PENNINGTONS MANCHES COOPER

GPDF Listening Supporting Influencing

PRIMARY CARE NETWORKS: FREQUENTLY ASKED QUESTIONS

12 MONTH NOTICE PERIOD

The draft schedules we have prepared for the Mandatory Network Agreement suggest, in Schedule 2, a 12 month notice period for a practice seeking to leave a PCN. We do so on the basis that such a significant change to the PCN should be one that allows the other practices time to adapt. Any PCN wishing to use shorter notice periods should feel free to do so. Likewise, 31 March has been picked as the usual financial year-end but this too can be varied. Our draft wording at clause 6.2 goes on to state that a practice that leaves the PCN without giving the notice period will indemnify the remaining practices for any funding shortfall. That paragraph need not be included.

CLINICAL DIRECTOR AND VAT

The engagement of the Clinical Director, whether as an employee or a self-employed person, will have the same VAT implications as other staff employed for the PCN. We refer to Guidance Notes 2,5 and 6. If the Clinical Director is engaged by the same practice that receives the Network Clinical Director Funding then a VAT issue will not arise. If, in either the Lead Practice, Federation or Hybrid models the practice (or third party) that engages the Clinical Director is not the same one that receives the Network Clinical Director Funding, then a VAT risk arises. As set out in our Guidance Notes and in Schedule 4, Part 2, there are ways of mitigating that risk:

- The practice receiving the Network Clinical Director Funding from the Commissioner should hold that money on a fiduciary basis as a trustee for the other practices and any practice then receiving monies in respect of the Clinical Director does so in relation to the provision of a healthcare service. The contract of engagement/employment for the Clinical Director should state that they are required to work across all members of the PCN and should include wording stating that they are responsible for leading the provision of medical care across the PCN.

  Further:

  - Where the Clinical Director is a partner in a member practice and that practice receives Network Clinical Director Funding, either directly from the Commissioner or from another practice, it will no doubt hold this as a ring-fenced sum and it will not affect partnership drawings. That practice may decide to adjust drawings in respect of the Clinical Director carrying out less work at the practice. That is a choice for each practice.
  - The practice engaging/employing the Clinical Director will deal with all applicable income tax matters. (Even in the Flat Model practice, the Clinical Director will have just one contract of employment/engagement albeit with all practices in the network and will there will just be one practice paying the remuneration).
  - The Clinical Director will have access to the NHS pension scheme if an employee, whether under the Lead, Flat or Hybrid models, of a member practice.

TOPPING UP CLINICAL DIRECTOR'S PAY

A small PCN will generally receive less funding for its clinical director than a larger PCN, even though the workload of the CD of the smaller PCN may not pro-rate down by the same proportion compared to that of the CD of the larger PCN. This is a function of the funding model, where funding correlates directly with patient numbers within the PCN.

However, a practice or a PCN may top up the CD's pay as it wishes, either from Network Participation Payments or other practice income. If the lead practice receives payments from other practices for the top up, there is a risk that the payments could be seen as being made for the supply of staff, which would attract VAT. However, this risk may be mitigated by the CD's contracts making clear that they are providing their services/fulfilling their duties on behalf the entire PCN, and that they are providing medical services.

We refer to Guidance Note 5 – VAT & Funding Implications, where we review the position of additional funding and VAT in relation to employees.

WHY DO THE GPDF MODEL SCHEDULES ONLY REFER TO ORGANISATIONS, WHEN INDIVIDUAL PERSONS CAN ALSO JOIN A NETWORK?

A PCN can have two different categories of member – its constituent GP practices; and other stakeholders in the local health economy. A GP practice will typically be a partnership, but could also be the practice of a sole practitioner, and for these purposes, the PCN GP practice member will be the person or organisation that is identified as the "contractor" under the practice's GMS or other primary care contract. Any new GP practice joining a PCN will require prior commissioner approval (see section 2.18 of the DES Network Specification).

PCNs can also have members that are not GP practices (referred to as an "Associate Member" in the GPDF model schedules). Although we would expect that such Associate Members would most often be organisations (for example, an NHS community trust; a GP federation; a pharmacy, etc.) that Associate Member could in principle be an individual (for example, a self-employed physiotherapist), although we do not know how likely that would be in practice.

Therefore, for the cases where an individual person rather than an organisation is a PCN member, we would expect that to be most relevant to a member GP practice operated by a sole practitioner who was also the named contractor under a primary medical services contract in his or her own name.

Any PCN can, of course, adapt the model GPDF schedules to describe individual PCN members if required.

IS THE NETWORK PARTICIPATION PAYMENT AN ANNUAL OR ONE-OFF PAYMENT?

Our understanding, from the DES Network Specification, is that this Participation Payment is indeed intended to be an annual (and so recurring) payment – see section 2.16 of the Specification. The basis for the Participation Payment is set out in the GMS Statement of Financial Entitlements or "SFE" (in the amendment Directions of 2019), and accordingly NHS England (or a CCG commissioner under delegated powers) will pay the Participation Payment as required by the SFE (see here, paragraph 8). The current SFE covers the Participation Payment up to 31 March 2020, and so the precise detail of PCN payment entitlements for the following NHS year will be contained in new SFE for 2020/21.

PLEASE CAN YOU CONSIDER

1. *If the wording of the administration staff contract is that they 'work across all practices within the PCN to support and facilitate the CD and PCN practices to fulfil the provision of medical care services in line with the duties of the DES' will this cover them providing a service rather than provision of staff? Can the same then be applied to any contracts of engagement where they do not have a specific additional employment contract but rather an addendum to their current contract of employment through 1 practice in the PCN so they are working across all the practices?*
2. *How do practices (if shared employment) or a single practice (if 1 practice is employing) draw down the money from the PCN 'bank' practice without attracting VAT? We understand invoices are not possible but if all the salary of the admin staff is through the core PCN funding we need a mechanism for this to reach the practices which is auditable and transparent without the invoice exchange. Is this simply through the drawings articulated in the schedule which will demonstrate one practice drawing more than another for PCN delivery provision?*

These questions have come about as our PCNs want to employ admin staff and/or reimburse practices for admin time for PCN Management Leads but are unsure how they can do this without having the added burden of VAT. We also have a Federation (holds an NHS E contract) that is the 'bank' for a number of PCNs but they have declined to employ the admin support staff as the 'lead practice'. This has left all practice wondering how they can employ and access funding for this key role in the delivery of the DES without attracting VAT and additional complications.

In answer to both question 1 and question 2, whilst the added protection of providing medical care services is not available in the employment of administration staff when seeking to avoid a VAT charge, a key remaining point is that there must be no express or implied suggestion that the staff members are being seconded or sub-contracted to the remaining practices by the employing entity. Therefore, express wording in the employment contract of the staff member that they are employed to work for and across all practices, making this clear also in the description of the staff member's duties, should avoid an assessment for VAT. The same principle applies to any addendum to an existing contract of employment which is agreed. This addendum should set out new or additional duties making clear, again, that the staff member is to work for and across all practices in the PCN.

In respect of the Federation which will not employ administrative support staff, the simplest approach from an operational point of view is for a single practice to employ the staff, with the same proviso about the staff being expressly required to work for and across all practices in the PCN. However, employment of a staff member by all practices equally, whilst more complex operationally, will avoid any risk of a VAT charge.

Obviously, whichever arrangement is used, the employing practice or practices will need to agree with the Federation that it will receive funding for that staff member's wages. If the funding is from Core PCN Funding only, there is a lower risk of VAT applying. The employing practice or practices should not send invoices to the Federation for any contributions in case the HMRC equate the sending of invoices with a supply of services. An express agreement that the Core PCN Funding is being held on trust by the Federation for the benefit of the PCN to be used for the provision of medical care services to patients of the network practices will also assist to avoid VAT charge. With regard to how this could be auditable this could be reflected in the schedule showing that one practice draws down more than others because it employs additional staff and that practice could send requests for payment instead of invoices.

I AM REQUESTING HELP FROM GPDF TO PRODUCE A NEW CLINICAL DIRECTOR CONTRACT THAT IS SUITABLE FOR A CD WHO:

1. IS A GP PARTNER AT PRACTICE A
2. THE CD IS RELEASED FROM PRACTICE A TO DO THE CD ROLE
3. PRACTICE A BACKFILLS FOR CD
4. PRACTICE A INVOICES PRACTICE B FOR BACKFILL TIME (PRACTICE B IS THE NOMINATED PAYEE FOR THE PCN)
5. THE CD CONTINUES TO RECEIVE THEIR PARTNERSHIP PROFITS

I BELIEVE THIS IS THE MODEL THAT WAS INTENDED BY THE PCN DES, BUT NONE OF THE 6 CD MODEL CONTRACTS THAT HAVE BEEN WRITTEN SO FAR, APPEAR TO REFLECT THIS ARRANGEMENT.

The self-employment Clinical Director contract - Hybrid Model can be used with a slight modification to the 'Fees' wording at clause 4:

"*The Engaging Member shall continue to pay the Consultant their [normal Partnership Profits] but allow the Consultant to take the time away from their duties to the Engaging Member (as set out in clause 3.1.3) so as to perform their duties under this Agreement*"

The Engaging Member Practice (Practice A) still engages the Clinical Director and claims money from the Member Practice in receipt of Clinical Director Network Funding (Practice B). In this particular case, the Engaging Member Practice continues to pay the Clinical Director their GP partner share of profit and takes the Clinical Director Network Funding itself to backfill (i.e. employs a locum, or pays existing GPs to work additional hours). None of this affects the other wording of the contract unless the Engaging Member Practice wants some preamble wording that helps with their own internal accounting process.

The engagement of a locum / existing GP arrangement should be VAT exempt because it is for clinical services.

As for the fact that Practice A pays the Clinical Director directly through partnership profits, this should not become a payment that is subject to VAT. It is questionable whether Practice A is "supplying staff" to the PCN for VAT purposes. Rather the Clinical Director is providing additional clinical services over and above what they already provide. Further, in the definition of the services in the template contract, it is referring to leading and organising the provision of medical care.

We refer you to Guidance Note 5 – VAT and Funding and to Guidance Note 6 – Clinical Director.

WHERE A FEDERATION EMPLOYS THE CLINICAL DIRECTOR, IS THE CLINICAL DIRECTOR'S PAY SUBJECT TO NHS PENSIONS WHERE THE PAYMENTS ARE BEING MADE DIRECTLY TO THE CLINICAL DIRECTOR OR VIA THEIR PRACTICE. WHO FUNDS EMPLOYER CONTRIBUTIONS?

As at February 2020, Federations cannot hold NHS contracts. It is therefore the NHS employer (and not a central body) that funds the employer's pension contribution.

WHERE THE FEDERATION RECEIVES THE FUNDS FOR THE PCN, AND THE FEDERATION DIRECTLY PAYS THE CLINICAL DIRECTOR, WHO IS A PARTNER IN A PRACTICE, BUT IS PERFORMING THE CLINICAL DIRECTOR ROLE AS A SELF-EMPLOYED ADDITIONAL ROLE, IS THIS A SUITABLE MODEL, AND WHAT VAT RISKS ARISE?

In effect the CD is engaged on a self-employed basis by the Federation. There is nothing wrong with this model in itself, although the usual risk exists that the CD will be deemed to be a worker or an employee from an employment law point of view, or as an employee from a tax point of view. The CD raising an invoice for his/her fee would go a little way to help argue that the relationship was a self-employed one – this could be arranged by the Federation raising the invoice for the CD (issued in his/her name, and payable by the federation).

VAT is only relevant if there is a supply of staff from one practice to another. Therefore, the contractual documentation should reflect that the CD is providing the CD services across the entire PCN, and it should refer to the objective of the Services being the leading and organisation of medical care across the whole PCN rather than administrative duties. Obviously, as far as possible, the reality of the services provided on a day to day basis should reflect that. The fact that the CD is engaging with the Federation, which represents all PCNs, makes it harder for HMRC to argue that there is a supply of staff.

We refer you to:

- FAQ – "Clinical Director and VAT"
- Guidance Notes 2, 5 and 6.
- Clinical Director Contracts – Guidance Note
- Network Agreement - Schedule 4, Part 2

WHERE THE FEDERATION RECEIVES THE FUNDS FOR THE PCN, AND THE FEDERATION PAYS THE CLINICAL DIRECTOR VIA THEIR PRACTICE, WHAT VAT RISKS ARISE?

This arrangement of the money being routed via the CD's practice should have no impact upon the risk of VAT being levied, so long as the factors described in the answer to the question immediately above are in place.
We refer you to:

- FAQ – "Clinical Director and VAT"
- Guidance Notes 2, 5 and 6.
- Clinical Director Contracts – Guidance Note
- Network Agreement - Schedule 4, Part 2

Note: These FAQs have been produced by Penningtons Manches Cooper LLP for GPDF Ltd as a guide only to assist with completion of the Schedules to the Mandatory Network Agreement, and do not constitute legal advice. Penningtons Manches Cooper LLP does not accept any responsibility or liability howsoever arising from the implementation or use of these FAQ.

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