NHS Improvement

New care models programme

Oversight of new care models

Key issues: your questions answered

February 2017

Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

Contents

About the new care models programme

The new care models programme is delivering a key element of the Five Year Forward View – the shared vision for the future of the NHS, published in October 2014 and developed by the seven national partner organisations: NHS England, NHS Improvement, Care Quality Commission (CQC), Public Health England, Health Education England and the National Institute for Health and Care Excellence (NICE).

www.england.nhs.uk/vanguards

#futureNHS

1. Introduction

As new care models take shape across England, we are working to support innovative change. With our national partners and a number of vanguards we are identifying potential issues and developing and testing solutions. We want to support and enable providers to innovate to give patients consistently safe and high quality care and to ensure the sustainability and long-term success of the NHS.

This is version two of our document answering questions we have received about our oversight and the guidance and support we can give providers developing or planning to develop new care models. Issues and questions will continue to emerge and we do not yet have all the answers, but we will update this document periodically to share further guidance and add more detail.

The Care Quality Commission (CQC) has published a consultation on their next phase of regulation,[1] including a proposed approach to emerging new care models, as well as answers to frequently asked questions,[2] in particular around registration. Both should be read alongside this document.

This document is produced as part of the Governance, Accountability and Provider Regulation workstream of the new care models programme.

If you have any queries regarding NHS Improvement's support and role around new care models, please email these to nhsi.newcaremodels@nhs.net

2. Integration and competition

2.1. What is NHS Improvement doing to help areas integrate services?

How does NHS Improvement support integration?

People benefit from care that is person-centred and co-ordinated within healthcare settings, across mental and physical health and across health and social care. Care can also be improved when patients are empowered to make choices about their care and which provider delivers it, and when

[1] http://www.cqc.org.uk/content/our-next-phase-regulation
[2] http://www.cqc.org.uk/sites/default/files/20160513_provider_faqs_v007_web.pdf

commissioners ensure that services are commissioned from the best available providers. All of these elements can work together to benefit patients.

We have a duty to enable better integration of services in healthcare and between healthcare, health-related services and social care.[3] We are helping providers to collaborate across local health economies to improve population health by:

- facilitating an environment that enables innovation and change supportive of integration
- offering direct support to areas planning integration, for example our support and advice for vanguards, pioneers and commissioners
- offering guidance to providers on what is expected of them in relation to the integrated care licence condition, and where we may take action
- supporting providers and commissioners to understand how integration works alongside competition, choice and procurement, with a clear focus on patient benefits.

In developing the NHS Improvement Single Oversight Framework,[4] we have also considered what more we can do to promote integration and other aspects of collaboration and strategic change.

2.2. How do we support procurement, patient choice and commissioning issues?

What support can NHS Improvement offer commissioners when procuring services through new care models?

Integration is a core objective of the commissioning regulations regarding competition, choice and procurement.[5] These regulations require commissioners to consider how best to integrate services. This means they should be collaborating with providers and implementing changes that will benefit patients. We can support providers and commissioners to resolve commissioning issues. For example, we provide guidance on:

- identifying and evaluating options for improving services and integration of health and social care services, including through new care models or alternatives
- implementing new care models while maintaining patient choice
- how organisations can assess when a competitive procurement may be required and when not, and develop a procurement process that will achieve good outcomes for patients.

[3] Section 62(4) and (5) of the Health and Social Care Act (2012). See also our guidance on the integrated care licence condition and an overview of how to comply with the integrated care requirements.
[4] https://improvement.nhs.uk/resources/single-oversight-framework/
[5] The National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013.

If you are planning to implement new care models, contact us via nhsi.newcaremodels@nhs.net as early as possible in the process for further advice.

3. Transition to a new care model

3.1. When will NHS Improvement assure new organisational forms?

- Do new care models have to be approved by NHS Improvement?
- How will NHS Improvement adapt the transactions process to support the creation of new care models?
- Where should you go if you have queries about transactions?
- When might a provider collaboration or transaction need merger review and how can it best be navigated?
- What other issues might arise in the transition to new care models?

We will be engaged when new care models involve transactions, mergers or raise other oversight considerations. We will also be involved if NHS trusts or foundation trusts are entering into new or novel contracts with their commissioners to deliver a new care model.

For foundation trusts, we will also continue to review transactions that are material, significant or statutory. For NHS trusts, we also have a role, on behalf of the Secretary of State, in overseeing and assuring transactions.[6]

We are working with NHS England to develop and implement the integrated support and assurance process (ISAP). The ISAP is designed to be a consistent, streamlined NHS England and NHS Improvement process for supporting and assuring novel procurements. An outline of the

[6] Please refer to our transactions guidance for foundation trusts (available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417799/Transactions_guidance_2015_FINAL.pdf) and the TDA accountability framework (available at http://www.ntda.nhs.uk/wp-content/uploads/2015/04/TDA_framework_final.pdf).

process was jointly published in November 2016.[7] More detailed guidance will be issued in the coming months.

We encourage NHS trusts and foundation trusts considering innovative organisational forms or significant diversification, for example, large scale health and social care integration, to discuss their plans with us as early as possible. We can help to clarify the strategy and ensure that potential problems are dealt with promptly. In particular, early engagement with us can help uncover any need for merger review and ensure that the process is navigated swiftly, and identify if the proposed transaction will work well for patients. We have published guidance on merger review and related matters.[8] We will continue to work closely with vanguards and other providers considering new care models to understand the arrangements they are proposing so that transaction review, if necessary, can proceed appropriately.

In addition, transition to a new care model may raise wider or more general issues relevant to our oversight such as those relating to finance or governance at a provider. Our Single Oversight Framework and associated guidance provide further detail of our oversight and regulatory role in relation to such matters.

Contact us at nhsi.newcaremodels@nhs.net if you have any queries or would like to discuss your plans further.

3.2. Will there be any adjustments to our oversight of providers transitioning to a new care model?

- Will transitioning providers be granted a 'regulatory performance holiday'?
- Will new care model plans be considered by NHS Improvement as part of recovery plans and projected trajectories?
- Will providers be penalised for taking on a troubled provider in their new care model?

We understand that moving to a new care model involves significant upfront investment of both finance and time. We want to support providers doing this while ensuring that high standards of

[7] https://improvement.nhs.uk/news-alerts/working-nhs-england-provide-support-complex-contracts/

[8] We have published guidance for providers on how to comply with the competition and choice licence conditions (available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329715/Guidance_on_choice_and_competition_licence_conditions.doc.pdf), as well as on the application of the Competition Act in the healthcare sector (available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/354078/cc_Guidance_on_application_of_CA98.pdf). An overview of all guidance around procurement, choice and competition, including on mergers, can be found at https://www.gov.uk/government/collections/procurement-choice-and-competition-in-the-nhs-documents-and-guidance

patient care are upheld. Where providers have a plan for improvement (for instance one related to the implementation of a new care model), this will continue to be factored into any assessment we make of their performance as part of our oversight role and should be discussed with your regional manager as part of the ongoing monitoring of performance.

We are aware of concerns around providers that acquire or merge with a poorly performing provider. Monitor's current transactions policy[9] permits providers in this situation to apply for an investment adjustment to agree relaxations in financial and/or operational standards for a specified period while historical performance issues are corrected through the integration. We are likely to continue to agree such investment adjustments, where appropriate, to assure high-performing providers that they can help tackle poor performance at another provider through merger or acquisition without fear of significantly impacting on their own performance.

High quality care and patient safety remain our top priorities. We expect NHS Constitution targets and appropriate grip on operations, finance and good governance to be maintained while organisations are transitioning.

Where a provider suspects it will fall short of any of the criteria against which it is assessed by NHS Improvement under the Single Oversight Framework, it should discuss this with our regional team as soon as possible, through the usual channels for ongoing monitoring of provider performance.

3.3. What should you do if you have technical questions about the NHS Improvement provider licence?

We offer guidance on technical questions relating to the operation of the licence and the details of our regulatory regime. For instance:

Does an organisation name change require a change in licence?

A licensee has to inform us of changes, including a change in name, so that the licence can be updated to apply to the correct legal entity. A name change is unlikely to happen in isolation. It may be connected to wider issues, such as whether the body still needs a licence, if it still fulfils the licence grant criteria and if it now provides commissioner requested services (CRS), which may make it subject to a wider regulatory regime and additional licence provisions. Please contact us as soon as possible if you are proposing a name or other relevant changes in your status as a licensed provider.

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9 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417799/Transactions_guidance_2015_FINAL.pdf

Can a non-trust (eg a GP federation) become a foundation trust?

Under current legislation, only NHS trusts can become NHS foundation trusts.

Please email your questions to nhsi.newcaremodels@nhs.net. As we receive questions we will update this document with the answers.

4. Oversight of new care models

4.1. What is NHS Improvement doing to ensure that its oversight is appropriate and proportionate for new care models?

As different care models begin to take shape, we continue to work closely with vanguards and our national partners to inform how we may need to adapt our oversight regime to accommodate this change. We are:

- mapping how the new care models fit into our oversight regime
- working closely with vanguards and other national partners to identify any issues that may arise
- developing possible solutions to the issues identified
- testing these solutions with a few vanguards and national partners
- engaging on any proposals or guidance.

We will share any changes we propose to make to our approach as early as possible. How we oversee new care models will depend on the type of providers involved and other relevant factors. See below for more detail.

4.2. How will NHS Improvement oversee NHS trusts and foundation trusts that form part of a new care model?

In line with our statutory duties, we will continue to license and oversee separate legal entities.[10] In response to the development of new care models, we will in due course consider whether we need to adapt our monitoring. For instance, where the licensed entity is made up of a number of merged organisations (eg a merger or acquisition involving two foundation trusts and/or NHS trusts), we may consider whether measures of quality and operational performance could more appropriately

[10] See our statutory guidance on the NHS provider licence: https://www.gov.uk/government/publications/the-nhs-provider-licence

be reported at the business unit level as well as, or instead of, current requirements. We will continue to work primarily with the trust board to tackle any issues as this is where overall responsibility and accountability ultimately lie.

See also the questions below on the regulation of multiple organisations and foundation groups.

4.3. How will NHS Improvement oversee foundation groups?

What is a foundation group?

The linking together of providers to form foundation groups is already being considered, and in some cases established, in some parts of the country. The various models under consideration for these differ but share a number of common themes, principally relating to the governance and management of acute services at different locations. Foundation groups may, for example, involve trusts joining together under the umbrella of a successful NHS provider and sharing of management skills, clinical expertise and back office functions.

Foundation groups may use a mixed economy of membership models, ranging from buddying through to full acquisition. They were described as part of the acute care collaborations (ACC) care model in the Five Year Forward View (5YFV).

How will NHS Improvement oversee NHS trusts and foundation trusts that create a foundation group?

Some foundation trusts are considering whether and how they can form a foundation group. We are working with a few vanguards to understand what will happen in practice and what support we can provide for this and any other new care model set up in the interests of patients. Where the foundation trusts or trusts involved become a single legal entity through merger or acquisition, they will be legally accountable as a single organisation, with a single provider licence. We are considering whether reporting and monitoring of finance, leadership and strategic change could be done at board level, and reporting on quality and operational performance at the business unit level. We will always work through the trust board where there are any issues, as this is where responsibility and accountability ultimately lie. The nature of any support or intervention at board or business unit level may depend on the extent and scale of the problem.

To understand how we will oversee multiple organisations implementing a new care model but not forming a single entity, please see question 4.5 below.

What is accreditation for foundation groups?

We are working on how we can best support the development and growth of foundation groups. We have accredited the first four foundation trusts to lead groups of NHS providers. The aim of linking hospitals is to improve their clinical and financial viability, creating better and more sustainable services for patients.

Foundation group leaders can help to improve efficiency and the quality of clinical services by sharing excellent practice across the group.

Our main considerations for accreditation include the performance of the existing provider and the management capacity to maintain performance, implement the group structure and deliver the benefits of the foundation group.

What happens if you want to add a new member to your foundation group?

- Will each new addition require a standard transaction review process?
- Will a new addition raise other potential considerations?

We are considering how to adapt our process for reviewing transactions (which includes mergers, acquisitions, significant investments, joint ventures and divestments). If the addition of a new member means that a transaction review takes place, we expect to consider the proposed membership structure (and therefore the level of risk transferred), the size of the group, its track record and the value of the individual transaction. The accreditation process for the addition of a new member will also be taken into account.

Transition to a new care model may raise wider or more general issues relevant to our oversight such as those relating to finance or governance at a provider. Our Single Oversight Framework and associated guidance provide further detail of our oversight and regulatory role in relation to such matters.

What guidance has NHS Improvement published in relation to foundation groups?

To support the successful development of foundation groups, we have published guidance on structuring options for foundation groups.[11]

When should you engage with NHS Improvement?

If you want to be accredited as a foundation group leader or join a group, please email nhsi.newcaremodels@nhs.net

4.4. How will NHS Improvement oversee independent providers that are part of new care models?

NHS Improvement (through Monitor's statutory duty) licenses all providers of NHS healthcare services, unless they are exempt.[12] Independent providers (that is, non-NHS bodies) that are

[11] https://improvement.nhs.uk/uploads/documents/Foundation_groups_guidance.pdf

required to hold a licence are overseen by NHS Improvement differently from NHS foundation trusts.[13] We are in discussions with the Department of Health, NHS England and CQC about the appropriate level of oversight of the different kinds of providers that may be awarded new care model contracts. We are also working with multispecialty community provider (MCP) vanguards to help both us and the vanguards more fully understand any issues faced.

4.5. Can multiple organisations implementing a new care model be overseen as a system/single organisation?

We expect and support providers to work collaboratively with partners locally in the interests of their population wherever appropriate. Provider planning, through operational plans and Sustainability and Transformation Plans (STPs), should reflect this joint working. Our Single Oversight Framework includes an assessment of providers' engagement in 'strategic change', such as their contribution to new care models.

It is, however, the legal entity providing NHS healthcare (unless exempt) that is required to hold a licence, and therefore accountable under it and overseen as such by NHS Improvement. Any collaboration that does not create a single legal entity is unable, under the law, to hold a single licence.

4.6. Can a group of foundation trusts and/or trusts be allocated a system control total?

We encourage partners in local health economies to work together in the interests of patients and to improve care and the use of resources through system leadership and collaboration.

Organisations in many local health economies are coming together to focus on their aggregate position and introducing risk and gain share arrangements to incentivise collaboration. We support this approach.

Where a group of providers all agree to the aggregate control total in the system and also can make a good case for the redistribution of individual control totals (including demonstrating clear long-term benefits), we will work with them and partners to take this forward.

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[12] Any organisation providing healthcare services for the NHS that is not exempt is required to hold a licence. Guidance on the exemptions is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268538/131220_Licence_exemptions_-_guidance_for_providers.pdf.

[13] Further information can be found at: https://www.gov.uk/government/publications/risk-assessment-framework-independent-sector-providers-of-nhs-services

5. Aligning oversight across national partners

5.1. How will we make sure that NHS Improvement teams are aligned to support and challenge new care models?

We are committed to being an organisation that speaks with one voice. We have people in senior roles that operate at a sub-regional level, mirroring NHS England areas, who oversee and advise providers and systems on STPs, vanguard plans and other integration initiatives.

We are improving how we share knowledge across the organisation. This will improve and widen understanding of how different care models are being implemented and how our different teams can support providers and local areas.

5.2 How will we make sure that we act in a joined-up way with our national partners to support the development of new care models?

- How will NHS Improvement and its national partners streamline regulatory requirements, particularly around reporting and planning, as well as interactions with providers and systems?
- What are NHS Improvement and its national partners doing to align top-level messages?

With our national partners, NHS Improvement aspires to align oversight for all providers of NHS services. However, the changing commissioner and provider landscape requires more integration of the oversight of health and care services, particularly as the distinctions drawn in the current oversight arrangements (such as care and provider type) are blurring in the context of new care models.

We are working with our national partners to make sure our regulatory and oversight regimes align as closely as they can. We are reviewing how we can better co-ordinate our monitoring, interaction and intervention functions to take a more joined-up approach to oversight, and to ensure that we and other national bodies speak with a consistent voice. This includes working closely with vanguard areas to review our processes and ways of working, within current regulatory and contractual oversight, and statutory arrangements.

Current projects include:

- continuing to work with CQC to align our approaches more fully as we move towards a single combined assessment of quality and use of resources
- using CQC's most recent assessments of whether a provider's care is safe, caring, effective and responsive, in combination with in-year information where available
- co-developing with CQC a methodology for assessing providers' use of resources
- working with system partners to help providers deliver the strategic changes set out in the 5YFV.

STPs are playing a significant role in helping to align planning requirements and incorporating plans for new care models. In developing STPs local areas should involve all their providers, commissioners and local authorities, to align commissioner and provider plans. We will still request operational plans at organisational level as part of our oversight of individual providers, and will map how well the organisation is delivering its part of the area's strategic plan, as well as organisational objectives.

6. Governance

6.1. What do we expect of providers collaborating in the development of new care models?

One theme in our Single Oversight Framework focuses on how well providers work with their system partners to deliver the necessary strategic changes set out in the 5YFV. We expect providers to collaborate across health systems, through, for example, STPs, new care models and, where relevant, devolution. We will consult on our proposed approach for overseeing strategic change under our Single Oversight Framework in due course.

We have consulted[14] on and will be publishing a new well-led framework with updated guidance on what it means to be well-led in the context of a health system. We have strengthened, in particular, the sections on successful leadership behaviours and information sharing with local health economy partners.

[14] https://improvement.nhs.uk/uploads/documents/Consultation_on_use_of_resources_and_well-led_assessments.pdf

7. Organisational form

7.1. What consideration needs to be given to organisational form in the implementation of new care models?

The new care models programme has initially focused on the development of service models that improve patients' experience and the quality of care provided. As providers scale up operations and the new care models programme designs a contract structure that enables and supports new care models,[15] consideration will shift to the organisation of services.

Capitated budgets have been a central plank of some of the new care models; they help to break down traditional organisational silos and allow resources to be shifted within a health economy to address population health issues.

We and the central new care models programme team are working with a number of vanguards to identify the potential benefits from different organisational or contractual forms holding new care models contracts.

7.2. What should you bear in mind when considering organisational form?

Any proposal to set up a new organisational form or contractual proposal should be made only after serious consideration of why a new form is required and the pros and cons of the different forms in delivering the new care model – and not as an end in itself. Many aspects need to be taken into account, especially the suitability from a governance, regulation and accountability perspective – these may all be considered by national partners in their evaluations of the benefits of different organisational forms in delivering new care models. Contact us at an early stage if you are considering setting up a new organisational form so we can provide further support.

Annex 1 gives an overview of some possible provider organisational forms, but the list is not exhaustive. A more detailed analysis may be required before any particular form is to be considered, and further advice should be sought where necessary.

Annex 2 (published separately) sets out scenario modelling to explore a range of issues and factors that could be relevant to providers considering developing their organisational form to

[15] Please see the draft multispecialty community provider (MCP) contract package for engagement, available at https://www.engage.england.nhs.uk/survey/mcp-contract-package/

deliver an MCP contract. Many of the findings are relevant to PACS also. It is not a prescriptive or comprehensive list of available or permitted models, or a prescriptive approach to choosing the appropriate form. The modelling is not exhaustive but is designed to help providers and commissioners consider different structures. Further advice should be sought before settling on the optimum organisational form for a specific procurement.

Before commissioning any legal, tax or financial advice, consider contacting your new care models programme account manager or care models lead. They may be able to answer your questions or share the experience of vanguards that have previously addressed the same issue. You may then have a better idea of the nature and extent of the specialised and tailored input you need.

8. Payment

8.1. How is NHS Improvement supporting providers to develop payment models for integrated care?

As we set out in *Reforming the payment system for NHS services*[16] improvements to the payment system are critical to developing and delivering new care models. We continue to work on guidance[17] to support the service, as well as running events and webinars[18] on new payment approaches. Later this year we will publish with NHS England a handbook for commissioners and providers on setting up whole population budgets to support integrated care. It will include chapters on calculating the whole population budget baseline, forecasting, adjusting the contract value in future years, and gain and loss sharing.

If you have any questions regarding payment models for integrated care, please email these to pricing@improvement.nhs.uk

16 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/381637/ReformingPaymentSystem_NHSEMonitor.pdf

17 https://www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models

18 http://www.workcast.com/ControlUsher.aspx?cpak=9747167076605020&pak=9835807670444027

Annex 1: Overview of key characteristics of potential different organisational forms

NHS trusts, foundation trusts and community interest companies

Issues	NHS trust	Foundation trust	Community interest company
Summary/ description of structure	Separate legal entity/statutory corporate body with a board of directors (non-executives appointed by NHS Improvement, executives appointed by the trust) Each trust is established by order of the Secretary of State (SoS) to provide goods and services for the purposes of the health service (NHS and public health). The establishment order may be more specific and provide that the trust must provide particular services or specify locations from which services are to be delivered	Separate legal entity/statutory corporate body with a board of directors, council of governors and members (divided into various categories and 'constituencies') Members elect most of the governors (some may be appointed by third parties), governors appoint the non-executives (NEDs), NEDs appoint the chief executive (although the appointment is subject to governors' approval), and the NEDs and chief executive appoint the other executive directors Principal statutory purpose is to provide goods and services for the purposes of the health service (NHS and public health) (note: must be more than 50% of income from providing goods or services)	A CIC is a corporate body (a company) and can be either a company limited by shares (CLS) or a company limited by guarantee (CLG). CICs are designed in particular for social enterprises that want to use their profits and assets for the public good. Each CIC is subject to a community interest test and an asset lock, and is registered with/by the CIC regulator The primary purpose of a CIC is to benefit the community and not its shareholders, directors or employees. It will have a 'community interest statement' that sets out the beneficiaries of the CIC and how the CIC's activities will benefit the community The board of directors will conduct the affairs of the company on a day-to-day basis
If being set up as a new entity,	Statutory process (consultation followed by order made by SoS. It is	1. Authorisation by Monitor of existing NHS trust, following TDA consent and	The pure formation of the company/CIC involves a slightly expanded version of the

what is the process? (ease and time)	not clear if this option is available in the current environment) (If an existing NHS trust is used, amendments to establishment order may also be required)	application by the trust – lengthy process. Monitor and TDA are both part of NHS Improvement 2. New foundation trust formed from merger of two existing trusts (two foundation trusts or a foundation trust and NHS trust). Requires boards (and majority of a trust's governors in case of foundation trusts) to agree and NHS Improvement approval. May require merger review by the Competition and Markets Authority (CMA) 3. Separation of existing foundation trust into two or more foundation trusts – requires NHS Improvement approval and approval of majority of the foundation trust's governors (If existing foundation trust is used, rather than establishing a new foundation trust, amendments to constitution may be required)	normal company formation process, but it will usually take some time to agree the constitutional documents Participants should consider relevant CIC Regulator guidance when setting up a CIC
Contracts – can it hold:			
General medical services (GMS)	GMS: no	GMS: no	GMS/PMS: only if a company limited by shares with eligible shareholders
Personal medical services (PMS)	PMS: yes	PMS: yes	
Alternative provider	APMS: yes, providing directors are not ineligible	APMS: yes, providing directors are not ineligible	APMS: yes, providing

medical services (APMS) **NHS Standard contract (NHSSC)**	NHSSC: yes	NHSSC: yes	directors/shareholders not ineligible NHSSC: yes
Use of profits/ surpluses	Some scope to use internally generated cash[19] but (a) SoS directions otherwise require surpluses to be returned to Consolidated Fund and (b) can't distribute to directors or staff (who are not in the position of shareholders or directors in a private company)	Trust retains but can't distribute to directors, staff or members (who are not in the position of shareholders in a private company)	Asset lock and aggregate dividend limits will affect use of profits/ surpluses
Insolvency/ continuity of services regime	Trust special administration (TSA) regime may be applied Whether or not TSA, dissolution is by SoS order, and must provide for transfer of all property, rights and liabilities to another NHS body Cannot otherwise be wound up or dissolved (except when merged with or acquired by a foundation trust)	Foundation trust may be subject to commissioner requested services (CRS) regime under Monitor licence (eg controls on transfer of assets) TSA may be applied if foundation trust is, or is likely to become, unable to pay its debts. End result may be dissolution and transfer of property, rights and liabilities to SoS or other trusts Foundation trust may also be dissolved: (a) as part of a merger with another trust (b) when acquired by another foundation trust or	As for other companies, plus CRS (if licensed)

[19] www.ntda.nhs.uk/wp-content/uploads/2013/06/NTDA-Capital-Regime-and-IBC-Approvals-Guidance-for-NHS-Trusts-Final.pdf - see paras 2.8 and 2.9

		(c) on application by the trust to NHS Improvement, with the support of the majority of governors	
Financing options	Loans, cash, public dividend capital (PDC) or guarantees from SoS (Independent Trust Financing Facility (ITFF)) Borrowing from private sector subject to SoS/NHS Improvement directions. Cannot mortgage or charge assets or otherwise use assets as security for a loan May enter PFI transactions (with SoS certification)	Loans, cash, PDC or guarantees from SoS (ITFF) Borrowing from private sector – but finances subject to NHS Improvement oversight (financial risk rating, rating of significant transactions, etc) May enter PFI transactions (with SoS certification)	As for other companies but subject to asset lock, aggregate dividend cap and performance interest cap – so access to finance may be slightly harder compared to a non-CIC company limited by shares
Corporation tax position of entity **(NB other tax issues to consider for the entity and participants)**	Not liable for corporation tax	Not liable for corporation tax (although Treasury order may impose liability for specified activity)	Company liable to corporation tax, etc (NB shareholders taxed on dividend income)
Key regulators	NHS Improvement (exercising powers of the NHS TDA) (NB subject to SoS/TDA powers to give directions about how exercise functions. To be regulated under the Single Oversight Framework underpinned by conditions equivalent to the provider licence, although NHS	NHS Improvement (exercising the powers of Monitor) (provider licence regime; including regulation of governance and finance, Single Oversight Framework, significant transactions assessment) CQC	Companies Act 2006 NHS Improvement (provider licence regime for continuity of services – NB not governance) CQC CIC regulator: www.gov.uk/government/organisations/offi

	trusts are exempt from requirement to apply for and hold a licence CQC		ce-of-the-regulator-of-community-interest-companies

Companies limited by guarantee, limited liability partnerships and companies limited by shares

Issues	Company limited by guarantee (CLG)	Limited liability partnership (LLP)	Company limited by shares (CLS)
Summary/ description of structure	A body corporate with directors and members, but not shareholders (members cannot transfer their interest, but can leave and join) The board of directors will conduct the affairs of the company on a day-to-day basis No obligation to conduct business for the benefit of the community Members' liability is limited to the amount guaranteed (usually £1). Unless expressly stated in the articles of association, there are no restrictions on the objects of a CLG	A body corporate with a legal personality separate from that of its members The profits of the LLP are taxed as if the business were carried on by partners in partnership rather than a body corporate Arrangements between the members will be documented in an LLP agreement, which is not publicly filed Established 'with a view to profit' so unlikely to be appropriate for 'not for profit' purposes Members cannot assign/transfer their memberships without consent of other members	A body corporate with directors and shareholders The board of directors will conduct the affairs of the company on a day-to-day basis No obligation to conduct business for the benefit of the community Members' liability is limited to the amount of their equity investment (including any amount unpaid on shares). Unless expressly stated in the articles of association, there are no restrictions on the objects of a company limited by shares
If being set up as a new entity,	Pure formation of the company will usually need some time to agree the	Pure formation of the company will usually need some time to agree the constitutional	Pure formation of the company will usually need some time to agree the constitutional

what is the process? (ease and time)	constitutional documents	documents	documents (including any shareholders' agreement)
Contracts – can it hold: **General medical services (GMS)/personal medical services (PMS)**	GMS/PMS: no	GMS/PMS: no	GMS/PMS: yes, if shareholders are eligible
Alternative provider medical services (APMS)	APMS: yes, providing directors/shareholders are not ineligible	APMS: yes, providing directors/shareholders are not ineligible	APMS: providing directors/shareholders not ineligible
NHS standard contract (NHSSC)	NHSSC: yes	NHSSC: yes	NHSSC: yes
Use of profits/ surpluses	No shareholders, so no ability to pay dividends (but unless the company's articles provide otherwise, it can distribute profits to members)	Profits will be shared among members according to the LLP agreement	Profits can be distributed to shareholders (subject to anything in the company's articles of association)
Insolvency/ continuity of services regime	Administration, liquidation, receivership, etc plus CRS if licensed	Broadly speaking the same as companies plus CRS if licensed	Administration, liquidation, receivership, etc, plus CRS if licensed
Financing options	Funds can be raised from members (eg as a condition of membership) or through debt – but no scope for equity investment	Likely to be via debt but could be via contributions from members	Can raise finance through either debt or equity

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