

PRACTICE BASED COMMISSIONING: CONSORTIUM WORKING

GENERAL PRACTITIONERS COMMITTEE GUIDANCE, APRIL 2006

BACKGROUND

This document is the first in a new series of guidance notes from the General Practitioners Committee (GPC) on practice based commissioning (PBC). For the most part, the series is aimed at practices who intend to take on a level of commissioning activity wider than the scope of the 'Towards practice based commissioning' Directed Enhanced Service (TPBC DES). Despite this, a large part of the guidance will still be relevant to practices undertaking the DES.

Before reading this and later guidance in the PBC series, practices should have an understanding of the aims of the TPBC DES – a low level, introductory scheme – and how it fits in with higher level commissioning activity. The GPC has already produced detailed guidance on the DES (February 2006), which can be accessed here:

www.bma.org.uk/ap.nsf/Content/focustpbcdes

Whatever level of commissioning practices take on, they should be aware of three overriding messages:

1. Practices are not obliged to undertake any commissioning activity if they do not wish, or are not being adequately resourced, to do so;
2. Practices should be fully aware of the arrangements pertaining to and implications arising from their involvement in commissioning. This applies equally to practices who choose not to be involved in the initiative; and
3. Clear and precise, written agreements must be in place, both between the PCT and practice(s) and between practices within a consortium, setting out the terms of engagement, particularly in relation to any financial matters.

The various Department of Health documents referred to in this guidance can be accessed online via the PBC homepage at the following address:

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/fs/en

This guidance has been structured as follows:

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1 INTRODUCTION

Although an individual practice can take on the commissioning role alone, there is an assumption that the majority of PBC activity will be undertaken through collaboration with other local practices, via PBC consortia. It is generally agreed that working in groups or clusters of practices will reduce the risks involved and will also provide economies of scale, which will be make bargaining power and commissioning influence greater.

Though this guidance focuses on consortium arrangements, parts of it will still be relevant to practices undertaking PBC on an individual basis.

2 FORMING INTO CONSORTIA

In most areas, consortia formations have already begun to emerge. We would re-emphasise that this exercise should be GP-led not PCT imposed and the Department of Health's Q&A document on its latest guidance 'Practice based commissioning: achieving universal coverage' (January 2006) says the following:

“Can practices engage in PBC on their own?”

Yes. GPs cannot be forced into locality or other commissioning groups. However, we would encourage practices to consider the benefits of working with others. For example, working with other practices will create a larger pool of resources for reinvestment in services, which can then be accessed by a larger number of patients across the practices involved (eg. diagnostic services provided to a number of practices).”

There is evidence to suggest that no one size fits all as regards the ideal commissioning group and that this will depend on the population base and the level of commissioning being taken on¹. There will be advantages in working in big groups as the larger the commissioning consortium, the greater the power it can exert in its commissioning decisions. This may be needed to influence a large, powerful secondary care Foundation Trust hospital. Where a consortium is particularly large, remember that the group can always divide into smaller units for specific projects and for locality collaboration. Practice consortia do not necessarily have to be geographically adjacent and could even cross PCT boundaries.

3 ESTABLISHING EARLY GROUPINGS AND SHARED PRINCIPLES

In some areas, practices have found establishing a set of shared, key principles via a 'statement of intent' a useful tool in the early stages of forming into groupings. A sample of such a document, as based on a local version, is attached at appendix 1. It should be noted that a statement of intent is not a legally binding document and does not constitute an actual consortium agreement. The parties involved are strongly advised to build upon the statement of intent with a more formal consortium agreement at a later date and within a stipulated timeframe.

4 FLEXIBLE INVOLVEMENT WITHIN THE CONSORTIUM

Individual practices will vary in their capacity to take on PBC and encouraging and accommodating different and flexible levels of involvement within the consortium structure may facilitate sign-up from those less enthusiastic practices. This would enable some practices to actively choose to be involved at a lower level than others, specifically suiting their capacity and aspirations. It would also allow practices to exercise commissioning at a practice level for certain clinical areas, should they wish, and with agreement by the consortium.

This need not be a particularly complicated system and for example could be arranged as follows:

¹ The Health Foundation (2004) *A review of the effectiveness of primary care-led commissioning and its place in the NHS*

A) *Minimum involvement at practice level.* This could be defined through participation in the TPBC DES, which practices can undertake individually, or as a group. Practices' DES plans therefore should fit into the consortium's wider commissioning plan.

B) *Higher involvement at consortium level.* There will be scope within this category for practices to undertake different levels of involvement, comprising some or all of the following: commissioning more complex services; actively engaging in contributing to commissioning policies; developing service redesign; personal audit and analysis of clinical behaviour and referrals; identifying personal needs for training and education; case management of targeted practice populations and actively managing the indicative budget. There will also be the option for some practices to 'block back' certain services/activities to the consortium and for the consortium to 'block back' certain services to the PCT. Additionally, the consortium could support flexibility for individual practices to commission certain clinical areas at a practice level should they wish.

Clearly commissioning at this level will require resources above the DES and this should have been agreed in advance as part of the commissioning plan with the PCT.

C) *PCT level commissioning.* This would include services that are at a higher financial risk to commission such as acute trust services (A&E, emergency admissions) or specialist commissioning which is low volume, high cost. It would also include areas where activity data is not available by practice, nor costed through the national tariff. Note that in areas where large consortia exist with particularly developed expertise, they may take on this level of commissioning in the future. This will be particularly important in areas where PCT reconfiguration has resulted in the establishment of very large PCTs and in turn, there is danger of local knowledge being lost to the detriment of patient care. In some areas, it may even be necessary for large consortia to start to undertake this high a level of commissioning from now. Naturally, PCT level commissioning will require commensurate additional resources that should be agreed with the PCT in advance.

The consortium commissioning plan and inter-practice agreement will need to specifically address the above flexible involvement arrangements within the group.

5 MANAGEMENT ARRANGEMENTS AND RESOURCES

The management team

Every practice should establish a PBC-lead (either GP, practice manager and/or another member of the practice team) to be responsible for taking forward PBC within the practice and who is the main contact both internally and externally.

Depending on how many practices are in one grouping, the consortium management team could either be comprised of all the practice PBC-leads or where this would make the team too large to be functional, the management team could be made up of a selection of these leads. Such a system is heavily based on trust and a commitment to a shared set of principles and objectives. In addition, effective communication channels must be put in place, with a mechanism for two way feed-back between the management team and GPs within the consortium, in order for the management structure to work; this will be essential to maintain engagement of GPs who will be taking a lesser role in the commissioning process. It would also be advisable for the consortium management team to be multi-disciplinary and where possible, it could include secondary care and/or public health representation.

In addition to the over-arching management structure, project or 'work-stream' groups should be set up to carry out separate, specialist work such as IT. It should be noted that members of these project groups may require specialist training.

Consortia may wish to consider buying in or employing external staff with a particular set of expertise in order to either be part of the management team or lead it. If doing so, remember that GP ownership in commissioning will be imperative to its success and so this individual should work in collaboration with GPs rather than on their behalf and in isolation. It would be advisable for practices to take some basic legal advice relating to the associated employment risks in the event of future redundancy.

There may be some advantages to agreeing to seconded staff from the PCT, with the proviso that the consortium is able to choose the individual(s); this may be seen by many PCT personnel as complementing their existing portfolio of experience. Although using PCT staff may help to prevent duplication of work and improve relations, it is still important to recognise the different agendas of the parties involved.

Part of the management team's role will be to forge links between other local commissioning groups in the PCT area, especially for higher levels of commissioning. It will also be the team's role to liaise with the Strategic Health Authority (SHA).

Calculating an appropriate clinical engagement/management allowance

The TPBC DES will fund minimum level involvement at practice level, but will not cover the work arising from more extensive commissioning activity at consortium level. The Department of Health's 'Making practice based commissioning a reality: technical guidance' (February 2005) stated the following:

"Initial costs, in terms of necessary resources and management support for Practice Based Commissioning, will be provided in advance by the PCT. The PCT can then recoup this outlay from resources subsequently freed up at the end of each financial year."

Although the latest Department of Health guidance, 'Practice based commissioning: achieving universal coverage' (January 2006), makes no mention of such an arrangement, the DES specification (paragraphs 4 and 9 respectively) sets out the following:

"Where PCTs and practices agree additional workload for practices, additional resource to this DES should be made available."

"For any activity above and beyond this DES plan, which the PCT and practice agrees, additional resources should be provided."

Practices/the consortium will need to define their management requirements according to their commissioning activity, calculate the cost and propose this to the PCT in the commissioning plan. The clinical engagement or management allowance should resource:

- Practice-level clinician and/or management/administrative time, taking into account locum costs to allow for backfill as necessary.
- Consortium-level clinician and/or management/administrative time, taking into account locum costs to allow for backfill as necessary;
- Any necessary training or research costs;
- Specialist advice where necessary; and
- Costs arising from data management, IT or administrative functions.

Where practices are working under the TPBC DES, they should do so within the resources available and not exceed them. Component 1 of the DES amounts to 95p per registered patient so for an average practice of c. 5,800 patients and 3 full-time GPs and at current market rates, it would fund about 1 locum session (of half a day) every fortnight. [Note that this does not take into account any practice managerial or secretarial time].

For consortium working, clinician time for workload above the DES must be remunerated. Practices should ensure that funding for this work is agreed with the PCT in advance and formalised in the PCT-practice/consortium agreement. **If the required management costs are not going to be met by the PCT, practices should seriously reconsider the level of commissioning they wish to take on as a result and in light of the funding available.** The consortium commissioning plan will need to identify areas where freed up resources are anticipated as any additional upfront management resources will be recouped from freed up resources at year end.

Practices should seek agreement from the PCT that, in event of no freed up resources being made, there is no claw-back of these management costs as this is essentially payment for work already completed. Even in situations where no freed up resources are made, it is likely that service redesign will have taken place to the benefit of the patient population, which in effect means that PBC has been successful.

Further management support could be given by the PCT from its existing staff, such as for:

- Contracting issues with providers;
- Data collation from providers and feedback to practices;
- Monitoring provider performance regarding Payment by Results (PbR) and ensuring appropriate activity;
- Support to practices in interpretation of data, and facilitating local commissioning; and
- Public health input.

Additionally, practices/consortia are entitled to make a request for upfront investment in order to deliver freed up resources. To receive such a resource, practices will need to submit a separate business case to the PCT. The PCT is then required to respond within 8 weeks to such a request, as is detailed in paragraphs 50-52 of the Department of Health guidance 'Practice based commissioning: achieving universal coverage' (January 2006).

6 GOVERNANCE AND CONSORTIUM AGREEMENTS

It is important for practices working together in a consortium to have sound governance arrangements which are defined, at the very least, in a written inter-practice agreement. Depending on how the consortium intends to function, the necessary additional governance arrangements will vary. At its most basic, the agreement should cover the following:

- Membership;
 - (i) Name the practices and PBC-leads
 - (ii) Name the consortium management team
 - (iii) Procedure for incoming and outgoing members
- Scope/range of commissioning;
- Define/formalise practices' involvement/commitment;
- Covering costs;
 - (i) Arrangements for management allowance to practices and the management team
 - (ii) Arrangements for resourcing consortium governance structure and/or other collective costs
- Use of freed up resources;
 - Whether at practice or consortium level, or a mix, including future arrangements relating to any shared equipment or communal premises/clinics in the event of a change in the make-up of the consortium

- Risk sharing and management amongst practices;
- Clinical governance;
 - Arrangements to ensure that safe clinical practice is maintained when referral reduction initiatives (i.e. inter-practice or GP to GPwSI referrals, or service redesign in the community) are put in place
- Conflicts of interest and probity;
 - (i) Measures to show that the process of choosing providers from which to commission will be fair, open and objective (i.e. against a set of agreed criteria such as accessibility, value for money etc.)
 - (ii) Measures to show consortium's commitment to patient choice
 - (iii) Arrangements for ensuring patient/public involvement
- Education and training proposals for clinicians;
- Liability;
 - Consider the associated risks and how liability is to be managed
- Indemnity;
 - Consider whether indemnity clauses are required and what the limits should be
- Duration;
 - Including a mechanism for extension and renewal
- Termination;
 - For individual members, individual practices and the consortium as a whole.

A list of some further questions that the management team should consider when putting together the consortium agreement is attached at appendix 2.

Furthermore, consortium working arrangements may need to be defined – principally for reasons of liability – through the built-in governance arrangements of a legal structure, for example, a Limited Liability Partnership (LLP), a Company Limited by Shares or a Company Limited by Guarantee. These structures would automatically set out many of the arrangements detailed above and more information on the relevant legal structures can be found at appendix 3.

Practices can either establish themselves under one of these legal structures from the outset, or move to do so at a later date. Note that these structures will also apply to practices coming together in order to provide primary care services beyond the scope of the existing GMS or PMS contract. Where a group of practices wishes to form a company under which it will both commission and provide services simultaneously, the issue of conflicts of interest will need to be explored in more depth.

BMA Law is a service designed for LMCs and offers legal advice and drafting on a number of areas. Where a pan-LMC consortium is being established and the group wishes to commission/operate as a company, BMA Law could offer a member LMC legal advice and a drafting service specific to the consortium's needs. For more information on how to access the BMA Law service, LMCs should email info.lmc@bma.org.uk or write to BMA Law, Legal Department, British Medical Association, BMA House, Tavistock Square, London, WC1H 9JP.

SAMPLE STATEMENT OF INTENT BETWEEN PRACTICES

This is not a legally binding document, rather a statement of intent with a view to collaborative preparation towards Practice Based Commissioning, with more formal agreement in due course.

1. Shared philosophy

- *This is to confirm that ...[practice names].....will work together as Practices in a consortium arrangement to maintain the strengths of general practice in this area, and develop services for patients as well as the profitability of our constituent Practices. We welcome approaches to participate from Practices, who are willing to work towards the principles in this statement of intent.*

- *We wish to build on the existing strengths of primary care in this area namely:*
 - *quality of services and staff*
 - *local relationship with local people*
 - *convenience of access for patients*
 - *strong IT infrastructure*
 - *premises*
 - *reputation*

- *We form a cluster of like minded practices that is of a reasonable size to develop Practice Based Commissioning for the benefit of our combined patient population.*

2. Preliminary objectives for the potential PBC consortium

- Analysis of referral data at practice and consortia level, with peer review
- Identifying areas of appropriate reductions in hospital referrals, within the context of service redesign and care pathways
- Establish an approach to hospital data validation
- To analyse patient pathways within the local health system with a view to improving services in a cost effective manner, sensitive to the implications for existing services.
- Development of alternative models of provision.
- To collaborate with neighbouring clusters to aim to give consensus guidance on commissioning to local providers.
- To propose use of any freed up resources, in accordance with the relevant Department of Health guidance and in line with the consortium's commissioning plan (to be established)
- To propose adequate management costs for the consortium (over and above DES funding) appreciating that PBC work may sometimes be at the expense of practice commitments or personal time.

3. Practical & operational issues

- Each practice is to designate a clinical and a management lead to liaise and meet with the consortium as required.
- An elected or appointed consortium lead will chair consortium meetings, attend PCT PBC project meetings [specify frequency], liaise with neighbouring consortia and report back to the consortium as appropriate.
- Cluster practices do not necessarily need to form a contiguous geographical area.
- Decisions on the operation of the consortium will be made on a majority vote

4. Commitment

Each practice signing up to this statement of intent is expected to commit to:

- Investing clinician and manager time to develop PBC in a manner agreed by the consortium *[unless agreed otherwise due to particular Practice circumstances]*
- Sharing referral data and prescribing data, electronically.
- Sharing specialist skills within the cluster.
- Sharing resources available for PBC, in a manner agreed by the cluster.
- Maintaining an open mind with regard to how services might be developed
- Maintaining a willingness to appreciate that PBC is a shared agenda between Practices
- To share information about the development of PBC within the cluster.
- To discuss, if mutually agreeable, the need to proceed to a more legal agreement in due course.

5. Timeframe

- Interested practices should aim to sign up to the statement of intent by [insert date]
- To aim to formulate a consortium commissioning plan by [insert date] and a more formal inter-practice consortium agreement by [insert date]
- To complete data validation by [insert date] (resources permitting)
- To be in a position to direct local commissioning by December 2006 and to liaise with PCT commissioners in the meantime (resources permitting).

On behalf ofPractice I agree to the terms of this statement of intent.

Signed

Date

SOME ISSUES TO CONSIDER FOR THE OPERATION OF THE CONSORTIUM*1 Staff undertaking consortium work*

If staff are required to undertake consortium work, it must be considered who would employ them. It could be the Consortium (i.e. whatever entity the Consortium operated under), but this may be an unlikely scenario. It may be that practice staff are utilised for part of the time and therefore there must be some agreement between the consortium and the individual practice for the use of that staff member. This is important if the consortium is claiming management costs from the PCT. Also, practices should be aware of changes to any employment contracts of their staff and gaining employees consent.

2 Reimbursement of GP time working for the consortium

Must consider the impact of consortium work on the individual practices and the effect of this work on partnership arrangements. GPs engaged in PBC consortium work will need to be paid for their time at market rates equivalent to enabling the GP/practice to resource locum cover should they wish. There will need to be agreement as to whether the payment is made to the individual GP or to the practice. Additionally tax and NI implications will need to be considered. It may be that these payments can be administered by the PCT on behalf of the consortium.

3 Assets to operate the consortium

Will the consortium operate utilising assets bought and owned by the consortium or utilise the assets belonging to each practice e.g. computer equipment, stationery etc.? If the consortium owns the asset, then what happens to that asset on liquidation or winding up? Can the utilisation of assets from individual practices be claimed through management costs?

4 Membership of the consortium

Who can belong to the consortium? Only GPs? Partners? What about non GPs or other bodies? What about suspended GPs or retired GPs?

5 Leaving the consortium

It should be considered what happens when one member or practice wishes to leave the consortium. This should be covered amongst other things in the agreement whether a formal legal entity or the company byelaws.

6 Use of freed up resources

If freed up resources are made there needs to be a clear procedure as to how these are utilised. Need to agree whether freed up resources are for practice use, or consortium use, or a combination, and if so what proportion between practice and consortium. If a saving is to be used for the purchase of a tangible asset such as a form of equipment, then who will own this? [As practices only have an indicative budget and therefore freed up resources come from PCT budgets, the assets may belong to the PCT]. If it is the consortium entity then what happens to that asset if the consortium is dissolved. If an individual practice owns it, does the practice in effect hold it on trust for the benefit of other practices? We may perhaps require additional advice on trust law. If the savings are used to provide additional premises for a particular practice or a new roof for example, is this permitted? And if it is, who owns this and what happens if the practice receives what is in effect a capital benefit, and then dissolves the partnership. If the saving is used to provide an employee e.g. a nurse, who employs this person? What about the ongoing costs of employment or redundancy or any other claims arising out of an employment? A solution would be allow the consortium entity to employ for the benefit of the practices. This does mean that the consortium will be liable for all matters arising out of that employment. It must be considered what happens if the saving is not sufficient to pay for an employee on an indefinite basis. It

must be considered who will make up any shortfall in employment costs, i.e. where does this money come from or how can it be claimed?

LEGAL STRUCTURES FOR PBC CONSORTIA

It is important for practices working together in a PBC consortium to have sound governance arrangements which are defined, at the very least, in a written agreement. Consortium working arrangements may need however to be defined further – principally for reasons of liability – through the built-in governance arrangements of a legal structure. This paper has been drawn up with PBC consortia in mind and covers the most appropriate legal structures under which they may wish to operate. Practices/consortia will need to decide whether or not to work under such a legal structure and the GPC is unable to recommend one option over another as suitability will depend on the individual aims and needs of the consortium.

These structures will also apply to groups of practices who have come together in order to provide services beyond the scope of their existing GMS or PMS contracts. So if practices wish to set up an Alternative Primary Medical Services (APMS) or Specialist Personal Medical Services (SPMS) organisation, they could do so via these structures. Further information on APMS can be found in the relevant GPC guidance note.

The structures covered in detail in this document are as follows:

- 1 Company Limited by Guarantee (page 10);
- 2 Company Limited by Shares (both private and public – page 12); and
- 3 Limited Liability Partnerships (page 15).

1 A COMPANY LIMITED BY GUARANTEE (NO-SHARE CAPITAL)

1.1 Key characteristics:

- Used by a small number of companies
- Liability of members limited to the extent of their guarantee and then only on winding up
- Company does not have share capital
- Members do not hold divisions of profit in the form of shares
- Most companies of this kind are not for profit e.g. Schools, charities, museums and some sports clubs.
- Unsuitable medium for a profit making business
- Board of Directors usually known as Governors or Trustees

The Companies Act 1985 does not allow for companies to be formed without the members having any liability at all. For companies where profit is not the objective and where the contribution of share capital is not an appropriate expectation of the members the act provides for companies to be formed where liability is limited by a guaranteed amount agreed by the members. In practice this guarantee is often for a nominal amount usually £1. In the event of liquidation the members will be liable for the amount of their guarantee.

Members may still be liable if they have acted fraudulently, negligently, ultra vires or continued to carry on in business when it was apparent to the member that the company was insolvent.

Historically there have been two forms of Guarantee Company a pure form and a hybrid form, where there is some share capital. The formation of Guarantee companies having share capital was abolished by the Companies Act 1980 although those that were in existence were permitted to continue and thus both types of Guarantee Company still exist, albeit only the pure guarantee company is an option for a new business and therefore no further detail on the hybrid shall be given herein.

The pure Guarantee Company is an appropriate medium for non profit making businesses and is widely used in the charitable and quasi-charitable context, often as a less risky and more flexible alternative to a trust.

As there is no intention to make profit there is no reason to divide the Company by way of shares. It is also unlikely in this context that Members will wish to contribute capital sums to the company which would ordinarily be the implication of a share issue. Because of this, this medium is only appropriate where either no funds are required for the running of the business or where the funds are coming from another source e.g. endowments, donations, fees, subscriptions etc.

Because there is no share capital it follows that companies Limited by Guarantee cannot be a public company as they are unable to satisfy the share capital requirements under s.117 of the Companies Act 1985. The only option for promoters wishing to use this format is a private company limited by guarantee.

The members will usually run the company democratically (depending on the size of the concern) this will either be all the members as directors or an executive board appointed by them in the form of a Board of Directors. In this context directors will usually be known as Trustees, Governors or some other term which is not synonymous with the pursuit of profit.

Another significant difference is the relaxation of the requirement to include the suffix "Limited" or "Ltd" as part of the company name. This used to be by process of application for a specific exemption however as this was a cause of unnecessary work for the registrar and can now be requested on application. The registrar will usually not object without good reason. The exemption will also mean that the company is exempt from all the requirements relating to the use of the word "limited" as part of its company name and is also exempt from the requirements relating to publication of its name and from sending the names of members to the company registrar.

1.2 Formation

Formation in most cases will be by registration under the Companies Act 1985 s.1(2)b.

Registration can be conducted by the promoters themselves, by a solicitor or by a company formation agent. Company formation agents will usually offer what are known as "off-the-shelf" companies; these are companies that have already been registered and which are adapted for the required use by changes to the memorandum and articles of association. This may be simpler and less expensive than forming a new company. Promoters wishing to incorporate themselves must send the following documents together with the fee to the registrar of companies:

- A memorandum of association
- Articles of Association
- Form 10
- Form 12

The memorandum sets out who the members of the company are and what the company will do or its "objects". The articles of association are the rules which apply to the internal running of the company.

The prescribed model memorandum and articles of association for a Private company Limited by Guarantee is Table C (here to appended) unlike Table A in the case of a Private Company limited by shares the application of table C can not be automatic and there is no option not to register memorandum and articles. Table C may be altered but should remain in the same form so far as circumstances permit.

If the company is a charity as is often the case for a guarantee Company then the promoters must also register the concern with the charities commission and send the an annual return in addition to the return to Companies House. The charities commission also produce a model memorandum and articles of association and guidance for registering as a charity and publish this on their web site.

To register; the Memorandum and Articles of Association must be sent to the registrar along with the relevant fee which is £20 or £50 for a premium (same day) service. This should be accompanied by Form 10 which gives the details of the first directors of the company and the company secretary as well as the intended address of the registered office. Details must include; names and addresses, date of birth, occupation and details of directorships held in the past five years. The form must be signed by each subscriber or their agent.

As previously mentioned a private company need have only one director but must also have a company secretary these may not be one and the same person unless there is more than one director in which case one of the directors may also hold the secretary post. For a public company there must be at least two directors.

Form 12 is a statutory declaration of compliance with all the legal requirements for forming a company. This form must be signed by a solicitor or by one of the people named as director or company secretary (in form 10). This MUST be signed in the presence of a commissioner for oaths, notary, JP or a solicitor.

Once these documents are received by the registrar they will perform the relevant check and register the company assuming that the documents (and the directors) comply with the legal requirements. Failing that incorporation will be rejected.

There is an electronic filing service offered by companies house for which special software is required this can either be purchased or developed the charging for the electronic service is at a reduced rate of £15 or £30 for the premium service.

1.3 Pro's and Con's

Pro's

- Minimises the risk and of liability of members
- All the usual benefits of a company over a trust can hold property, borrow money and make contractual arrangements in its own name and trade in perpetuity
- Has formal democratic control of it members enshrined in its articles
- It is easy to set up a subsidiary company to hold capital and conduct non-charitable trading

Con's

- Not appropriate for a profit making business

2 A COMPANY LIMITED BY SHARES

2.1 Key Characteristics

- Most common form of company
- Liability limited to the members share capital or amounts unpaid on shares
- Profit divided according to share holding

There are two types of company limited by shares a private company limited by shares and a public company limited by shares. Whereas the former describes a situation in which a

group of private individuals wish to form a business using their own contributions as capital; the latter describes a situation in which the promoters of a company seek to attract investment from the public by selling shares in the company on the open market. The greater extent of company law applies equally to both types of company but there are certain important differences.

In either case the fundamental attribute of incorporation is the creation of a corporate personality the “company” which can create its own legal relationships with third parties notably; owning property, employing staff, entering into contractual relationships, suing and being sued etc. All in such a way as is distinct from the legal personality of its members who will not by virtue of their membership be personally bound by the legal relationships of the company as they would be in the case of a partnership.

2.1a A Private Company Limited by Shares

This is by far the most common vehicle for company formation as it embraces the manner in which most businesses come into existence; the situation where a group of individual wish to enter into business with each other with a view to profit, whilst protecting their personal wealth.

Although liability is limited to the value of their shares, members, who will often also be directors in this context, may be subjected to unlimited liability if they act fraudulently, negligently, ultra vires or if they have continued to carry on trading when it is obvious to them that the company is insolvent.

The law assumes that the working capital of this type of company will be contributed by its members to some extent. Their contributions float the company on launch and they then hold a share in the company as a whole and its assets in proportion to their share holding.

Shares may be paid up in real terms by the members in which case in the event of liquidation the members would stand to lose only what they have already invested or they may be part paid or even unpaid in which case the member is liable to pay up the balance on their shares, in money or monies worth, in the event of a liquidation.

Private companies limited by share must include the suffix “limited” or “Ltd” as part of their company name.

2.1b A Public Company Limited by Shares

It is uncommon for a company to be formed in the first instance as a public company although it is not uncommon for this to be a long term goal of promoters forming a private company. More often a public company is formed by reregistering a private company and issuing shares with a view to raising capital from public investment.

The shares of public companies are capable of being traded on the stock exchange, although not necessarily, they may be traded privately or on an alternative exchange. Where a company’s shares are traded on the stock exchange they must comply with the provisions of the Financial Services Act 1986 which requires a level of transparency in order for investors to properly assess the value of the company.

A public company must have a minimum of two members; if this drops to one there is 6 months grace after which the remaining member will be deemed to be personally liable for the company’s debts and liabilities.

A public company must include the suffix “public limited company” or “plc” to its name rather than the equivalent “limited” or “Ltd” in the case of a private company limited by shares.

A public company must maintain a prescribed minimum allotted share capital at any one time. The minimum amount is set at £50,000 under the Companies Act 1985 or such other amount as may be specified by statutory instrument. It is further required that a public companies shares must be paid up to at least a quarter of their value where there is a failure in this respect the share shall be deemed to be worth a quarter of its full value .

2.2 Formation

Formation in most cases will be by registration under the companies act 1985 s.1(2)a.

Registration can be conducted by the promoters themselves, by a solicitor or by a company formation agent. Company formation agents will usually offer what are know as “off-the – shelf” companies; these are companies that have already been registered and which are adapted for the required use by changes to the memorandum and articles of association. This may be simpler and less expensive than forming a new company. Promoters wishing to incorporate themselves must send the following documents together with the fee to the registrar of companies:

- A memorandum of association
- Articles of Association
- Form 10
- Form 12

The memorandum sets out who the members of the company are and what the company will do or its “objects”. The articles of association are the rules which apply to the internal running of the company.

The prescribed form of memorandum and articles of association for a private company limited by shares under the Companies Act 1985 is Table A. Where the promoters of a company wish to have a Table A constitution unamended then this need not be filed with the registrar and will apply in default as long as a letter is attached to the application confirming this intention.

To register; the Memorandum and Articles of Association must be sent to the registrar along with the relevant fee which is £20 or £50 for a premium (same day) service. This should be accompanied by Form 10 which gives the details of the first directors of the company and the company secretary as well as the intended address of the registered office. Details must include; names and addresses, date of birth, occupation and details of directorships held in the past five years. The form must be signed by each subscriber or their agent.

As previously mentioned a private company need have only one director but must also have a company secretary. These may not be one and the same person unless there is more than one director in which case one of the directors may also hold the secretary post. For a public company there must be at least two directors.

Form 12 is a statutory declaration of compliance with all the legal requirements for forming a company. This form must be signed by a solicitor or by one of the people named as director or company secretary (in form 10). This MUST be signed in the presence of a commissioner for oaths, notary, JP or a solicitor.

Both forms are available free from Companies House and can be downloaded from their website <http://www.companieshouse.gov.uk/>

Once these documents are received by the registrar they will perform the relevant check and register the company assuming that the documents (and the directors) comply with the legal requirements. Failing that incorporation will be rejected.

There is an electronic filing service offered by companies house for which special software is required this can either be purchased or developed the charging for the electronic service is at a reduced rate of £15 or £30 for the premium service.

For public limited companies, registered as such in the first instance, the prescribed articles are in the form specified in Table F or as near as circumstances permit and these will need to be sent to the registrar.

As discussed above the company must have allotted shares of £50,000 of which a quarter (£12,500) must be paid up. The PLC may not begin to do business until it has received a certificate issued under s.117 of the Companies Act 1985. This certificate is available from Companies House by completing Form 117 and complying with the requirements as discussed.

2.3 Pro's & Cons

Limited Company

Pro's

- Flexible
- Easy to set up
- Protects members personal wealth
- Table A articles need not be registered
- Sole directorship

Cons

- Limited borrowing potential
- Must be floated by members own capital (or their debt)

Public Limited Companies

Pro's

- Borrowing / capital raising potential
- Can advertise publicly to attract investment

Cons

- Tighter regulations
- Increased transparency
- Volatile
- Minimum share capital requirements
- Minimum of 2 directors

3 LIMITED LIABILITY PARTNERSHIPS

3.1 Key Characteristics

- Has a separate legal personality
- Unlimited capacity
- No directors or shareholders not subject to company law rule on capital
- Members have limited liability (to the extent of the firms assets)
- Flexible internal structure (by agreement no memo and arts)
- Recording and filing requirements similar to a company

- Taxation similar to a partnership

Limited liability partnerships (LLPs) were introduced by the Limited Liability Partnerships Act 2000 and are governed by the LLP Regulations 2001 along with the Companies Act 1985 and the Financial Services and Markets Act 2000 (provisions on insolvency).

They were introduced following intense lobbying by the accountancy profession to provide a form of business which protected their members from liability. One of the primary reasons for choosing this vehicle is that it offers some of the protections of a limited company whilst being taxed as a partnership.

An LLP is a separate legal entity and can form legal relationship in its own right importantly it can be the subject of its own debts and liabilities. An LLP is liable to the extent of its assets and members stand to lose their contribution to those assets on liquidation whilst their personal wealth is theoretically protected from creditors. There is a question as to whether members may be required to make a further contribution to the firm's assets on liquidation. The Insolvency Act 1986, s.74 (as amended) goes some way to answering this. It provides that member's liability to make further contributions is limited to the amount that the member has agreed with the other members. This is not a requirement and whether or not this is to be the case must be stated specifically.

Similarly to a limited company members are still liable for wrongful, fraudulent or negligent trading.

Any legal person can be a partner to an LLP which includes companies registered under the Companies Act 1985.

Two or more members must be identified as "designated members" and will have a statutory duty to undertake certain tasks on behalf of the other partners and are subject to penalties for failure to comply with these. The statutory tasks of designated members include:

- Signing accounts
- Sending accounts to the registrar
- Appointing and removing auditors
- Notifying the registrar of membership changes
- Conduct of the annual return
- Removing the LLP from the register (where appropriate)

If the LLP fails to identify the designated members to the registrar then all members will be deemed designated members and all will be liable to sanctions in the event of default.

All members owe the duty of and agent to the LLP i.e. the legal entity itself, which includes; acting in the interest of the entity, to avoiding conflicts of interest and prohibiting making secret profits. Members do not necessarily owe this duty to each other. The relationship between members will be regulated by agreement in the same way as an ordinary partnership.

This agreement should cover all the usual areas; capital, division of profits, decision making etc. There are however additional default provisions which will apply in the absence of an agreement which would not apply in the case of a normal legal partnership, although these are similar to the provisions of the Partnership Act 1890 in respect of partnerships at will. These include the equal division of capital, profit, liability and voting rights.

3.2 Formation

Incorporation as an LLP is under statute namely the LLPA 2000 the members will need to submit Form LLP 2 to the registrar of companies along with the fee which is £20 or £50 for the premium (same day) service.

The form asks for the partners to set out:

- The name of the business (subject to the same restrictions as company names save for the need to apply the “limited”, “plc” suffix, this will be LLP instead)
- Location and address of the registered office
- Name, address and date of birth for each member
- Which members are to be designated members

The form includes a statement of compliance which must be executed by either a solicitor or one of the proposed members (who must state in what capacity they sign it). All members must sign and date the incorporation document to give their consent to act.

Once the documents are sent to the registrar they are subjected to certain checks and if nothing therein is a bar to incorporation the LLP will be incorporated and the formation documents made available for public inspection. This will take up to five working days unless via the premium (same day) service.

3.3 Pro's and Con's

Pro's

- Limited liability
- Flexibility

Con's

- Reporting requirements including annual returns
- Need for an agreement no easy or default option as with the Companies Act tables
- Legal uncertainty – this is a developing area of law with many untested issues

4 COMMUNITY INTEREST COMPANIES

Community Interest Companies have been created recently as a new type of company for those wishing to establish social enterprises. Organisations wishing to be a Community Interest Company can choose one of three company forms: private company limited by shares, limited by guarantee or public limited company. To ensure that Community Interest Companies use their assets and profits for the community interest, they are restricted from distributing profits and assets to their members. To register as a Community Interest Company, companies must satisfy a community interest test. Community Interest Companies limited by shares have the option of paying a capped dividend on shares to investors. More information on these bodies can be found at www.dti.gov.uk/cics

5 COOPERATIVES AND MUTUALS

These structures would not protect individual practices against the risk involved in commissioning and to operate as such, would expose the personal assets of the practice/partners to liability and risk.