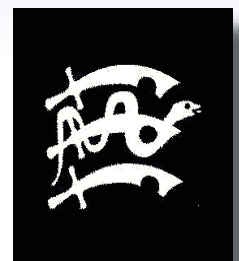




Practice Based Commissioning

A guide for practices

North & South Essex
Local Medical Committees





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INTRODUCTION

This Guide has been produced as a point of reference for practices on the implementation of Practice Based Commissioning (PBC). It is intended to supplement information contained in the two earlier LMC Briefing Notes on PBC and includes extracts taken from guidance produced by both the GPC and DoH. Both these documents can be downloaded via the lmc website. http://www.essexlmc.org.uk/guidance/practice_bc.html

PBC as originally envisaged would have provided real opportunities for clinicians and other health care professionals working in primary care to influence changes in service provision for the benefit of patients. More recent guidance and the restrictive interpretations placed on it have raised questions about the benefits to be gained from participating in PBC.

This Guide will hopefully assist practices who are still in the process of deciding whether PBC is an option worth pursuing. **Issues surrounding PBC have become more complicated and the Guide explains in more detail why the LMCs' advice to practices is to consider PBC as a two stage process.** Examples of a DES Plan (Stage 1) and an Enhanced Commissioning Activity Plan (Stage 2) are included in the Appendices together with more detailed advice for practices wishing to work as part of a large group/ Consortium.

WHAT IS PBC?

- PBC gives practice teams the freedom to plan and develop high quality services in an innovative way. Patient care pathways can be changed to improve both the quality and timeliness of care.
- Payment by Results will ensure that money moves with the patient. PBC is pivotal in ensuring that funds transfer from secondary to primary care to accompany any changes in the pattern of service provision.

UNIVERSAL COVERAGE

The Department of Health's stated aim is to achieve universal coverage of PBC by the end of 2006. PCTs have been charged with putting in place arrangements to facilitate universal coverage.

PCTs will be responsible for ensuring that:

- All practices receive information that will allow them to understand their clinical and financial activity compared with local and national indicators
- All practices receive an indicative budget covering an agreed scope of services
- All practices receive appropriate support and the offer of an incentive payment in the form of a Directed Enhanced Service [DES] (see Stage 1 – Page 5)
- Governance and accountability arrangements for PBC are in place and are agreed with practices
- PCTs remain accountable to the Strategic Health Authority [SHA] and will be performance managed against these arrangements in 2006/07

DO PRACTICES HAVE TO TAKE PART?

- PBC remains voluntary for all practices
- Practices who wish to participate in PBC are free to determine the level of that involvement
- **It may be helpful to practices to consider involvement in PBC as a two-staged process. This is explained in more detail on pages 5-7.**
- There is no information regarding what will happen if practices choose not to take part. The suggestion is that all practices will be involved passively eg receive monthly level information and have an indicative budget.



IS IT POSSIBLE TO JOIN WITH OTHER PRACTICES?

- Practices may choose to take part on their own or in groups, clusters, consortium.
- The decision rests with practices.
- It is not the remit of PCTs to determine localities or groups of practices for the purpose of PBC.
- There is nothing that prevents practices in different PCT areas from forming a consortium. Boundaries are artificial in view of the pending Reorganisation.
- Practices wishing to work together are advised to consider agreeing a Statement of Intent (see Appendix 3). This is not a legally binding document. It should aid collaborative working and is a precursor to a more formal Agreement.
- It is considered important for consortia wishing to enter into a commissioning agreement with the PCT to have in place sound governance arrangements which are defined, at the very least, in a written agreement.

Appendix 4 gives more detail on legal structures, for PBC consortia. Practices who wish to work as part of a consortium are advised to note the contents of the GPC Paper – Practice Based Commissioning – Consortium Working, which can be accessed on the LMC website. www.essexlmc.org.uk.

WHAT SERVICES DOES IT INCLUDE?

- It is for practices to decide which healthcare services they wish to have included in their indicative budgets.
- Practices should be aware that the scope of their indicative budget will be used to determine the scale of freed up resources [savings] that the practice has to redirect. (see page 6 for more details)
- As a minimum the indicative budget for 2006/7 must include:
 - » All services covered by the national tariff under payment by results;
 - » Prescribing.
- The following services are excluded from indicative budgets:
 - » Core GMS/PMS services;
 - » Specialist services, services commissioned regionally and nationally and national screening programmes.
- Services commissioned by PCTs from other primary care providers, eg dentists, pharmacists and optometrists cannot be changed without full consultation and consent with other professionals.

BUDGET SETTING – KEY PRINCIPLES

- All practices should receive an indicative budget by April 2006.
- Practices will be provided with information on their current share of the PCT's overall commissioning resource.
- Practices will also receive information on their target fair share of the PCT's resources. This will allow them to ascertain whether they are receiving the appropriate level of resource given the relative needs of their registered patients.
- Over time the intention is to move towards target fair shares at practice level which will be calculated on the basis of weighted capitation allocations.
- The indicative budget for 2006/07 will be calculated on the basis of:
 - » Actual 2005/06 activity [based on data available at January 2006] converted into 2006/07 prices.
 - » Current formulae for prescribing budgets.
 - » Weighted capitation for any services for which no data is available.
 - » An uplift to meet any agreed additional activity over 2005/06. This is not guaranteed and will depend on practices use of resources compared to target fair share and overall financial position of the PCT.
- Practices should note that the indicative budget will be the practice's share of the PCT's allocation. This



may mean that where PCT financial deficits exist practices will inherit their share, however PCTs should spread the deficit over their entire budget and not just pass this to PBC.

FINANCIAL/RISK MANAGEMENT

- PCTs will retain accountability for allocations and their statutory duty to break even.
- Practices and PCTs will need to work together to agree arrangements for managing the financial risk.
- One suggestion is a top-slicing of budgets to create a contingency fund.
- **Practices must ensure that any top-slice is not excessive, 3-5% is recommended as being reasonable.**
- Any fund should only be used to cover the overspends of participating practices. Any unspent contingency monies should be returned to practices at the end of the financial year.

FUNDING/RESOURCING OF PBC

- The level of involvement in PBC and the resources needed to support that involvement are important issues for practices.
- Recent DoH Guidance and the introduction of a one year DES for PBC have the potential to confuse matters further and hinder the engagement of practices.
- In parts of Essex sensible local arrangements have already been agreed that recognise both the significant clinical and management time needed to successfully implement PBC. It is crucial that these agreements are not lost.

ESSEX LMCs' VIEW IS THAT PRACTICES SHOULD CONSIDER PBC AS A TWO-STAGE PROCESS.

- The two stages, the work involved and the funding issues are detailed below. In summary the key message to practices is to only work within the resources available. e.g. work at Stage 1, should be realistic and only amount to that which is possible for 95p per patient.
- The significant clinical time required to influence and negotiate service redesign is considered to be Stage 2 involvement and needs to be resourced as such.

PBC – A TWO STAGED PROCESS

STAGE 1

- Stage One is a low level introductory scheme that is primarily intended to promote the engagement of practices in PBC.
- The requirements placed on practices as part of Stage One and the associated levels of funding are covered by the one year PBC DES.

There are two components to the DES as follows:

Component 1 – Value – 95p per registered patient [as at 1 April 2006]

- This is payable once a practice plan for delivering the DES has been agreed with the PCT.
- This payment is in effect income for the practice. There is no requirement that this should be reinvested in service delivery.
- Practices can take up the DES at any time in 2006/07. Ideally a plan should be agreed with the PCT by the end of April 2006, with payment being made to practices by the end of June 2006.
- A Template Plan has been produced by the LMC for use by practices. (see Appendix 1)
- **The Template is based on a model produced jointly by the GPC and the NHS employers. Practices are strongly advised to use this model and not the one produced by the Department of Health, the requirements of which are in line with Stage 2.**
- Stage 1 involvement requires practices to look at a few clinical areas in more detail and agree a couple of



key objectives.

- Objectives should be measurable, realistic and achievable and where possible should be areas that are not subject to influences outside the control of the practice eg validation by practices of hospital data; management of demand and referrals; reduction in follow-up out-patient appointments; changes to specific therapeutic areas of the prescribing budget.
- As part of the plan, practices should identify alternatives to hospital services where possible which demonstrates support for the principle of service redesign.

Component 2 – Value – Minimum of 95p per registered patient (as at 1 April 2007)

- This will be paid by the end of the financial year, provided the practice successfully meets the objectives detailed within the plan.
- Practices will be expected to invest reward monies from Component 2 in practice activity to ensure continued or improved achievement against objectives agreed in the DES plan.

STAGE 2

- Any commissioning activity over and above the limited scope of the PBC DES is considered to be Stage 2 involvement.
- Typically Stage 2 work will involve looking in more detail at service redesign, care pathways, submission of business plans etc.
- This level of involvement will require significant clinical and management time which is NOT funded by the PBC DES [Stage 1].
- Practices wishing to take on this wider range of commissioning activity need to discuss and agree with the PCT the level of resources available to do this.
- Once agreed, practices are advised to produce an Enhanced Commissioning Activity Plan (see Appendix 2) which builds on the objectives agreed as part of the stage 1 DES plan.

RESOURCING

- The resourcing of work involved in Stage 2 needs to be the subject of local negotiation. Experience suggests that there is unlikely to be a common approach across Essex.
- At least one PCT in the County has already agreed a system of funding the payment of clinical and management time [at an hourly rate] to each participating practice. The hourly rate is clinical £75.00, Management £15.00. Payments are made monthly relative to list size.
- In its earlier guidance on PBC the LMCs recommended the following payments to practices:
- Management Allowance of £25,000 per practice plus a capitation payment of between £1.25 - £2.00 per patient depending on the percentage of eligible services being commissioned.
- Where practices group together it is envisaged that management allowances may be subject to reduction following negotiation between practices and the PCT.

FREED UP RESOURCES [FURs]

- The terms “savings” and “efficiency gains” have been replaced by “Freed Up Resources” [FURs].
- Practices are entitled to make recommendations about how to redirect resources freed up from their indicative budgets.
- FURs must be used to fund services for the benefit of patients locally. Resources can be spent on equipment, training, clinical and non-clinical staff. FURs can also be used for premises development, subject to approval of the PCT Board.
- **It has been confirmed by the DoH that in respect of 2006/07 practices are entitled to access and redirect at least 70% of FURs. The remaining 30% can be used by the PCT to meet the needs across the PCT area.**
- **In the case of overspending not being contained within the contingency, and as a last resort, the 30% and ONLY the 30% may be used to cover PCTs overspends. These arrangements will be reviewed in 2007/08.**
- Practices who achieve their objectives in the DES plan and as a consequence also free up resources will be



entitled to redirect up to 70% of those FURs in addition to the payment for Component 2 of the DES.

All practices to note

- To avoid any misunderstanding practices are advised to obtain precise and clear agreement from the PCT in writing about the use of any FURs.
- The LMC view is that this should preferably take the form of a letter signed by the PCT's Accountable Officer. [Chief Executive] Otherwise it should be contained in either the DES Plan. (see Appendix 1) in respect of Stage 1 and in the Enhanced Commissioning Activity Plan in respect of Stage 2. (see Appendix 2)
- Practices should be aware that the scope of their indicative budget [when compared to the total available to the practice] will be used to determine the percentage of FURs available.

INFORMATION FOR PRACTICES

- All practices will be provided with information about their historical referral patterns, historical spend and how these compare with other practices in both the PCT and nationally.
- From 1st April 2006 practices will receive monthly information packs from the PCT.
- PCTs are required to provide practices with bench marking information and financial activity. Practices should be able to identify all the PCT unified allocation attributable to them.
- Activity and financial information on their own practice will be provided as follows:-
 - » Elective activity – inpatient and day case
 - » Non-elective admissions, including information on length of stay
 - » First Out-patient appointment and follow-up appointments
 - » Use of diagnostic tests and procedures
 - » Consultant to Consultant referrals
 - » Prescribing
 - » Community and Mental Health Services
 - » Primary Care including essential and enhanced PMS and GMS services
 - » Accident and Emergency attendances
- Benchmarking data that will allow practices to make local and national comparisons will also be provided as follows:-
 - » Referral rates
 - » Admission rates
 - » First Out-patient attendances;
 - » Follow-up rates
- **PBC objectives should be selected from these two lists.**
- Practices will require information on the needs, demands and demographics of the local population.
- PCTs have a responsibility to ensure that data are accurate and up-to-date. Data quality will improve over time. PCTs should not delay sharing data with practices because of concerns about complete accuracy.

PATIENT INVOLVEMENT

- At the level of practice/consortium it is essential that patient representation is included. A strong alliance between clinicians and patients represents an almost irresistible lever for change.
- Patients can be informed of local commissioning changes and improvements through their practices. Patient involvement is crucial in the decision making process and will assist in issues of patient education and expectation levels.



- A structure involving two larger PCTs should allow resources to be redirected to practices/consortia to put in place effective arrangements to engage patients.

SUPPORT FOR PRACTICES

- PCTs will be expected to have in place support arrangements to enable practices to engage with PBC. Support should be targeted to meet practice needs and requirements.

ARBITRATION

- Where ever possible disputes should be managed and resolved locally.
- The LMCs are available to assist practices and broker solutions with PCTs.
- Where local resolution is not possible a formal system of arbitration exists that is overseen by the SHA. An LMC representative is included on the Committee constituted as part of these arrangements.

NEXT STEPS FOR PRACTICES

Is PBC WORTH PURSUING FOR US?

This is the issue to which practices need to give careful thought. This is not helped by the moving of goal posts and restrictive interpretations of guidance by some PCTs.

Some questions worth asking are:-

- Do you feel in control of the process? Are you able to join with like minded practices of your choice?
- Are there benefits to patients and the practice from participating in PBC?
- Is the PCT's approach to PBC one that will allow you to influence and negotiate changes for the benefit of your patients?
- Is it evident from your discussions with the PCT that they are willing to confirm in writing, arrangements for the use of 70% of FURs?
- Is the PCT willing to properly resource your involvement in PBC above Stage 1?
- Do you consider there to be a risk to the practice in not participating eg loss of influence, increasing use of alternative providers?
- Are you comfortable with accepting an indicative budget that by association may mean sharing the blame for overspends and financial deficits?
- Might it be at least worth becoming involved at Stage 1 level, to test the water?

REMEMBER – PBC IS VOLUNTARY FOR PRACTICES!

IF IT SEEMS RIGHT FOR YOU – SUGGESTED NEXT STEPS ARE:-

- Decide whether the practice wishes to work on its own or as part of a consortium.
- Ascertain whether any of the practice team/other primary care performers have skills that could be utilised as providers under PBC.
- Involve local primary care providers in discussions. New contractual arrangements allow greater flexibility for joint working.
- Look in detail at the Information Packs, Financial Activity and Benchmarking Activity provided by the PCT.
- Decide whether practice involvement will be at Stage 1 only or continued through to Stage 2.
- Agree a DES Plan [Stage 1] and/or an Enhanced Activity Commissioning Plan [Stage 2] with the PCT.
- As part of your Plan[s] agree objectives or changes in service provision for 2006/07.
- Ensure that what ever is agreed is realistic (and measurable) given the timescale.
- Ensure resources are agreed in writing with the PCT to fund Stage 2 involvement. The funding attached to the DES is not sufficient to allow practices to participate at Stage 2.
- Agree how patient/local representatives will be involved in the commissioning process. [This is likely to be Stage 2 work]
- Decide how any FURs will be redirected, particularly in the case of a consortium.



TOWARDS PRACTICE BASED COMMISSIONING DIRECTED ENHANCED SERVICE (DES)

DES Sample Practice Plan - (Stage 1 Involvement)

Name of practice / consortium and contact details, including details of the practice / consortium lead for PBC:

--

Indicative Budget and scope of services covered by indicative budget:

(available from PCT)

Details of scope of activity to be undertaken:

--

Practice / Consortium Objectives, achievement of which will trigger payment of component 2 of the DES:

--

Details of Practice / Consortium engagement in undertaking DES activity:

The practice / consortium will engage within the limit of the DES funding in the following ways:

Identification of alternatives to Hospital Services

The redesign of these services will be explored in more detail by the practice as part of Stage 2

Information and Monitoring requirements by PCT and Practice / Consortium:

- i) *The PCT will provide the practice / consortium with the information detailed in paragraph 12 of the TPBC DES;*
- ii) *The Practice / Consortium will advise the PCT on progress towards the agreed objectives on a quarterly basis. If extra support is required to achieve the objectives the practice /consortium will inform and discuss with the PCT;*
- iii) *Peer-review within the practice /consortium will take place on an informal basis as and when necessary.*



Arrangements for Payment of DES:

- i) Component 1: Upon agreement of this plan payment of component 1 will be made to the [each] of the practice(s) of 95p per registered patient based on the practice list size as at 1st April 2006.**

- ii) Component 2: The arrangements for payment of component 2 will apply to the practice / each of the practices within the plan. Achievement against the agreed objectives will be measured on an individual practice basis. Where this is a joint plan and one of the practices does not meet the objectives, this will not effect the other practices' entitlement to payment of component 2 where they have achieved the objectives. *The payment scenarios are detailed below. In summary practices will receive 95p per patient if they achieve the objectives detailed in the plan irrespective of the level of FURs. In addition 70% of any remaining FURs will be available to the practice/consortium for reinvestment in patient services.***
 - o On achievement of objectives but where there are no freed up resources from the indicative budget, practices will be paid 95p per registered patient on the practice list size as at 1st April 2007.**

 - o Where practice activity results in freed up resources and these are less than the equivalent of component 2 and the practice has achieved its objectives the difference will be met by the PCT.**

 - o Where practice activity results in freed up resources and these are less than the equivalent of component 2 but the practice has not achieved its objectives, the practice will be able to retain control of the use of this resource.**

 - o Where practice activity results in freed up resources and these are equal or equivalent of component 2, whether or not the practice has achieved its objectives, the practice will be able to retain control of the use of this resource.**

 - o Where practice activity results in freed up resources and these exceed the value of component 2, the equivalent of component 2 will be retained by the practice as a minimum. 70% of freed up resource in excess of component 2 will be retained by the practice either to go towards practice activity to ensure continuing achievement against the plan objectives or for reinvestment in services for the benefit of patients locally. The PCT will retain the remaining 30%.**

 - o Payment of component 2 and, where applicable, freed up resources will be made where possible by the end of April 2007 but no later than June 2007.**

Arbitration:

In the event of any subsequent disagreement between the practice / consortium and the PCT, the Strategic Health Authority will be requested to appoint a group to oversee and rule on the disagreement.

Signature:
(Practice Lead)

Signature:
(PCT Representative)



Enhanced Commissioning
Activity Plan (Stage 2 Involvement)

Practice Name:

Practice lead for PBC:

Contact details:

Details, if applicable, of other practices within the consortia

Where practices are re-designing or re-providing services as a consortia, details of the inter-practice agreement in place

Brief scope of services to be re-designed and how these services will be provided in the future (including whether single practice or consortia) – full details will be cross checked with Business Plans

Estimate of the value of resources freed up through re-design or re-provision of services – not definitive and in year variations welcomed. Individual business cases will need to define this more fully.

Early indication of how these freed up resources will be redirected – full details in business plans



Indication of how patients and users will be involved in re-designing services

Indication of how other professionals and stakeholders (including providers) will be involved in re-designing services

Indication of how the impact on other services will be considered in the re-design or re-provision of services

PCT should offer bullet point options of how this can be done to be ticked

We agree to measure progress, as per individual Business plans, with the PCT

In 2006/7 the amount of freed up resources that may be redirected by the practice/consortium is 70%

Signature:

.....
(Practice Lead)

Signature:

.....
(PCT Representative)



SAMPLE STATEMENT OF INTENT BETWEEN PRACTICES

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

1. SHARED PHILOSOPHY

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

We wish to build on the existing strengths of primary care in this area namely:

- quality of services and staff
- local relationship with local people
- convenience of access for patients
- strong IT infrastructure
- premises
- reputation

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

2. PRELIMINARY OBJECTIVES FOR THE POTENTIAL PBC CONSORTIUM

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

3. PRACTICAL & OPERATIONAL ISSUES

- Each practice is to designate a clinical and a management lead to liaise and meet with the consortium as required.
- An elected or appointed consortium lead will chair consortium meetings, attend PCT PBC project meetings [specify frequency], liaise with neighbouring consortia and report back to the consortium as appropriate.



- Cluster practices do not necessarily need to form a contiguous geographical area.
- Decisions on the operation of the consortium will be made on a majority vote

4. COMMITMENT

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

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

5. TIMEFRAME

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

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

Signed

Date



LEGAL STRUCTURES FOR PBC CONSORTIA

It is important for practices working together in a PBC consortium to have sound governance arrangements which are defined, at the very least, in a written agreement. Consortium working arrangements may need however to be defined further – principally for reasons of liability – through the built-in governance arrangements of a legal structure. A paper has been drawn up by the GPC that covers the most appropriate legal structures under which Consortia may wish to operate. Practices/Consortia will need to decide whether or not to work under such a legal structure .

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

The structures covered in detail in the paper are

- Company Limited by Guarantee
- Company Limited by Shares
- Limited Liability Partnerships

Practices need to decide which of the options is the most suitable depending on the aims and needs of the Consortium. The LMCs would suggest that practices consider, initially at least, opting for the status of Company Limited by Guarantee. The full paper, Practice Based Commissioning - Consortium Working can be accessed via the LMC website: <http://www.essexlmc.org.uk>

A brief summary of the three structures is detailed below:

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

KEY CHARACTERISTICS:

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

PRO'S AND CON'S

Pro's	Con's
<ul style="list-style-type: none"> • Minimises the risk and of liability of members 	<ul style="list-style-type: none"> • Not appropriate for a profit making business
<ul style="list-style-type: none"> • All the usual benefits of a company over a trust can hold property, borrow money and make contractual arrangements in its own name and trade in perpetuity 	
<ul style="list-style-type: none"> • Has formal democratic control of its members enshrined in its articles 	
<ul style="list-style-type: none"> • It is easy to set up a subsidiary company to hold capital and conduct non-charitable trading 	



2 A COMPANY LIMITED BY SHARES

KEY CHARACTERISTICS

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

There are two types of company limited by shares, a private company and a public company.

PRO'S AND CON'S

Limited Company

PRO'S	CONS
• Flexible	• Limited borrowing potential
• Easy to set up	• Must be floated by members own capital (or their debt)
• Protects members personal wealth	
• Table A articles need not be registered	
• Sole directorship	

Public Limited Companies

PRO'S	CONS
• Borrowing / capital raising potential	• Tighter regulations
• Can advertise publicly to attract investment	• Increased transparency
	• Volatile
	• Minimum share capital requirements
	• Minimum of 2 directors

3 LIMITED LIABILITY PARTNERSHIPS

KEY CHARACTERISTICS

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

Pro's	Con's
• Limited liability	• Reporting requirements including annual returns
• Flexibility	• Need for an agreement no easy or default option as with the Companies Act tables
	• Legal uncertainty – this is a developing area of law with many untested issues