Somerset CCG Incorporation Application (V1.2)

Guide and Template

Introduction

1. This document forms part of a wider support package developed by NHS England and Improvement to improve the incorporation approvals process and introduce greater consistency in the way that incorporation applications are considered for approval or rejection by Commissioners.

2. There is no express right to incorporate – the decision to approve or reject the application is the responsibility of Somerset Clinical Commissioning Group (CCG). We will carefully consider the proposal including assessing the application for its benefits, for example to patients, but also the opportunities including strategic alignment with local priorities to transform services and improve care quality. Risks will also be considered.

3. To ensure that applications are given due consideration, this application form template and user guide has been developed to provide the contractor with a structure to capture the necessary information and evidence that the commissioner will need to assess to reach their decision.

4. This incorporation application template and user guide are intended to help contractors and have been developed to align with the Commissioner Assessment Framework (CAF). The CAF is risk-based and draws on the considerations set out in national Primary Medical Care Policy and Guidance Manual (PGM). The CAF has been designed to help Commissioners to:

    a. undertake their due diligence in a structured and consistent way
    b. reach an approval or rejection decision based on risk and to inform the contractor in an open and transparent basis
    c. apply any approval conditions to mitigate identified risks

5. The contractor should refer to the CAF and supporting guidance when completing their application. The CAF template can be found online https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-annex-3-assessment-framework/ or on page 207 of the national Primary Medical Care Policy and Guidance Manual (PGM). The application template has been designed to be completed electronically and includes references to the relevant section of the CAF.

6. Completed applications should be submitted, along with any supporting information attached, to the CCG via email to somccg.generalpractice@nhs.net. A copy of the physically signed signatory page should also be returned to the commissioner.

Overview of approvals process and timeframe

7. The following table sets out a 'typical' request and process through to decision. The timeframe to complete the assessment will vary locally and is subject to a range of factors including local circumstances and resourcing. However, as an indicative guide, the anticipated timeframe for assessing a complex or novel incorporation request, once the commissioner receives the application, is up to 3 months but it could be longer depending on the complexity:

STEPS	DESCRIPTION
1. Preliminary discussion and cooperation	The contractor enters into initial discussions with the Commissioner about their intentions and the opportunities including alignment to wider local strategic priorities.
2. Incorporation Request	A formal request to incorporate is submitted by the existing contractor. The Commissioner will acknowledge this request and provide the contractor with this template for completion. The content of the application will be used to inform the commissioners decision making process. The contractor is expected to submit supplementary documentation alongside a completed application.
3. Eligibility check	The eligibility check by the Commissioner ensures the proposed new contractor can lawfully hold a GMS/PMS contract. If they are not eligible, this will result in a refusal letter being sent using the national template letter in the PGM. At this stage, the request will be refused and no longer progressed unless eligibility issues are addressed. If the proposed new contractor is eligible, and there are no identified barriers to moving forwards with the assessment, the Commissioner will undertake a full assessment using the CAF and other relevant resources to ensure that consideration has been given to the implications of the proposal, including any procurement risks and whether there is a service change requiring patient and public involvement.
4. Commissioner assessment and decision making	The Commissioner will assess the incorporation request. Based on the final assessment, the request can be approved or rejected by the commissioner. A commissioner may wish to make approval conditional to address identified risks – this should be documented in a novation agreement. The novation agreement will also audit the change in contractor. The final terms of the novation agreement will need to be approved and ratified by the commissioner.

5. Notification of decision outcome	The contractor will be notified of the outcome. If the application is rejected, the commissioner should provide the contractor with an explanation for their decision and a summary of the issues that did not satisfy the approval criteria. A contractor may wish to act upon that feedback before resubmitting their application.

8. The above presents an overview of the established approvals process and the stages it entails (the CAF would be applied from stage 3 onwards). In practice, it is likely to be an iterative process with the commissioner to ensure that they have all the relevant information and evidence to be able to make their decision. Both parties are encouraged to invest time and energy into the pre-application stage (i.e. stage 1) to discuss the proposal and the alignment with wider strategic priorities. This can help set expectations and may help minimise additional information exchanges once the application has been submitted.

APPLICATION TEMPLATE

This template has distinct sections that correspond to key areas of the CAF, including Key Lines of Enquiry (KLOE) that will be used by Commissioners to decide on the incorporation request. It is important that these sections are completed in full and with any supporting information relevant to your application attached alongside.

All contractors wishing to incorporate must complete this application. Please indicate in the relevant section below the documents and evidence that you have attached in support of your application.

Please note all sections must be answered. If a question is not applicable, please provide an explanation.

- **CONTRACTOR DETAILS** *(supports KLOE 1.2 – 1.4)*

Applicant Name:	Minehead Medical Centre
Address:	Harley House Site, 2 Irnham Road, Minehead, TA24 5DL
Telephone:	01643 703441
Fax:	N/A
E-mail:	janet.loe@nhs.net

1.1 Current status of organisation – please mark 'x' in the appropriate box:

Individual medical contractor(s)		Partnership	x

1.2 Current contract type – please mark 'x' in the appropriate box:

GMS	x	PMS		APMS	

1.3 Please provide details of the proposed contractor

Name of Proposed Contractor:	Minehead Medical Limited
Trading Name:	Minehead Medical Limited
Previous Trading Name (if different)	N/A

Registered Address:	Harley House Site, 2 Irnham Road, Minehead, TA24 5DL	
Registered company number:	14035881	
Total Number of proposed Directors:	3	
CQC registration	(CAF 1.2) CQC has been informed and has acknowledged the notification. The practice is in the process of contacting the local inspector to keep them up to date and to seek their support and advice on the process to transfer the CQC registration to the new company.	
Details of proposed Directors, including full name:	Name (please print)	
	(1) Edward Andrew Ford	
	(2) Janet Elizabeth Hewlett	
	(3) Sarah-Jayne Milton	
	(4)	
	(5)	
	(6)	
	(7)	
Proposed date of incorporation:		Company formed 8/4/22 – novation of contract target 1/7/22

1.4 Please provide other supporting information as relevant.

Other relevant info: (CAF 1.3) It is intended that the new Company will be called “Minehead Medical Centre Limited”, and, in accordance with the rules, we have applied to the Department of Health for confirmation/permission to use “Medical Centre” as part of the name. We are awaiting their response. In the meantime, so as not to delay the process, the company has been incorporated in the name of “Minehead Medical Limited” with the intention to amend the name as and when the permission from the Department of Health is received.

1.5 Mandatory documentation checklist to accompany application

- ❑ Companies House Certificate detailing all Directors (once available) Appendix 1 attached along with confirmation of request for permission to use “Medical Centre” in the name. When this is granted, the company name will be amended to Minehead Medical Centre Ltd
- ❑ Copy of passport for all Directors Appendix 2 attached
- ❑ Articles of Association Appendix 3 attached
- ❑ Professional indemnity Appendix 4 attached
- ❑ Employers’ liability Appendix 5 attached
- ❑ Public liability Appendix 6 attached
- ❑ Premises insurance Appendix 7 attached
- ❑ Provide evidence the practice has informed CQC of its intentions and a request to commence the necessary assurance process. Written confirmation from the CQC that they do not intend to impose any restrictions on registration as the incorporated company will be required before incorporation takes place. Appendix 8 attached

2. **Eligibility** *(supports KLOE 1.1)*

2.1 If you are proposing to incorporate, please confirm you satisfy the necessary legislative requirements in respect of eligibility to hold the contract as per the GMS/PMS regulations. If you are proposing to incorporate as a qualifying body, please confirm the requirements of the NHS Act 2006 (Part 4, clause 93, paragraph 1) are satisfied in relation to that qualifying body.

Please mark ‘x’ in the appropriate box:

Yes	x		No	

2.1 Please provide a complete breakdown of share ownership.

Shareholder: Percentage of shares	Edward Ford

held: Eligibility under s86 (GMS) or s93 (PMS) NHS Act 2006:	33.33% General Practitioner
Shareholder: Percentage of shares held: Eligibility under s86 NHS Act 2006:	Elizabeth Gillies 33.33% General Practitioner
Shareholder: Percentage of shares held: Eligibility under s86 NHS Act 2006:	John O'Dowd 33.33% General Practitioner
Add additional rows as required	

2.2 Have any of the proposed directors been convicted of any of the following offences:

- Conspiracy
- Corruption
- Bribery
- Fraud
- Money laundering
- Any other offences

Please mark 'x' in the appropriate box:

Yes		No	x

If Yes, please provide details in the box below:

Details:	

2.3 Legal and regulatory status details - Please provide details of any criminal conduct of any director, officer or senior employee of the current or proposed organisation resulting in conviction or in respect of which a prosecution or investigation is pending or in progress. If none, please state 'None'.

Details:	None

2.4 Please state whether any medical practitioners employed by the current or proposed organisation have, during the last three years, had their professional registration removed or suspended or whether they are currently under investigation, and provide relevant details. If none, please state 'None'.

Details:	None

2.5 Please provide the status and details of the company registration with CQC. If this is pending, final confirmation will be required as an approval condition.

Details:	Pending – see section 1.3

2.6 Please provide the status and details of the company registration with Company House. If this is pending, final confirmation will be required as an approval condition.

Details:	The company has been incorporated

3. **Statutory duty compliance** *(supports KLOE 3.1, 4.1)*

3.1 Please refer to the CAF – this section is intended to set out how your proposals support the Commissioner to comply with its statutory duties relating to public consultation and innovation.

Please summarise and attach any supporting information and evidence, for example, business/case for change, patient engagement/consultation plans.

The practice, like many, has struggled to attract GP partners over the last few years. When this application commenced, the practice had four partners, one of whom has since retired at the end of March 2022. One aims to retire at the end of March 2023 and a third will retire in the next year or two although has not confirmed when. This would leave the practice as a single partner entity. Hence, the practice commenced discussions with the CCG regarding future models of ownership which would make the practice more sustainable.

The practice would like to become an Employee Ownership Trust (EOT), sometimes known as the John Lewis model. This would facilitate the appointment of Trustees who all legally must be NHS employees. There would be five Trustees comprising of the Clinical Director and members of staff representing different disciplines. In addition, the practice would appoint a patient representative as an advisor to the Trustees although this person would have no legal responsibilities and therefore no voting rights. The Trustee Board would provide oversight and governance of the running of the practice.

To become an EOT, the practice must first incorporate into a Limited Company (Ltd Co). However, the intention is very firmly to then move to an EOT. Whilst continuing to be a Ltd Co, becoming an EOT would ensure that the Ltd Co would not be owned by a small number of key individuals but would be accountable to the staff and the community rather than to a small group of shareholders. The practice would be managed locally so patients and staff would have more control over the direction in which the practice could develop. Patients and staff have clearly demonstrated that this is the direction in which they wish

to move.

The legal advisers have confirmed that the contract can novate to the Ltd Co and the Ltd Co can transfer 99 shares to the EOT on the same day. The transactions can be made simultaneously so there will be no need for the practice to trade as a Ltd Co and then change again into the EOT.

The practice has explored all other options and now feels that moving to an EOT is the only way forward to attract and retain staff and avoid having to terminate their GMS contract. The purpose of this incorporation and the subsequent move to become an EOT is to attempt to provide sustainability for the practice and to avoid a deterioration in patient care. It should be noted that the ultimate aim is for the practice to become an EOT and they see no merit in simply incorporating into a Ltd Co.

(CAF 2) The practice had four partners at the start of 2022. One retired at the end of March 2022, one aims to retire at the end of March 2023 and a third will retire in the next year or two although has not confirmed when. The three partners who remain post March 2022 have all agreed to become equal shareholders in the new Ltd Co and will all become salaried GPs, relinquishing their shares in the company to the EOT. As Dr Ford will be a trustee of the EOT, we did explore whether this would have sufficed to fulfil the requirement of the GMS contract, but it would not. He will therefore retain ownership of one share but will not receive any dividend from the company, being salaried like all the other staff.

Attached is an organigram (Appendix 9) showing the current staffing structure and the practice's recruitment policy (Appendix 10). The practice currently has vacancies for a Primary Care Practitioner, a Patient Services Advisor, and a Practice Nurse in addition to the vacancies for GPs. At present they are recruiting to 18 sessions of GP time. As has been explained elsewhere, the two partners who will be retiring in the next two years will create further GP vacancies. This is the main reason for wanting to move to the EOT, to attract GPs to a practice with an innovative ownership model although it is hoped that it will help to recruit all disciplines of staff.

The practice is happy to include a change control clause in the novation agreement to ensure the CCG is notified of ownership changes.

(CAF 3.1) The practice has an active PPG and has consulted with them on ideas for the future. The PPG has given a clear steer that they would want to see local ownership of the business retained and they support the move to become an EOT.

Discussions have also taken place with staff and the alternative option of joining an organisation such as Symphony has been

explored. The staff, like the PPG, expressed a strong preference for retention of local ownership which would be lost by joining a larger Primary Care Organisation. Therefore, the EOT option is the preferred option.

(CAF 4.1) The practice is fully committed to the PCN and has signed up for the PCN DES. They informed the PCN of their intentions to move to an EOT at its meeting on 29 March 2022 – see minutes attached (Appendix 11). As the largest practice in the PCN, the practice is very aware of the effect any changes will have on the wider group of practices. Therefore, they are keeping the PCN informed of progress, providing reassurance and mitigating against any risk of destabilisation. The PCN is recruiting to several ARRS roles to support the primary care agenda. Attached is the PCN Workforce Strategy (Appendix 12) showing how they intend to spend their ARRS monies. One aim is to recruit Mental Health Practitioners via Somerset Foundation Trust as the current mental health workload in primary care is increasing. Unfortunately, the Trust has been unable to recruit so efforts are ongoing. In addition, the PCN is recruiting pharmacists, paramedics, a Population Health Management Lead for identifying gaps in service and future strategy, Living Better HCAs and Nurses and Village Agents. Attached is the Living Better Impact report (Appendix 13) although most of the actions on the driver diagram have now been completed. The PCN strategy is now focusing on social prescribing including pain management in reducing opiate prescribing, pulmonary rehabilitation projects, carers and cancer support, horticultural therapy and weight management. In addition, the PCN pharmacy team is looking at good practice across the PCN to share learning. Minehead were the first practice in the PCN to employ Allied Health Professionals (AHPs) and have been instrumental in spreading knowledge and learning to the other practices. The PCN has a single point of access for all PCN related activity and is reviewing its website to facilitate self-referral by patients. The PCN practices are implementing personalised care planning with one practice piloting BRAVE AI which will be rolled out to all practices shortly.

Dr Ford has consulted with Mandy Chilcott, the local County Councillor and Deputy Leader of SCC, who is very supportive of the plan to become an EOT. They discussed whether there were any other groups that she felt the practice should engage with (apart from staff/PCN/PPG). Her view was that it was unlikely as it is a change in business model and the population are more interested in service provision.

At present, there is high level support in principle from partners, staff and the PPG.

The practice has consulted with Gillian Keniston-Goble, the Manager of Healthwatch, who agreed that this way forward was desirable for the sustainability of services in future and gave the project her full support. Please see attached email from Gillian Keniston-Goble confirming the conversation (Appendix 14). In addition, Janet Loe has been invited to join the Board of Healthwatch for their informal Board meeting on 5 May to explain the changes.

Practice representatives have had informal discussions with the Chair of the ICB Board and the proposal has been positively received. The CCG is supporting the practice in this process as it is in all interests to ensure that the practice is sustainable in the future.

The practice has started the HR consultation with staff and will comply with all TUPE regulations. They have taken advice from MLP Law and will be writing to all staff notifying them of the change in mid-May.

4. **Strategy and Delivery** *(supports KLOE 5.1, 5.2, 6.2)*

4.1 Please refer to the to the CAF – this section is for you to describe your rationale for seeking to incorporate. This should include how this request will support delivery of: the wider local system strategy for primary care; the wider system [ICS/STP] strategy and transformation priorities; and support the sustainability of services delivered under the contract.

Please summarise your response under each sub-heading and attach any supporting information and evidence, for example, case for change.

Case for change

Strategic alignment

Supporting service sustainability

(CAF 4.1, 5.1. 5.2) As outlined in section 3, the practice is endeavouring to provide sustainability. The move to an EOT is aimed at making the practice more attractive to future staff thus providing increased continuity of care for patients and reducing the financial risks. At present, the practice has vacancies for 18 sessions of GP time, and this will increase with the two partners who are due to retire in the next year or two. At present this is putting severe pressure on the practice as they are having to rely on locum GPs. Not only does this make the practice financially unsustainable but also impacts on patient care and continuity. If the practice is unsuccessful in recruiting GPs, the workload of the permanent GPs will increase, and current standards of clinical care will inevitably suffer. The practice has made good progress in achieving Medicines Management Scorecard targets, but these will drop again if more permanent GP time cannot be secured.

The practice has been involved in two Quality Assurance Framework visits with the CCG during the first few months of 2022 and the feedback from the CCG was very positive. Attached are the draft actions from the second visit (Appendix 15).

In addition, the practice is putting together a strategy to improve their position on the Diabetes QI project. It was acknowledged that many patients are still reluctant to attend the practice in person, but the practice is working hard to make contact with patients to improve their position post COVID.

The PPG has asked for a set of Q&As in order that they are able to answer questions from patients confidently and accurately. This has been drafted by the practice and sent to the CCG for scrutiny by the CCG Communications Team.

During the QA visit, it was noted that, like many practices, MMC has experienced difficulty in reaching patients with severe mental illness (SMI). Work is ongoing in the practice and linking with the PCN to see if there is more the practice can do to engage with this group of patients. In addition, the importance of coding when patients did not attend despite reminders, was acknowledged.

The practice has recently undertaken a wound care appointment audit, the results of which will be shared with the PCN.

With regard to patient access, the practice is reviewing its triage protocol to ensure that it is up-to-date and has undertaken a real time telephone audit to identify how many (non-urgent) patients are unable to be accommodated on the day. They will share this information with the CCG once it has been analysed. In addition, this information will be shared with the MIU Task and Finish group.

Initial discussions with the PPG and staff confirm that the move to an EOT is seen as innovative and the hope is that this will attract and retain staff. Currently, the practice is faced with the negativity of being an “unstable” practice and this makes it impossible to attract staff including GPs. With two further partners being so close to retirement, it is essential that the practice finds a way of making itself more attractive and less of a risk to GPs wanting to join the team. The practice believes that moving to an EOT will give staff more certainty regarding who they will be working for and will attract staff including GPs. Already, one regular locum has expressed interest in possibly joining the team as a salaried GP due to the direction in which the practice is moving. In addition, two staff who had resigned have decided to stay due to the potential move to become an EOT.

Having considered all the possibilities, the practice cannot see an alternative. It is the largest practice in the PCN and, therefore, if it were to terminate its contract, it would destabilise the whole PCN. No-one wants the practice to fail, and this move to an EOT is seen as the best possible solution. As a seamless change of ownership, it will not affect the day-to-day running of the practice or impact on patient services but will hopefully provide sustainability for the future.

In becoming an EOT, it is hoped that the community will feel that they have more ownership of the practice as it is being run by the EOT rather than by a small

group of GPs. As a result, there are many possibilities for community involvement and development. The practice could have its own League of Friends type not-for-profit organisation and volunteer group. Becoming an EOT would open up opportunities to focus on the prevention agenda if the Management Team and Trustees felt this was appropriate. As it removes the business risk currently held by the partners, the practice could invest in more services for the wellbeing of patients and staff. The EOT model could facilitate fundraising as the practice would be a community asset rather than a private business.

When the practice incorporates, there will be a lease between the practice and the five premises owning partners (see attached list of premises owning partners Appendix 16). When the current mortgage arrangement expires in approximately eight years' time, the premises owning partners and the practice will explore the options available to them then. It is possible that the premises could be owned as a community asset but, due to the speed at which health policy changes, it is felt to be unwise to explore this option now to save wasting valuable legal time and money on an option which may not be possible or viable in eight years' time.

There will be no TUPE requirements when the practice moves from being a Ltd Co to an EOT.

In addition to the attached Recruitment Policy, the practice is planning a recruitment drive. There was an article in a recent edition of the Health Service Journal which explained the benefits of the EOT model for primary care. It is hoped that the practice can capitalise on the national interest in this model and promote itself as the innovative lead for moving to this model, thus again attracting staff to fill vacancies.

5. **Provider entity** *(supports KLOE 6.1, 6.2, 6.3, 6.4, 7.1)*

5.1 Please refer to the to the CAF – this section is for you to describe the proposed entity that will become the new contractor.

Please summarise your response under each sub-heading and attach any supporting information and evidence, for example, business and operating plan.

Performance history (current contractor)

(CAF 6.1 and 7.1) The practice has always been a high QOF achiever and actively engaged in SPQS. It has a history of working collaboratively with the other local practices long before it was formally required. The practice has worked hard to improve the quality of the services it provides.

The practice has been involved in two recent assurance framework meetings with the CCG, see details in previous section. It is committed to a QI approach

to improving patient services. The practice actively uses Eclipse and the prescribing scorecard to monitor and improve prescribing performance. It is a training practice which demonstrates its commitment to the future of primary care in general.

MMC was one of the first in the country to employ paramedics and nurse practitioners in primary care and two of the practice clinicians have since gone on to lead the training of ALPs for SGPET across the county.

Details of proposed provider entity including governance and operating model (new contractor)

(CAF 6.2) MMC was formed from the merger of Irnham Lodge and Harley House which were two separate practices on adjoining sites. Irnham Lodge has now closed as a branch surgery as the premises were not owned by the partners. As another demonstration of their commitment to the future of primary care in the locality, the partners have built an extension to Harley House to provide space for the services previously sited at Irnham Lodge. As a result of the merger, the management team has very recent experience of managing change and specifically of integrating two sets of staff. The practice has a strong history of staff engagement and involvement which has resulted in very low levels of turnover, despite the recent changes.

Rather than having existing partners who run the business of the practice with a Management Team reporting into them, the EOT will allow for a Management Team that runs the practice reporting to the Trustees, thus releasing the GPs to concentrate on their clinical work.

There will be three Directors as follows:

Managing Director – Janet Hewlett

Medical Director – Dr Edward Ford

Clinical Director – Sarah Milton

The three Directors will form part of the Management Team along with the following:

Finance Lead – Katheryn Antonelli

HR Lead and Deputy PM – Alex Groves

There will be regular business meetings, finance meetings, SEA/QI meetings, staff meetings and PPG meetings. The Business and Finance Teams will require robust financial and performance data, scorecard, emergency admission rates and other key performance measures.

The SEA/QI Team will oversee all clinical aspects of performance using Eclipse, the prescribing scorecard, QOF data and other data as provided by the newly appointed PCN Population Health Management Lead.

There will be regular clinical and non-clinical staff meetings which will have a strong educational element.

The PPG is already established and will continue to meet, receiving regular reports from the Patient Trustee.

There will be five Trustees; the Clinical Director (Dr Edward Ford) and four other members of staff drawn from the following; Acute Team, Chronic Disease Team, Admin Team and Reception. It was originally planned to have one member of the PPG as a Trustee but the practice has since been advised that all trustees must be NHS employees in order to fulfil the requirements of section 86 of the NHS Act (2006). The PPG member will therefore be appointed as an advisor to the Trustees which will alleviate them of any legal responsibility but still allow them to have input into oversight and governance of the practice although they will not have any voting rights. The practice had offered for one of the Trustees to be a commissioner representative but the most recent feedback on the application says that this would not be appropriate.

The Trustees will meet quarterly plus as required for exceptional items. This is expected to be a voluntary role. The Management Team will undertake the recruitment of the Trustees who would have a contract, similar to a Non-Executive Director. The Management Team will also be responsible for ensuring the Trustees have the knowledge and understanding to ensure that the practice delivers against national and local aims and strategies such as the NHS Long Term Plan.

The Directors will meet weekly. The Clinical Leads, Dr Edward Ford and Sarah Milton will both be Directors. The practice is confident that this will provide sufficient clinical input and oversight to maintain and improve care quality.

The staff Trustees will engage with their teams to gauge views and feedback from the wider staff population. In addition, the patient representative will gauge views and feedback from the Patient Participation Group.

It should be noted that, at the recent Quality Assurance Framework Visit, it was acknowledged that the practice's Medicines Management Scorecard performance was much improved and the data showing the decreased performance was out of date.

Mobilisation plans

(CAF 6.3) The practice has engaged a Project Manager to support them through this process. In addition, the practice is currently engaging with two legal companies, one of which has expertise in novating GMS contracts to limited companies and the other which has expertise in advising on the move from being a Ltd Co to becoming an EOT. Furthermore, the practice's accountants have been providing advice and expertise and the partners have obtained independent legal advice regarding the premises and the lease required. Details of the two legal companies, MLP Law and Postlethwaites have been provided to the CCG as they have agreed to financially support the practice with the legal fees. To evidence the support being provided by the different legal and accountancy teams, attached is a document giving answers to questions posed at an all party Teams meeting on 27 April with actions to facilitate the very short timescales to which all parties are committed (Appendix 17).

Attached is an outline EOT structure summary which has been provided by Postlethwaites (Appendix 18).

As mentioned previously, the legal advisers have confirmed that there will be no TUPE requirements when moving from being a Ltd Co to an EOT.

The ambition is for the Primary Care Operations Group to agree the proposal to become a Ltd Co plus to move to an EOT at its meeting on 11 May 2022 and recommend approval to the Primary Care Commissioning Committee on 8 June 2022. It is important for the practice to have approval to move to an EOT prior to the ICB coming into existence at the end of June 2022. This will prevent any further delays which may be caused by the emergence of the new commissioning organisation whilst they form their governance structures.

Contingency planning

(CAF 6.4) There is a time contingency built into the project in that the ICB comes into existence at the end of June. The CCG has agreed to fund the legal and accountancy costs involved in the incorporation and the move to an EOT and the practice has agreed to share its learning from the process for any practices who wish to go down this route in future. The Partners will absorb their own legal costs including the drawing up of a lease for the premises and the partnership transfer to new ownership.

Ultimately, the practice cannot see an alternative to this course of action. The contingency plan would be to terminate the GMS contract.

6. **Patients and care quality** *(supports KLOE 5.2, 7.2, 7.3, 7.4, 7.5)*

6.1 Please refer to the to the CAF – this section is for you to describe the benefits to patients and how they will be delivered.

Please summarise your response under each sub-heading and attach any supporting information and evidence, for example, engagement feedback. You should provide further detail on proposed changes to the service model in paragraph 8

Impact on care quality

Benefits for patients – including improved population health outcomes

Impact on patient choice

Clinical input and oversight

(CAF 7.1 and 7.2) The main aim of this proposal is to attract staff to work in this innovative practice and, more specifically, assist with the succession planning for the GP team. Having a happy team of staff will improve quality and productivity. (CAF 7.3) As outlined elsewhere, the key benefits for patients will be the continuation in service provision and the avoidance of a deterioration in patient

care.

See previous section referenced CAF 6.2 for details of structure, meetings and clinical governance.

(No 7.4 on CAF spreadsheet)

(CAF 7.5) By moving to an EOT, staff and patients will be more involved in running the practice. This change in business model affects the running of the practice but is not expected to impact on patient services, except for providing stability and sustainability. It is hoped that, as an additional benefit in future, it will create potential for community involvement. The practice may be able to explore prevention and wellbeing rather than just focussing on the treatment of patients once they become ill.

(CAF 7.6) Dr Edward Ford will be the Medical Director and will be one of the Trustees as well as being one the Directors on the Management Team. He will retain one share when the remainder of shares are transferred to the EOT in order to fulfil the requirements of section 86 of the NHS Act 2006.

There has already been discussion with the PPG and attached are the minutes of their meeting on 18 March (Appendix 19) along with an email exchange (with permission from those involved) demonstrating support.

7. **Finance** *(supports KLOE 8.1, 8.2, 8.3, 8.4)*

7.1 Please refer to the to the CAF – this section is for you to describe the benefits to patients and how they will be delivered.

Please summarise your response under each sub-heading and attach any supporting information and evidence, for example, engagement feedback.

Financial plan/model underpinning the new delivery model

Financial plan/model underpinning the new delivery model

(Can't get rid of the duplicated line as it affects the formatting!)

(CAF 8.1) The biggest financial risk to the practice is the risk of not being able to recruit staff including GPs. The locum costs involved in covering potential GP vacancies are too high for the practice to remain financially viable. Moving to an EOT will, it is hoped, attract and retain staff including salaried GPs, thus reducing the locum costs for the company. Attached is a breakdown of forecast expenditure on locum GPs (Appendix 20). It should be noted that locum costs are increasing significantly as of 22 May 2022 and these are noted on the 21-22 tab on the spreadsheet.

(CAF 8.2 and 8.3) The practice has robust financial management mechanisms in place. The new model of ownership will allow for more financial transparency and scrutiny. The practice will hold monthly Finance Meetings, led by the Finance Director, Katheryn Antonelli, using financial reports from QuickBooks. The Management Team will oversee day to day financial management accounts to ensure that any financial risks are identified early, and contingency plans put in place to mitigate against these risks. Attached is the financial projection for the

Ltd Co and EOT which has been drawn up with the Financial Manager and the practice accountants (Appendix 21). In addition, attached are three years of annual accounts which demonstrate good financial management and financial solvency (Appendix 22).

It is acknowledged that the current model of ownership protects the practice finances as the partners adjust their drawings according to the financial performance of the practice. With all staff, including former GP partners, being salaried, the company will need to build up a financial contingency to protect the practice against any potential financial risks. This contingency will be managed by the Management Team and overseen by the Trustees.

The current partners will initially become shareholders in the new Ltd Co and their capital account will be treated as a shareholder loan whilst the company builds up its cash reserves. The legal teams have advised that this is the most efficient way to finance the start up of the new company. The EOT may have to take out a loan to repay the capital owing to the already exited partners and, in time, the shareholder loans. The practice has liaised with the bank regarding this and the lease for the premises. It is not anticipated that there will be any difficulty in obtaining the necessary finance.

The current partners and the premises owning partners are obtaining their own legal advice and are responsible for their own legal costs.

In the latest feedback there was a question regarding Dr Ford still being a single-handed GP. With the new Ltd Co and ultimately the EOT, all staff including all the GPs would be salaried, including Dr Ford. This is the whole point of moving to this ownership model – to avoid Dr Ford being a single-handed partner. There are already salaried GPs in the practice, but the practice has found it impossible to attract new partners. It is hoped that the new model of ownership will attract GPs who wish to work in a new innovative way, all as salaried GPs. It will also allow for the GPs to have a more equal share of clinical responsibilities as it takes away the inequity between salaried and partner GPs. The only difference for Dr Ford is that he will be the Clinical Lead for the practice and will hold the overall responsibility for clinical services within the practice.

Investment plans post contract novation

In addition, the EOT model will potentially allow for more investment in the practice as it takes away the financial risk on the small number of individual partners. If all staff, including GPs, are guaranteed a salary, there is no individual anxiety regarding financial decision making and thus the practice is likely to be more willing to invest and develop services. In addition, because the practice is not financially “owned” by the partners, the community may be more willing to fundraise to enable the practice to invest in further services.

Having just invested in an extension to the building, there are no plans for any further significant capital investment at this stage.

As outlined elsewhere, the premises owning partners will continue to own the premises and there are no immediate plans for the Ltd Co or the EOT to take over

the responsibility for the existing financial loans. However, the lease between the company and the premises owning partners will cover the financial arrangements necessary to cover the existing financial loans.

Existing liabilities of contractor

The practice has a GMS contract and the Standard Contract covering the Enhanced Services but no other contracts in place. MMC employs 33.63 WTE staff who will all transfer over to the Ltd Co/EOT. All utility contracts, insurance etc will transfer to the new Ltd Co/EOT.

Clinical indemnity will be provided in the same way as in the current partnership. The NHS Resolution website quotes the following which we believe confirms that staff will be covered by the national scheme.

The place at which activities are carried out, the status of the person carrying out the activity, the form of the entity responsible for the provision of the NHS services in question and the individual circumstances of the patient concerned are not relevant to the scope of CNSGP. The question is whether the services provided are NHS primary medical services, and where they are not NHS primary medical services, whether they are NHS services provided by general practice [namely, by a provider whose principal activity is to provide NHS primary medical services]. This means that different kinds of organisations are covered under the scheme for activities they carry out which are in scope of the scheme.

The additional cover provided by the MDU, MPS and other organisations will also transfer.

Proposed liabilities of contractor at the point of novation

All existing contracts will transfer. All existing liabilities, except for those pertaining to the premises, will transfer to the new company.

Proposed governance arrangements for financial matters and decision making

MMC has a Finance Officer who oversees the day-to-day finances. The Management Team will be responsible for managing the overall finances under the governance of the Trustees who will also have responsibility for financial scrutiny. Attached is an Action Plan for the internal financial controls required for the new company (Appendix 23). The practice will publish an annual report which will include annual accounts which will be available at an Annual General Meeting.

Details of business and clinical insurance cover (includes for private work)

(CAF 8.4) The practice has Employer Liability and Public Liability Insurance, clinical negligence and building insurance in place. These insurance policies will be transferred to the new company.

8. **Supplementary information on proposed changes to service model** *(supports KLOE 2.1, 3.1, 4.1, 5.2, 7.1-7.4)*

8.1 Please detail below any proposed changes to the service model:

Please summarise changes None

8.2 Will the process of incorporation have any effect on the location of current service provision – please mark ‘x’ in the appropriate box:

Yes		No	x

8.3 Will the process of incorporation have any effect on the current range of services provided – please mark ‘x’ in the appropriate box:

Yes		No	x

8.4 Will there be any change to the practitioners providing the service – please mark ‘x’ in the appropriate box:

Yes		No	x

8.5 If any of these questions receives a YES response, please provide details of the effect and the reasons for this:

Please describe each ‘YES’ including the implications

8.6 For any/all effects described above please confirm any involvement or engagement with patients and provide evidence of the outcome of this involvement or engagement:

Note: evidence of patient engagement and outcomes may be attached separately) See previous and attached

8.7 Service access

Day	AM	PM
Monday	8.00	6.30
Tuesday	8.00	6.30
Wednesday	8.00	6.30 + Improved Access
Thursday	8.00	6.30 + Improved Access
Friday	8.00	6.30 + shared rota for Improved Access
Saturday	Closed	Closed
Sunday	Closed	Closed

8.8 Please provide details of how you will maintain/improve access for existing and new patients.

Details:	See previous. The move to an EOT will provide sustainability for the practice and, hopefully, attract staff, including GPs, to join the team.

8.9 Please provide any further details that might be relevant to your request / proposal:

Details:	

9. Signatories

9.1 Please ensure that all current partners on the GMS/PMS contract physically sign this application. A copy of the physical signature sheet must be returned to the commissioner.

Name.....

Signature.....

Date.....

[*Name*.....

Signature.....

Date.....

Name.....

Signature.....

Date.....

List of Appendices

Appx 1	Companies House Certificate detailing all Directors plus confirmation of request for permission to use Medical Centre in the name
Appx 2	Copy of passport for all Directors
Appx 3	Articles of Association
Appx 4	Professional indemnity
Appx 5	Employers' liability
Appx 6	Public liability
Appx 7	Premises insurance
Appx 8	Evidence the practice has informed CQC of its intentions.
Appx 9	Organigram
Appx 10	Recruitment Policy
Appx 11	PCN Minutes
Appx 12	PCN Workforce Plan
Appx 13	PCN Living Better Impact Report
Appx 14	Email from Gillian Keniston-Goble at Healthwatch evidencing support
Appx 15	Draft Action Notes from Quality Assurance Visit 20 April 2022
Appx 16	Confirmation of Property Owning Partners
Appx 17	Response following All Party Legal and Accountancy Meeting 27 April 2022
Appx 18	Employee Ownership Structure Summary
Appx 19	PPG Minutes and email exchange demonstrating support
Appx 20	Outline of Locum Costings
Appx 21	MMC Financial Model
Appx 22	Annual Accounts for the years 18/19, 19/20 and 20/21
Appx 23	Financial Internal Controls Action Plan