for the PCN is the level of control that it requires over the Clinical Director. Broadly speaking, an employee will be under the firm control of the PCN. Mutual obligations and duties will go both ways - the Clinical Director will have a duty of loyalty to serve the PCN to the best of their abilities. The PCN in turn will have a stronger duty of care toward the Clinical Director. A self-employed Clinical Director will have contractual and professional duties toward the PCN, but will be more independent in their overall engagement.

It is important that:

- whether employed or self-employed, the working patterns reflect either the close relationship of employment or the more independent one of self-employment. This will avoid any questions from HMRC
- practices are aware that it is unlikely responsibilities and liabilities to the Clinical Director can be placed fully at arm's length. Even if self-employed, the Clinical Director will have a close ongoing relationship with the PCN. Unless that Clinical Director is also providing services as a business person in their own right elsewhere, they are likely to have certain employment rights as a 'worker'. Although some Clinical Directors will also be partners within their GP practice, this alone is unlikely to negate the suggestion they are a 'worker'. As such they may have rights to holiday, sick pay, and whistleblower status.

If the Clinical Director is self-employed, regardless of the employer, they will not have access to the NHS Pension Scheme. In terms of the NHS Pension Scheme, and the current capped allowances, it is quite possible that the Clinical Director will not want access to the scheme in this role.

Whether self-employed or not, the practicalities of who engages the Clinical Director will be the same as in Guidance Note 2 – Employment & Pensions and Guidance Note 5 – VAT & Funding Implications:

- the Lead Practice, Hybrid and Federation models allow for the simplicity of a single



employer whilst the Flat Practice model's joint employment structure is workable but might create some complexities in terms of reporting lines and responsibilities. Indemnities for additional employment / engagement costs can be agreed between the practices.

- where the provision of funds to pay the Clinical Director is not paid directly to the Clinical Director but is provided by one practice to another, the VAT risk can be mitigated if certain terms are included in the contract of employment / engagement
- if the Clinical Director funding is used as follows:
 - The practice where the Clinical Director is a partner or employee releases that partner from some or all practice duties in order to fulfil the CD role and
 - The practice continues to pay the Clinical Director as normal and
 - The practice then employs a locum to cover the Clinical Director's practice duties and
 - The practice, not the Clinical Director, receives the Clinical Director funding (i.e. to pay the locum)

then this will be a supply of healthcare services between members of a network and VAT exempt. The worker in question, the locum, is a health professional within the profession which they are registered to practise.

The Clinical Director is likely to be one of the GPs from the practices within the network but could be any appropriately qualified person. We refer to Guidance Note 3 - Governance, Accountability, Liabilities & Internal Arrangements, but again for simplicity it would be best if the Clinical Director reported into a board consisting either of one GP from each practice or all partners from member practices. For any future appointments of a Clinical Director, we recommend a process of applications (both internal and external) and an interview process subject to a final decision by the board.