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Trusts in Primary Care

Guidance Note on Registration Requirements in England & Wales
Prepared 13 October 2022

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1. Executive Summary

A trust is a legal relationship by which one or more 'Trustees' hold and manage assets (such as money, investments, land or buildings) on behalf of one or more other people (the 'Beneficiaries'), and may be created (whether expressly or by operation of law) for convenience or through necessity.

There are a significant number of trust relationships in primary care, generally created by necessity as a substitute for a 'missing entity' – particularly in the case of GP partnerships and Primary Care Networks (PCNs). The most common of these trust relationships relate to the ownership of a practice's surgery, a PCN's Bank Account, and shares held by GP partnerships in Federations or PCN companies.

Express trusts and taxable non-express trusts must now be registered with the Trust Registration Service (TRS), but the majority of such trusts in primary care settings will be able to benefit from an exemption for "public authorities" and will not need to be registered. In addition, a smaller number of such trusts will be able to benefit from an exemption for "legislative trusts". It is therefore likely that only a small residual minority of primary care related trusts will need to register with the TRS.

This guidance note explains how to recognise a primary care related trust, and outlines a process by which practitioners can determine whether their trust may benefit from one of the exemptions.

The deadline for registering non-exempt trusts created before 3 June 2022 passed on 1 September 2022; trusts created after 3 June 2022 must be registered within 90 days.

2. Background

The TRS was established in 2017 to satisfy European anti-money laundering requirements. It is an online system managed by HMRC, by which Trustees (the administrators of a trust) can register the names of the Beneficiaries (the individuals who benefit from the trust) and other details about the trust.

When the Register was first introduced, only trusts that were, or became, liable for a variety of taxes were required to register. Most primary care related trusts are not subject to these

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taxes and were thus exempt. However, new rules were introduced on 6 October 2020 as part of the UK's implementation of the Fifth Anti-Money Laundering Directive, which extended the scope of the Register to all UK 'Express Trusts' and some non-UK trusts, regardless of whether the trust is taxable. This extended scope was likely to encompass many primary care related trusts.

3. How are trusts relevant to primary care?

There can be many reasons to establish a trust, but the most common reasons in primary care are due to a lack of legal capacity on the part of the Beneficiaries. This is because most GP practices operate as General Partnerships (also known as 1890 partnerships or unlimited liability partnerships). A General Partnership is a legal relationship between the partners and does not exist as a separate legal entity, so it is not legally able to hold assets in its own name - partnership assets are therefore normally held in the names of one or more of the partners on behalf of the partnership. Common examples include:-

- freehold and leasehold properties, where the named owners of the legal title (at the Land Registry) may be different from the current partners in the partnership; and
- shares in limited companies, which are often held by a nominee partner on behalf of all the other partners.

There are two other common types of primary care related organisation that lack a separate legal identity:-

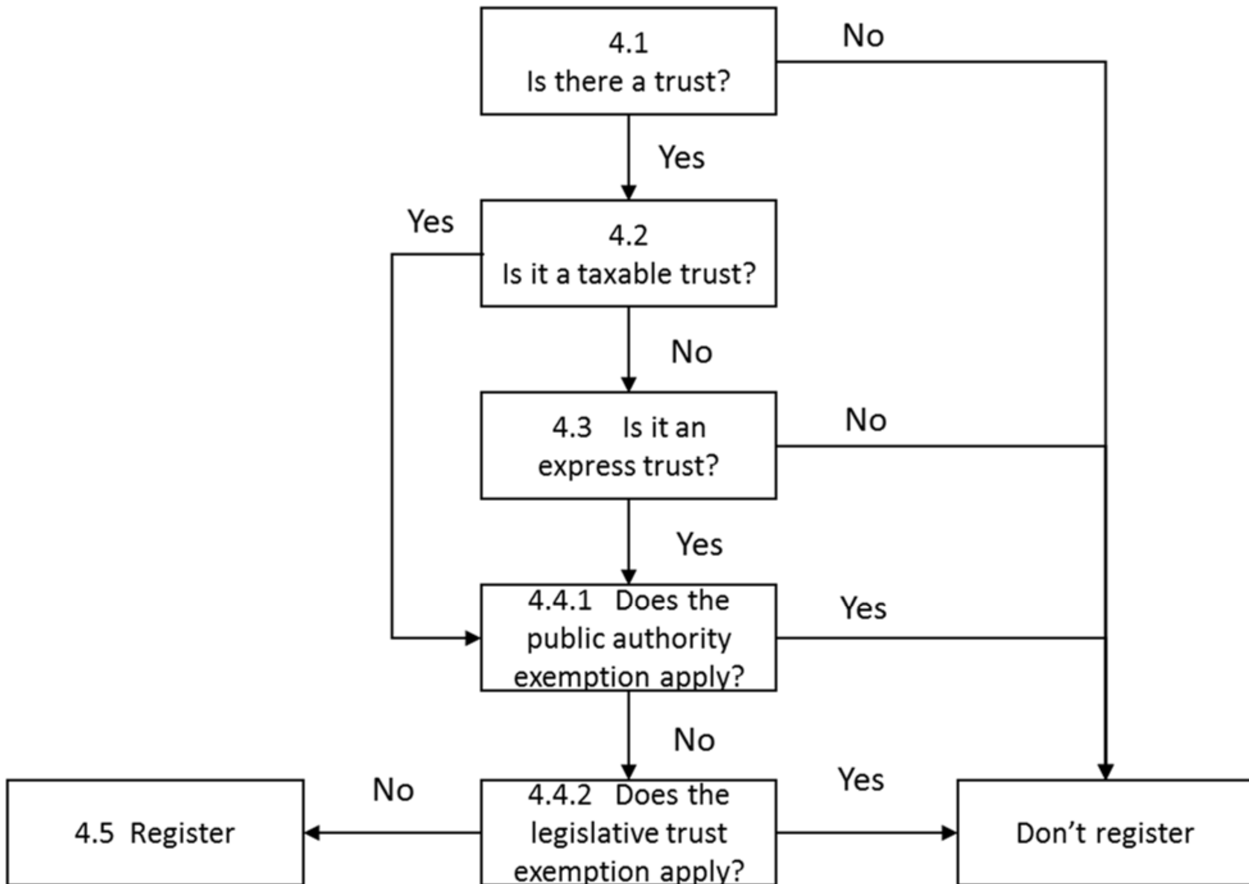
- A PCN is simply the name of a working arrangement between GP practices based around an Enhanced Service that happens to require the participating practices to share resources and expenses. The most obvious PCN asset shared by all member practices is the PCN funding, which is held by a single 'nominated payee' as the legal owner on behalf of all the member practices. In addition, some PCNs have begun to acquire other 'assets', such as leases and service contracts. Since an unincorporated PCN does not exist as a separate legal entity, the vast majority of PCNs are unable to hold any of these assets in their own name. The situation is further complicated by the fact that most PCNs are made up of arrangements between or including General Partnerships, which also lack legal personality.

- Local Medical Committees (LMCs) are normally unincorporated membership organisations, recognised by the local commissioner. Even where an LMC has formed a limited company, this commonly exists alongside the membership organisation, rather than replacing it. Whilst the limited company is able to trade in its own name, this is more difficult for the membership organisation, which may need to contract or hold property or assets in the names of one or more of its officers. This can then create a situation where the contract or asset is held by such individuals on behalf of the LMC members, by way of a trust.

The GPDF has sought the opinion of leading Counsel Simon Taube QC on how the legislation associated with Trust Registration should applied to Primary Care. This opinion is attached as Appendix 2. DR Solicitors have then applied this to various common primary care scenarios in Appendix 1 and assisted in the preparation of this guidance note.

4. Determining if you have a Registerable Trust

This is not a straightforward question, and each situation can be slightly different. However, there are strong similarities between most primary care related trusts, and the question can be approached through a decision tree as set out below. Each node in the tree is then explained in more detail below:



4.1. Is there a trust?

A trust can arise in a variety of ways, and does not need to be called a trust to exist. This can lead to confusion, because people sometimes refer to arrangements by a different name – such as a ‘nominee arrangement’ - without realising that they are actually referring to a trust. Some trusts arise through a course of conduct, and others arise by operation of law. Common situations in primary care are:

4.1.1 Freehold Surgeries held as Partnership Assets:
Where a partnership has an interest in a legal estate or an interest in land, the Partnership Act 1890 makes clear that it is held ‘in trust so far as necessary’ for the partnership. This means that if a leasehold or a freehold surgery is held by a practice as a partnership asset, it will necessarily be held on trust because the partnership (not being a separate legal entity) cannot own property in its own name. With regard to the surgery, the first question

to be addressed is therefore 'is the surgery a partnership asset?' If the answer is 'yes', then the surgery will be held on trust by the registered owners for the partnership.

Most practices, which are partnerships, hold their surgeries as partnership assets because there are tax advantages in doing so, but this is by no means a given and establishing whether or not a surgery is a partnership asset can be surprisingly difficult. Ideally, a Partnership Deed will make the position clear and practices should check their partnership deed does this, as a written statement that the surgery is a partnership asset is very strong evidence. However, if the deed is silent (or there is no partnership deed) the situation would have to be determined on the facts. It is perfectly possible for the property to be included in the accounts, but for a court to determine nevertheless that there was insufficient intent on the behalf of the legal owner(s) to make it a partnership asset. This 'intent' is critical because the courts are reluctant to establish trusts in the absence of intent.

However, an exception arises when property is bought with partnership money. In this scenario the burden of proof is reversed and the court would deem any property <u>bought with partnership money</u> to be a partnership asset 'unless the contrary intention appears'.

It is important to be aware that a surgery can be a partnership asset even if only a subset of the partners have equity in the building. How partners share equity in a partnership asset is a matter for them to agree among themselves, so it is perfectly possible for a building to be owned beneficially by the partnership as a whole, but for only a subset of the partners to have any say in how the building is owned and managed, and to take all the equity risk. It should also be noted that a partnership asset would normally remain a partnership asset, even after the retirement of an 'owning partner', unless something else is agreed.

In summary, it is unlikely that land or buildings owned by some of the partners before the formation of the partnership will become a partnership asset unless the said partners have clearly stated this intent, ideally in writing. However, it is likely that land or buildings acquired after the formation of a partnership and bought with partnership money (either cash or, more likely, a partnership mortgage) are a partnership asset, regardless of the names on the title; unless something has been written down to refute this.

4.1.2 Leasehold Surgeries as Partnership Assets

The position with leasehold surgeries is similar to freeholds, except that most GPs are keen to see them as partnership assets, rather than individual assets, because surgery leases normally have no market value and are simply a liability for the tenant(s). Leases are usually signed by some or all of the partners in a practice in their personal capacity because the partnership (not being a separate legal entity) cannot sign in its own name. The lease is then registered at the Land Registry, with a maximum of four of those partners who are named on the lease able to be shown on the Register.

Once again, the lease will only become a partnership asset if it is clear that this was the intent. Ideally, this would be made clear in a partnership agreement or, possibly, in the lease itself. However, given that the lease will be paid for through rent reimbursement from the practice and the practice is probably in sole occupation, it would normally be

difficult to refute that a surgery lease was a partnership asset and was therefore held on trust.

4.1.3 Freehold Surgeries not held as Partnership Assets

When an owner-occupied surgery is not a partnership asset, it is usually held by one or more of the partners in their individual capacities. So long as all of the owners are named at the Land Registry, there is not a trust within the definition of the TRS.

If, on the other hand, only a subset of the owners are named on the title at the Land Registry, then those who are named will almost certainly be holding the property on trust for all the owners collectively (but see also paragraph 4.4.2, below).

4.1.4 Nominee Shares

It is common in primary care for GP practices to own shares in shared healthcare provider companies. These companies are often referred to as ‘GP Federations’ and (for Primary Care Networks that have been incorporated, or which have established limited companies to carry out certain activities) ‘PCN Companies’. Where these companies are established as companies limited by shares (as is usually the case), the shares will normally be ‘owned’ by member GP practices. Because partnerships (not being separate legal entities) are not capable of holding shares in their own names, the shares are usually held on behalf of a partnership by a nominee partner. The nominee will then have obligations to exercise the rights in the shares on behalf of all the partners in the partnership, and to assign the shares to another partner in the practice in the event that they are no longer eligible to hold them. This means that the nominee partner is normally holding the share(s) as a trustee on behalf of their fellow partners.

4.1.5 Primary Care Networks (PCNs)

One of the rules of the PCN DES is that the majority of funding must be received into the bank account of a single member practice, known as the ‘nominated payee’. The PCN DES requires that member practices sign a ‘Network Agreement’ between themselves, and goes on to state that: “*The PCN will include in the Network Agreement the details of arrangements with the Nominated Payee and may indicate the basis on which the Nominated Payee receives the payments on behalf of the other practices, e.g. as an agent or trustee.*” In this way, it is left up to the core network practices to define the basis on which the nominated payee holds the shared funding.

In practice, the main options available to PCN members are that:

(a) the nominated payee is holding the money on behalf of the core network practices which make up the PCN;
(b) the nominated payee is holding the money on behalf of the PCN itself (as an unincorporated association or a partnership); or
(c) some or all of the money has been paid or gifted to the nominated payee practice in its own right

Most PCNs would almost certainly contend that the first option was what was intended, and most well drafted PCN Schedules will make clear both this trust relationship and that the PCN is not a partnership. In this case, the relevant monies in the nominated payee bank

account would be held on trust for the core network practices and the money would 'belong' to the core network practices.

In the second option, the money would 'belong' to the PCN itself and not to the practices. The nature and extent of any trust arrangement would then depend on whether the bank account had been set up in the name of the PCN or in the name of the nominated payee practice. The difference between options one and two can appear subtle but is fundamental, as it determines beneficial ownership and control of the PCN monies – essentially, whether decisions are made collectively at practice level or through the PCN's decision-making processes. It is critical that the position be made clear in the PCN Agreement and it is likely that most member practices would prefer option one over option two.

In the absence of any clarity, there would be a risk that a nominated payee could contend that the third option had been the intention, and that all the PCN money therefore belonged to them. The viability of this argument would depend on the facts.

In summary, most PCNs comprising more than one core network practice will likely be of the view that the PCN monies are held 'on trust' for all the core network practices (option 1), but it is critically important that this is set out in the PCN Schedules to avoid any ambiguity.

4.1.6 Local Medical Committees (LMCs)

The vast majority of LMCs are organised as unincorporated membership associations with an elected executive board and rules set out in a constitution. The BMA have produced a model LMC constitution, and it is expected that the majority of LMCs have adopted that template or a variant thereof. The model constitution does not refer to how assets should be held, but does define various officer roles.

Unincorporated associations are entities without legal personality, meaning they cannot themselves enter into contracts, bring legal claims or own property. In this sense, LMCs are similar to partnerships. Where an LMC owns assets such as land or property, these will therefore normally be held in the name of someone else (usually an officer) on trust for the LMC organisation. The same would be true of other assets like company shares. We are aware that many LMCs have established trading companies to help them better limit their liabilities and to contract with third parties. Where these are established as directly-owned membership organisations (usually a company limited by guarantee) then no trust arrangement would likely exist between the LMC and the company. However, where an LMC company is established as a company limited by shares and the shares are held by officers of the LMC, the shareholder(s) would probably hold such shares as nominees on behalf of the LMC and a trust relationship would then exist. The exact nature of these relationships should be carefully considered in each case and, if not already documented, written down to avoid ambiguity.

4.2. Is it a Taxable Trust?

This section is under review with tax advisers and will be updated with further information in due course, but where trusts are created in relation to primary care partnerships they are unlikely to be

taxable trusts since partnerships are ‘transparent’ for tax purposes. It is important to note that the exemptions identified below are relevant regardless of whether the trust is a taxable trust or an express trust.

4.3. Is it an Express Trust?

An ‘express trust’ is a trust that has been created intentionally, rather than being imposed by operation of law. The majority of trusts are express trusts.

To create an express trust the settlor (the person or persons who are transferring the asset(s) into the trust) must make clear their intent to do so. This is to reduce the risk of assets being transferred into trusts ‘by accident’. Whether or not the settlors are successful in creating a trust will depend on whether they have fulfilled the ‘three certainties’:

- **certainty of intention**; that they clearly intended to create the trust
- **certainty of subject matter**; that they have clearly defined assets to be held in trust
- **certainty of objects**; that they have clearly identified the intended beneficiaries of the trust

Certainty of intention is often the most difficult area in primary care. Clearly, if the settlors sign a document that states they wish to establish a trust then this would be prima facie evidence, but there are certainly examples where courts have held that the intent was clear, even without using the word ‘trust’. It is important to be aware that each situation will turn on its facts. The more ambiguous the arrangement, the more likely that you should seek legal advice to clear up any doubt.

It is also worth noting that ‘certainty of objects’ does not require that the full names of all the intended beneficiaries are known when the trust is established, and it is sufficient that the beneficiaries are identifiable as a class. For example, some common trusts might include ‘all unborn children and grandchildren’ as beneficiaries, or more relevantly to primary care ‘all the partners of a particular GP partnership from time to time’.

The alternative to an express trust is an implied (or non-express) trust. Implied trusts arise when it can be established that one or more individuals hold legal title to an asset on behalf of others, even though this has never been stated explicitly. The most common reasons for the creation of non-express trusts are:

(a) because a court has made this decision on an equitable basis (a constructive trust), or
(b) because it was clear simply from the nature of the transaction (a resulting trust)

The problem with non-express trusts is that the ‘rules’ of the trust will often have to be inferred or imposed. This may result in unintended outcomes. For example, a property would be held as a partnership asset on a non-express trust if it were purchased with partnership money and nothing further agreed. In this case, all partners would have equal rights to, and shares in, the property regardless of the names at the Land Registry. However, if the intent is for there to be any other arrangement (such as some partners having more rights to the property than others), this would have to be agreed between the partners and the trust would then become an express trust.

4.4. Is the Trust exempt from Registration?

Certain trusts are however exempt from the requirement to register with the TRS. Schedule 3A of The Money Laundering, Terrorist Financing and Transfer of Funds (Information on the Payer) Regulations 2017 sets out a list of trusts, which are excluded from registration. Two categories of exemption are of particular relevance:-

4.4.1. Public Authority Exemption

The exclusion, which is likely to be most relevant to primary care, is the 'public authority' exemption. This excludes "*A trust created for the purposes of enabling or assisting a public authority, within the meaning of section 3(1) of the Freedom of Information Act 2000 (FoI Act), or a body specified in section 80(2) of that Act.*"

For these purposes, the FoI Act defines a public body in England and Wales as a GMS or a PMS contractor (see advice from Simon Taube KC in Appendix 2). Whilst this exemption does not extend to APMS contractors, it will likely extend to most primary care practices in England & Wales. The key test is therefore whether the trust was created for the purposes of enabling or assisting a GMS or a PMS contractor to deliver their primary care contract. If it was, then the trust is exempt from registration.

4.4.2. Legislative Trust Exemption

Whilst the majority of primary care related trusts are likely to benefit from the public authority exemption, a small number of others may need to consider relying on the legislative trust exemption. This is where a trust is "*imposed or required by an enactment*."

The most obvious example of this in primary care would be where a property is owned by five or more persons, but – due to the limitation placed by the Law of Property Act 1925 - only four of them can be registered as owners at the Land Registry. So long as there were four named individuals registered at the Land Registry and all four are current beneficial owners, then the legislative trust exemption would apply.

4.5. Registration Process

There is a legal obligation for the trustees to register the trust. HMRC may enforce penalties on trustees who are required to register their trust but fail to do so, and on trustees who do not keep the details on the register up to date. Since 3 June 2022, the period for registration is 90 days from the creation of the trust.

The trustees are the persons who hold the property in the trust for the benefit of the beneficiaries and are responsible for administering the trust. The TRS rules state that the trustees have general duties to keep and maintain an up-to-date written record of the beneficial owners involved in the trust (including settlors, trustees and beneficiaries) as well as people with control over the trust (for example, trust protectors).

The registration process will sometimes need to go further than the trust document itself, since there is a requirement on trustees to identify the members of a class where this is 'reasonably

possible'. Thus a primary care related trust might identify 'the partners in GP practice A' as beneficiaries, but the trustees would have to identify the individual partners on the register, and keep the register up to date as the membership of the relevant partnership changed.

When a trust has multiple trustees, the trustees must nominate one of the trustees to act as the Lead Trustee. The Lead Trustee is then responsible for the administrative duties in relation to the tax affairs of the trust and is the main contact point that HMRC will use, although all trustees remain jointly liable. The Lead Trustee must update the register if the trust becomes liable to tax, or if there are any changes to trustees', beneficiaries', or settlor's details. If there are no changes, this must be confirmed annually. Changes must be recorded in the Register within 90 days of the change to avoid fines and penalties.

Appendix 1
Scenarios

We have set out below a series of common scenarios in primary care, and explained what, if anything needs to be done in each scenario.

1. **Owner Occupied Freehold Surgeries held as a Partnership Asset**

   The freehold will be held on trust in order for it to be a partnership asset. The individuals named at the Land Registry would be the trustees responsible for the trust. However, so long as the surgery was being used for the purpose of delivering services for a GMS or a PMS contractor, the trust would be exempt from registration due to the public authority exemption.

   It is less likely that a freehold surgery would be held as a partnership asset by a partnership delivering an APMS contract but, if this were the case, the trust would normally be registerable.

2. **Leasehold Surgeries held as a Partnership Asset**

   The leasehold will be held on trust in order for it to be a partnership asset. The individuals named at the Land Registry would be the trustees responsible for the trust. However, so long as the surgery was being used for the purpose of delivering services for GMS or a PMS contractor, the trust would be exempt from registration due to the public authority exemption.

   If an APMS contract is being delivered by a partnership from a leased building and the lease is a partnership asset (as is likely), the trust would normally be registerable. A possible exception would be if the partnership agreement were silent on the trust status of the lease, such that the trust is a non-express trust. Whilst possible, this may be unlikely, given that retiring partners named on the lease would generally want there to be a mechanism to be released from their obligations upon retirement, and this would normally be written into the partnership agreement.

3. **Leasehold and Freehold Properties <u>not</u> held as partnership assets**

   Although rarer in primary care, some surgeries are held by several individuals jointly outside of the partnership and not as partnership assets, albeit the practice is occupying the surgery. So long as all the owners are named at the Land Registry, there is no trust. This is possible with up to four owners. If there are more than four owners, then there will need to be a trust whereby the four owners named at the Land Registry hold it on trust for all the owners, but in this case (provided that there are at all times four current owners named on the Land Registry title) this trust will benefit from the legislative exemption so will not normally be registerable with the TRS.

4. **Nominee shares in PCN Companies**

   Where a PCN has elected to establish a company to deliver PCN services (often known as PCN Incorporation), it is common to establish the company as a company limited by shares where each core network practice holds one or more shares via a nominee share holder. The nominee holds the shares on trust for the core member partnership as a whole. Since the PCN DES is an integral part of the GMS, PMS or APMS contract, the public authority exemption should be available for GMS and PMS practices which hold shares in PCN Companies in this way. If an APMS practice uses a nominee shareholder

approach, they would not be able to benefit from any exemption. In practice, most APMS practices are likely to be incorporated so would hold the share in their own name, but if they do use nominee shareholders, the nominee(s) would be trustees and would need to register the trust.

5. **Nominee Shares in GP Federations**

Where a GP partnership holds one or more shares in a GP Federation via a nominee share holder, the most important test will be to establish the purpose of the federation. GP Federations have evolved over time and now undertake a diverse set of activities. Each federation should assess whether its primary purpose was, and still is, 'enabling or assisting GMS and PMS primary care'. If the answer to this is 'yes', then the same registration rules apply as for PCN Companies. If the answer to this question is 'no', then, assuming the trust is an express trust, each nominee shareholder would need to register at the TRS as a trustee acting on behalf of the partners in their partnership.

Whilst, in theory, it would be possible that the share might be held without any documentation, in practice this is unlikely. It would be very surprising if it were not mentioned somewhere in any of all of the company articles, any shareholders' agreement, and the partnership agreement (or an addendum thereto) that the share was a nominee share, so it will likely be very hard to argue anything other than that the trust is an express trust.

6. Primary Care Network (PCN) Nominee Bank Account

It is very likely that monies in the PCN nominee bank account are held on trust for all the member practices. Assuming that the majority of the practices in a particular PCN are GMS or PMS practices, Counsel's opinion indicates that the trust should benefit from the public body exemption and therefore would not need to be registered with the TRS.

7. Assets held on trust for Local Medical Committees (LMCs)

LMCs are not 'public authorities' within the relevant definition, and so are not themselves able to benefit from the public authorities' exemption. Whilst it is clear that LMCs were established to assist primary care practitioners, this is unlikely to be arguable for any trusts created in support of LMCs. Such trusts are most likely to arise where a property (such as a lease) has been registered in the name of one or more of the officers on behalf of the LMC, or where nominee shares in an LMC company are held on behalf of the LMC. Where this has happened, we would anticipate that the relationship has been documented in some way, so it will likely be an express trust. In these situations, the trust relationship would be registerable with the TRS.

Appendix 2
Opinion of Simon Taube QC

TRUST REGISTRATION:
GENERAL PRACTITIONERS IN PARTNERSHIP

OPINION – 9 SEPTEMBER 2022

A. Executive summary

1. This opinion considers whether the obligation to register trusts applies to general practitioners ("**GPs**"), who carry on business in a partnership in England and Wales which is governed by the Partnership Act 1890.[1]

2. The original Money Laundering, Terrorist Financing and Transfer of Funds (Information on the Payer) Regulations 2017 (SI 2017 No 692) ("**the 2017 Regulations**") implemented the EU's Fourth Money Laundering Directive ("**4MLD**"). Those original 2017 Regulations imposed obligations on trustees to register with the Commissioners for Her Majesty's Revenue and Customs ("**HMRC**") details of beneficial ownership and other matters in relation to "taxable relevant trusts".

3. Subsequently, the UK government implemented the EU's Directive 2018/843 - the Fifth Money Laundering Directive ("**5MLD**") - by amending the 2017 Regulations. The amended 2017 Regulations widen the scope of the registration obligation to cover specified non-taxable "relevant trusts." The amendment of the 2017 Regulations has given rise to concerns

[1] I am not advising on the position in Scotland since I am not qualified to do so.

that "express trusts" of the assets used by GPs in their partnership business could fall within the scope of the extended obligation to register trusts.

4. Under the 2017 Regulations the new obligation to register non-taxable relevant trusts does not apply to "excluded trusts". For the reasons set out in more detail in section B below, it is my opinion that a trust will be an "excluded trust" if -

   (i) the GP partnership is a "public authority" within para 23 of schedule 3A of the 2017 Regulations, because the partnership is a "GMS" contractor or a "PMS" contractor, and

   (ii) the trust exists for the purpose of "enabling or assisting" the public authority "to carry out its functions" under the contract.

5. A "GMS" contractor or a "PMS" contractor is a partnership providing primary medical services under a general medical services ("**GMS**") contract or a personal medical services ("**PMS**") contract (as the case may be) if the contract is made with the NHS Commissioning Board ("**the Board**") under section 84 or 92 of the NHS Act 2006 (or the Welsh equivalent). In practice, as I explain in section C below, the assets held on trust for the use or benefit of the partnership of a GMS contractor or PMS contractor will ordinarily be held for the purpose of enabling or assisting the partnership to carry out its functions.

6. On the other hand, if a partnership provides primary medical care under an alternative personal medical services ("**APMS**") contract, the APMS contractor is not a "public authority" under the 2017 Regulations. Where an APMS contractor has trust property, which is not held within a limited company, the trust is likely to be registrable.

B. The amended 2017 Regulations

7. Prior to the 5MLD, under the original 2017 Regulations the obligation to register applied to a "taxable relevant trust": regulation ("**reg**") 45. A "relevant trust" includes a UK trust[2] which is an express trust: reg 42(2). For the purposes of reg 45, a "taxable relevant trust" is a relevant trust in any year in which its trustees are liable to pay in the UK any of the following taxes, namely, income tax, capital gains tax, inheritance tax, stamp duty land tax, the Scottish land and building transaction tax, the Welsh land transaction tax or stamp duty reserve tax: reg 45(14).

8. A partnership regulated by the Partnership Act 1890 has no legal personality. As a general rule, the UK's tax legislation provides for the individual partners of a partnership to be taxed in relation to their income, capital gains, land transactions and so on, which arise in the partnership business, as opposed to the trustees who hold partnership assets in trust for the individual partners. Accordingly, the trustees of partnership assets usually fall outside the scope of reg 45 of the original 2017 Regulations.

9. However, to implement the 5MLD, the amended 2017 Regulations have introduced reg 45ZA. It extends the obligation to register beneficial ownership to additional types of trust. The obligation now extends to "type A trusts, other than taxable relevant trusts", as well as others.[3] A type A trust is defined in reg 45ZA(2) as –

> "a UK trust which is an express trust and is not an EEA registered trust[4] or a trust listed in Schedule 3A".

10. Schedule 3A of the 2017 Regulations lists various types of excluded trusts, which are not subject to the registration obligation. For present purposes the most important excluded trust is in para 23, which is headed "public authorities" and, so far as material, states:-

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[2] Broadly, a UK trust is one where one or more of the trustees is resident in the UK.

[3] Reg 45ZA also applies to type B and C trusts, being non-UK trusts, (i) where at least one trustee is resident in the UK and the trustees have a specified business relationship or land in the UK or (ii) the trustees acquire an interest in UK land, excluding trusts listed in schedule 3A.

[4] An "EEA registered trust" is a trust established in a country or territory other than the UK where national legislation applies having a broadly equivalent effect to the requirement laid down in the 4MLD: reg 42(4).

"A trust created for the purposes of enabling or assisting –

(a) a public authority, within the meaning of section 3(1) of the Freedom of Information Act 2000 …

to carry out its functions …"

11. Section 3(1) of the Freedom of Information Act 2000 defines "public authority", and the term includes "any body which, any other person who, or the holder of any office which … is listed in schedule 1" of the 2000 Act; and, under the heading "The National Health Service", Part III of schedule 1 includes paras 43A and 44, as follows:-

"43A Any person providing primary medical services. … –

(a) in accordance with arrangements made under section 92 or 107 of the National Health Service Act 2006, or section 50 or 64 of the National Health Service (Wales) Act 2006; or

(b) under a contract under section 84, 100 or 117 of the National Health Service Act 2006 or section 42 or 57 of the National Health Service (Wales) Act 2006;

in respect of information relating to the provision of those services."

"44. Any person providing general medical services … under the National Health Service Act 2006 or the National Health Service (Wales) Act 2006, in respect of information relating to the provision of those services"

12. My instructions are that there are three kinds of primary care practice, commonly referred to by the type of contract under which they provide their services:-

(a) GMS;

(b) PMS; and

(c) APMS.

In England all three types exist, but in Wales only GMS practices exist.

(a) GMS contractors

13. GMS contractors are practices that provide general medical services under section 84 of the National Health Service Act 2006 ("**the NHS Act 2006**") or section 42 of the NHS (Wales) Act 2006.[5] The NHS (GMS Contracts) Regulations 2015 (and the Welsh equivalent of 2004) govern the contents of the GMS contracts.

14. It follows that each GMS contractor is a "public authority" for the purposes of para 23 of schedule 3A of the 2017 Regulations; and any "trust created for the purpose of enabling or assisting" it "to carry out its functions" is an "excluded trust" within para 43A of schedule 1 of the Freedom of Information Act 2000. In my opinion, where a person, whether or not a partner in the GMS contractor, owns freehold or leasehold land or other assets as trustee for the purpose of enabling or assisting the members of the partnership to carry out its functions under a GMS contract, the trust will be an excluded trust; and there will be no need to register the trust.[6]

(b) PMS contractors

15. PMS contractors provide primary medical services under arrangements made under section 92 of the NHS Act 2006. The NHS (PMS Agreements) Regulations 2015 govern their contracts with the Board.[7] As regards para 23 of schedule 3A of the 2017 Regulations, the position of a PMS contractor is substantially the same as that of a GMS contractor. The PMS contractor is a "public authority". Where a person, whether or not a partner in the PMS contractor, owns freehold or leasehold land or other assets as trustee for the purpose of enabling or assisting the members of the partnership to carry out its functions under a PMS contract, the trust will be an excluded trust. Accordingly, there will be no need to register the trust.

[5] My instructions are that c. 75% of English primary care GP practices are GMS contractors.
[6] Prima facie, the reference to the trust being "created" refers to the coming into existence of the trust, whether in writing or orally, by words showing an intention that the owner holds the assets for the use or benefit of the partnership.
[7] In Wales there are no equivalent Welsh Regulations, and apparently no PMS contractors.

(c) APMS contractors

16. By contrast, APMS contracts arise under the Alternative Provider Medical Services Directions 2020 made by the Secretary of State in exercise of his powers conferred by sections 98A(3), 272(7) and (8) and 273(1) of the NHS Act 2006. Consequently, APMS contractors fall outside the scope of the "public authorities" mentioned in paras 43A and 44 of schedule 1 of the Freedom of Information Act 2000. A trust holding assets for the purpose of enabling or assisting an APMS contractor to carry out its functions will not be an excluded trust under para 23 of the schedule 3A of the 2017 Regulations, and so the trustee may be obliged to register it under reg 45ZA of the 2017 Regulations.

17. My instructions are that an APMS contractor usually carries on business as a limited company. Where an APMS company holds the assets, the *trust* registration obligations will not apply, although the *company* beneficial ownership registration obligations might be in point.

18. On the other hand, if an APMS contractor were a partnership and one or more persons held assets on an express trust for the use or benefit of the partnership but the partners were not identical to the trustees, the trustees might well be subject to an obligation to register the trust. *Prima facie*, such a trust is not within the other possible categories of excluded trust in schedule 3A of the amended 2017 Regulations, namely:-
    (a) "a trust imposed or required by an enactment" (para 1); or
    (b) "a trust of jointly held property where the trustees and beneficiaries are the same persons" (para 9).[8]

[8] HMRC's TRS Manual notes at TRSM23050 that if legal title to land is in the name of more than four persons, so that section 34(2) of the Trustee Act 1925 requires the legal title to the land to be registered in the name of just four of them, the trust falls within para 1 of schedule 3A of the 2017 Regulations (not para 9). In practice, it is unlikely such a case will arise.

C. Trust assets held to assist public authority to carry on functions

19. In para 23 of schedule 3A of the 2017 Regulations the exclusion from the registration obligation for "public authority" trusts focuses on the functions of the public authority. The trust must be created – i.e. exist – "for the purpose of enabling or assisting" the GMS or PMS contractor "to carry out its functions". The addition of the words "or assisting" after "enabling" widens the extent of the excluded trusts. A trust for the purpose of "assisting" the public authority to carry out its functions includes trust of assets that help the public authority to carry out its function without being essential for the purpose.

20. In the present context the relevant "functions" are those derived from the terms of the GP partnership's contract with the Board. A GMS contractor enters into a standard form contract with the Board to provide "essential services" which are widely defined in reg 17 of the NHS (GMS Contract) Regulations 2015, together with any additional services to which the contractor opts in, and "enhanced services" which the Board may commission. The form of a PMS contract is based on the template of a GMS contract and contains similar sorts of provisions.[9]

21. It is therefore clear that a trust, under which the trustee holds the freehold or leasehold surgery of the GMS contractor or the PMS contractor, exists for the purpose of enabling or assisting the contractor to carry out its functions. It is an excluded trust.

22. Similarly, where a nominee or trustee for a partnership that is a GMS or PMS contractor holds a PCN (or primary care network) bank account or shares in a PCN company, the trust will be an excluded trust. Such nominee or trust arrangements exist to enable or assist the partnerships to carry out their functions.

(1) Under a PCN directed enhanced services ("**DES**") contract a PCN bank account must be established to hold shared monies in the name of a "nominated payee". A PCN DES contract is an annual contract between the GMS or PMS contractor and the Board. Such a DES

[9] See the NHS's recent 2022 standard forms of GMS and PMS contracts.

contract enables or assists the GMS or PMS contractor to deliver services under sections 84 or 92 of the NHS Act 2006.

(2) My instructions are that: the function of a PCN company is to support the delivery of essential services or DES; only PCN core network practices can be shareholders in PCN companies; and the shares are normally held by nominees on behalf of all the partners in a member practice. Provided the PCN company is performing this function and not straying into other activities outside the scope of the sections 84 or 92 of the NHS Act 2006, the trust of the shares would be an excluded trust.

23. My instructions raise two questions in connection with such PCN arrangements. First, would the foregoing analysis be altered if the PCN also included an APMS contractor? In my opinion if the PCN comprised a majority of GMS and PMS contractors it would still be possible to satisfy the requirement that the trust of the PCN bank account existed for the purpose of enabling or assisting the GMS and PMS contractors within the PCN to carry out their functions.

24. Secondly, if at the time of the initial creation of the trust of the shares in a PCN company its function was to enable or assist practices to provide services under sections 84 or 92 of the NHS Act 2006 but later this ceased to be the function of that PCN company, would the trust of the shares continue to be an excluded trust? In my opinion para 23 of the schedule 3A of the 2017 Regulations must be construed purposively, and therefore the trust would cease to be an excluded trust once the PCN company ceased to enable or assist GMS or PMS contractor to carry out its functions under a section 84 or 92 contract.

25. Finally, my instructions ask whether a trust of shares in a GP Federation company held by a trustee or nominee of the partnership would be an excluded contract? My instructions are that a GP Federation company is a similar vehicle to a PCN company, but it has a longer history. Most GP Federations were established to deliver “extended access” contracts for a locality beyond the services during “core hours”, so as to assist in the provision of primary care. However, GP Federations then developed in different directions, some becoming active

in developing a large range of services way beyond traditional primary care, whilst others never moved beyond extended access and are now facing difficulties as GP practices are now contracting directly through the PCN DES to provide extended access.

26. In my view it will be necessary to look at each GP Federation company and its GMS or PMS contractor shareholder on a case by case basis. The object of the inquiry will be to identify whether the holding of shares in the GP Federation company by a trustee or nominee for the GMS or PMS contractor enables or assists the partnership to carry out its functions under the contract with the Board made under section 84 or 92 (as the case may be) of the NHS Act 2006. If the answer is yes, the trust is an excluded trust. If not, then there is likely to be an obligation to register the trust.

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