healthcare.
Your quarterly news update from Sintons

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Healthcare Drinks
Transfer of NHSPS/CHP Estate

A NHS Trust or Foundation Trust wishing to take ownership of property owned by NHSPS or CHP may request approval from the Department of Health and Social Care ("DoH") for the transfer of the property. Many NHS providers and stakeholders believe that locally owned property enables more effective clinical service delivery.

It could also be argued that NHS Providers are better equipped in terms of skill, experience and resource to manage NHS properties, enabling them to provide better overall value for money in respect of the ongoing management and lifecycle costs of a property.

From the perspective of any NHS Provider thinking about making an application to transfer, each property will need to be considered on a case by case basis and some detailed investigation undertaken at the outset.

NHSPS ESTATE

NHSPS own a large number of properties, which are split between freehold ownership, leases, licences and PFI arrangements.

In relation to any properties that are leased or occupied on a day to day basis, any required from the landlord or project (as the case may be) in respect of the transfer to the NHS Trust/Foundation Trust. A review of the occupational documentation would be needed to establish whether this consent would be required and whether the consent could be subject to any onerous conditions.

Where any NHSPS properties are licenced, NHSPS will most likely not hold a transferable interest. In essence, a licence is a personal arrangement between the parties to it and cannot be transferred to a third party.

CHP ESTATE

CHP are head tenant in a large number of NHS LIFT schemes under a Lease Plus Agreement (for a term of generally 25 years) or Land Retained Agreement.

A number of those NHS LIFT schemes will now be over 10 years old. This means that the operational arrangements in place will have less than 15 years left to run. In the case of a Land Retained Agreement, the freehold will revert to CHP at the end of this term, however, in all other cases, a new operational arrangement will need to be agreed between the parties at the end of the term.

BUSINESS CASE

A formal business case will be required for each individual property to be transferred. This will need to cover a number of areas in detail, including:

1. Support of local stakeholders and alignment to local health and social care plans;
2. Demonstration of clear understanding of the liabilities associated with the property;
3. Determination of value for money compared to NHSPS/CHP property ownership;
4. Funding for the transfer and long-term affordability;
5. NHS Trust/Foundation Trust’s capacity and ability to manage the property efficiently and ensure it remains safe, secure and fit for purposes;
6. NHS Trust/Foundation Trust’s capacity to carry out any requisite site development.

This will take time to prepare, however the majority of the work will need to be done ‘up front’ in terms of investigations into the property, occupants, title and financials.

DUE DILIGENCE AND THIRD PARTY OCCUPATIONS

Before proceeding with preparation of a business case for the transfer of any particular property, it is essential that a Trust carries out initial due diligence in respect of the ownership, tenure and title of the property.

This will reveal whether any third party consents would be required in respect of the transfer. It will also establish whether the title to the property contains any encumbrances, such as restrictions, that could adversely affect the title or cause issues in respect of the transfer.

It is imperative that a clear picture of third party occupations is established, including the following:

1. Areas occupied by each occupant
2. Identity of each occupant
3. Whether the occupational arrangements are documented; and
4. Whether there are any arrears in rent or (most likely) service charge and how much the outstanding amounts are in relation to each.

The DoH has stated that it will expect that all liabilities and indemnities of NHSPS/CHP in respect of a property to be transferred to the NHS Trust/Foundation Trust on transfer of the property. This will include any contracts in place for facilities management services, any litigation ongoing with a former tenant, any compensation payable to a tenant, and any indemnities in service contracts.

Where there are any arrears or outstanding amounts due from a tenant or occupant, the DoH will not give approval to a transfer of a property until there is a binding agreement in place between NHSPS/CHP and the tenant/occupant for payment of any outstanding amounts. The DoH have stated that they will expect a receiving NHS Trust/Foundation Trust to be responsible for any failure by the tenant or occupant to comply with its obligations for payment set out in such agreement. It therefore expects the receiving Trust to also be party to any such agreements.

We are aware that currently NHSPS/CHP are struggling to recover a high level of outstanding payments from current tenants across their respective estates. We understand that the majority of outstanding payments relate to services and FM charges. In view of this, it is imperative that a Trust establishes at the outset the amount of any tenant arrears or outstanding payments in respect of any property. It is likely that any third party occupier with arrears of service or FM charges will be strongly advised against entering into a binding agreement to secure payment of those arrears. The Trust may therefore be asked to produce an alternative suggestion in respect of those payments.

Alongside this, where a service contract is in place between NHSPS/CHP and a third party, to provide facilities management services in relation to a property, the Trust will be expected to either take on the remaining term of that contract, or compensate NHSPS/CHP for the costs of terminating the contract early. This could also form part of the initial due diligence checks.

This information will enable the receiving Trust to form a view on the financial impact or benefit of taking on a property.

TUPE

As part of the overall due diligence carried out on a property, it is important that the Trust considers whether TUPE may apply to any members of staff wholly or mainly assigned to maintaining or managing the property transferring, or providing services to or benefitting from the property.

TUPE requirements will need to be observed strictly if there is any possibility that it may apply to any staff at the property. Where a staff member transfers to the Trust under TUPE, all liabilities, rights and obligations will transfer with them and therefore the Trust needs to establish a full picture of the employment arrangement along with any pension obligations.

TRANSFER CONSIDERATION

Any freehold or long leasehold property transferring from NHSPS/CHP will be transferred at the Net Book Value shown in NHSPS/CHP’s accounts at the point of transfer. It is important for the Trust to undertake its own valuation and pick up any discrepancies it may have with NHSPS/CHP as soon as possible.

This may relate to dilapidations or the condition of the property.

A number of NHSPS properties in particular are still sub-standard in terms of condition and maintenance. They have suffered from a long history of back-log maintenance and poor investment. It is therefore likely that some discussion around value will be possible in relation to those properties.

Where there is no movement on the stated value of a property, the Trust will need to consider whether it is worth taking on a property which requires a large amount of work. This will require estimates of the cost of the works required and a qualified surveyor should be engaged to undertake a survey to establish the relevant costs involved.

It is important when taking a property to consider the future of the property, which will undoubtedly be impacted by the state and condition of the property.

OVERAGE PAYABLE ON SALE

Where a property is transferred and subsequently sold, the Trust must pay 50% of any uplift in the value from the sale to NHSPS/CHP. This payment would be calculated before deduction for indexation or marketing costs.

A restriction will be placed on the title to exclude any freehold or long leasehold property which requires a large amount of work.

As part of the overall consideration, a Trust will need to think about the future use of the property where that is the case to ensure it is not left with void costs.

It is possible that a Trust may believe that the property could be used by its own staff, thereby freeing up space elsewhere and all future alternative uses by local health providers should be considered as part of the due diligence process. This will need to form part of the business case for approval.

INITIAL STEPS

We can assist at the outset of this process by reviewing any reporting to you on the title of the property and any occupational documents in place. We will liaise with NHSPS/CHP to gather the relevant information on financials, arrears, staff and occupational interests to help inform your decision.

We can assist in producing distinct sections of the business case, which should also be supplemented by input from your financial advisors and your estates team.

If you would like our assistance or to discuss options available, please contact our Healthcare or Real Estate partner Victoria Armstrong.
Primary Care Networks
Employment issues

Dealing with employment issues can be complex in the simplest of employment structures. However, in the context of PCNs there are many additional issues which will need to be considered and dealt with.

In order to avoid, or at least minimise, future difficulties within the PCN it is advisable to make decisions regarding network staff and their management and ensure that, as far as possible, these are dealt with in the Workforce Schedule. However, it is worth noting that PCNs are likely to be created some time before actually taking on staff, so there is no immediate rush to populate the Workforce Schedule prior to formalising the PCN itself.

The Workforce Schedule can be amended at the point in time that the PCN decides to take on staff. It is also worth remembering that the Schedules can be amended. So if you become aware of an issue that has not been addressed in the schedule you can amend it at that time.

The directed enhanced service ("DES") will cover funding for additional staff who would effectively be network employees rather than employees of an individual practice.

However, as the PCN may not in itself be a legal entity, the network employees will need a formal employer which is. When considering who the employer is, a Tribunal will inevitably results in choices needing to be made in terms of an employment structure. Some issues which should be considered when taking on network employees and deciding how they should be employed are:

- How do you intend to employ network employees? The BMA has proposed several structure options and each option has a different intended employer which is.

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  - How do you intend to employ network employees? The BMA has proposed several structure options and each option has a different intended employer which is. However, it is important to be mindful that just because you intend Practice X, the lead practice, to be the employer of the PCN pharmacist, Employee A, if this is not reflected in practice then, if it was ever questioned by an Employment Tribunal, you could find that the actual employer is not who you intended it to be. When considering who the employer is, a Tribunal will consider issues such as who pays the employee and who has day-to-day control of them.

  - How do you intend to manage network employees on a day-to-day basis? For instance, if Employee A is technically a joint employee of 5 GP practices, i.e. in a flat practice structure, you would need to consider who would be responsible for managing her and how this would work on a day-to-day basis. This would include issues such as who would deal with performance or conduct issues and who would manage sickness absence.

  - If Employee A is employed by the lead practice, but works across all the practices, how will this be managed? If the intention is that Employee A will be seconded, the PCN will need to ensure that the appropriate secondment agreement is in place to address issues such as cost and the division of time.

  - How would you deal with cross-practice issues? For instance, if Employee A is being managed by a practice manager at one practice but has an issue with an employee of another practice within the PCN and raises a grievance, who would be responsible for dealing with this issue. How would the practices work together to resolve this? Or, if Employee A is considered to be employed by a limited liability vehicle ("LLV") how would that company then deal with an issue raised by Employee A?

  - For instance, if employees in Practice X have 28 days’ annual leave, but Employee A has 33 days to match Practice Y as the lead practice, how will this impact on the morale of employees of Practice X who may work alongside Employee A?

  - These are just a few examples of employment issues that need to be considered when choosing the network structure and working practices for your PCN. However, the most important thing is that you and the other intended members of the PCN discuss and agree both how you intend to deal with employment issues on a practical day-to-day level and how you intend to address legal issues before formally establishing the PCN.

  - The more issues that have been pre-empted and addressed in the Schedules to the Network Agreement, then the smoother your PCN should run in practice.

  - If you would like to discuss further the legal or practical employment issues arising from the creation of your PCN, or the content of the Schedules to your Network Agreement, please do not hesitate to contact the Healthcare Team at Sintons LLP.
Primary Care Networks
Mandatory Network Agreement
Mind the Gaps

With the launch of the Network Contract Direct Enhanced Service and Primary Care Networks (PCNs), NHSE have issued the PCN Mandatory Network Agreement (Network Agreement) required to be signed by all members of each PCN. The purpose of the Network Agreement is to govern the operation of the PCN and its terms can be broadly separated into two groups:

1
Nationally negotiated terms which cannot be changed but can be supplemented (essentially the Clauses in the main body of the Network Agreement).

2
Terms agreed by individual PCNs to account for local operating requirements (essentially the Schedules to the Network Agreement).

The Schedules are blank for each PCN to complete based on what they have agreed locally, but filling in the details required for each Schedule is by no means an easy task as there are some difficult decisions to be made before preparing comprehensive Schedules, and the knock-on effect this can have for practices.

Given the deadlines that practices are having to work to, this detail will have to develop over time and the initial Network Agreement required as part of the joint submission is likely to require further development and amendment in the coming months to ensure it is workable. Some of the issues that members should be mindful of for their PCN include:

- **Decision Making** – how decisions are made and voting rights are allocated is entirely at each PCN’s discretion. Members are likely to be familiar with these issues where they currently operate in partnership or are a member of a Federation but decision making at scale can be unworkable if every practice member has a vote for all matters. Delegation of certain decisions may be more appropriate with only certain crucial reserved matters being put to all members and potential requirements for unanimity and veto. The administration required for meetings and operation of the PCN should also not be underestimated.

- **Risk Sharing/liabilities** – the Network Agreement refers to additional financial matters that the parties may want to consider including such as whether members are required to provide indemnities and any caps on liability. This is a key issue for the PCN and will depend on the proposed structure but matters such as allocation of responsibility for liabilities will need to be agreed and documented where, for example, a member is employing staff on behalf of the PCN or contracting for services on behalf of the PCN. Members also need to consider whether liability is joint, several or joint and several, and the consequences that flow from the agreed position.

- **Joint responsibility** – there is a balance to be had between collaborative working and being clear on what each member of the PCN is responsible for but joint responsibility in a legally binding contract is best avoided as it can cause enforceability issues due to lack of certainty.

- **Flexibility** – the BMA handbook acknowledges that the Network Agreement will have to be updated year on year as new services, workforce and funding are added but operational matters will also need to be considered. As with any new venture/structure, how the PCN operates in practice will develop over time and will not necessarily be how the parties envisaged on day one. This will require the Schedules to the Network Agreement to be retrofitted to reflect the reality. As the Network Agreement is legally binding, it is important that a valid variation procedure is followed.

- **Contract Variations** – the Network Agreement provides that no variation is effective unless it is in writing and signed by all members. Parties can agree a different variation procedure and practices may want to consider agreeing a template document to govern variations to streamline the process, particularly where there are numerous members in the PCN. It is also important that the Network Agreement and any variation is properly executed by each member of the PCN – in particular, for those practices operating in partnership.

- **Data Protection** – the guidance refers to a national template data sharing agreement being made available for PCNs which is helpful but the issue is wider than the sharing of personal data between members of the PCN. Members also need to be mindful about having appropriate measures in place for the sharing of personal data outside the PCN, as well as each member reviewing its privacy notice to ensure it continues to comply with data protection legislation following creation of the network.

- **Relationship with third parties** – it is easy to forget that the PCN may not be a legal entity in its own right and members will need to consider this when deciding how the “PCN” contracts with third parties.

If you would like to discuss further the legal issues arising from the creation of your PCN or the content of the Schedules to your Network Agreement, please do not hesitate to contact the Healthcare Team at Sintons LLP.
Spotlight on Victoria Armstrong

Victoria Armstrong is a Partner in our Healthcare team specialising in real estate. She has acted on behalf of more than 20 NHS Trusts over the last 11 years. She has led a large number of complex transactions on behalf of those Trusts.

Victoria has extensive expertise in dealing with a wide range of property issues within the NHS.

She has particular expertise advising on NHS development projects, including 3PD schemes, PFI/PPP schemes and NHS LIFT. Victoria has also advised on a number of NHS outsourcing projects.

Victoria has been involved in some of the most significant changes within the NHS, most recently advising on strategic estates plans.

EXPERIENCE
- advising a number of NHS Trusts on their estates rationalisation programmes and disposal of surplus land
- acting on behalf of both occupiers and developers of healthcare premises including 3PD, polyclinics and social care centres
- advising a wide range of NHS Trusts and Local Authorities in connection with the development of new health centres and hospitals including leading on LIFT projects
- Victoria regularly advises on Landlord and Tenant matters, acting for both owners and occupiers
- She is experienced in advising on the sale and acquisition of healthcare property, including hospitals, surgeries and specialist clinics
- Victoria has advised a number of NHS Trusts on the property elements of their outsourcing projects
- She is currently providing advice and support in relation to STPs and strategic estate planning.

Our Team

Our team of dedicated healthcare lawyers has a well-established track record in acting for healthcare organisations on both a regional and national basis.

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