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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.