Londonwide LMCs

The professional voice of London general practice

Collaborative Provider Models:

A Handbook for General Practice

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Introduction

Provider development is our first key priority in which we analyse alternative ways in which GPs can work together to deliver patient care in an increasingly challenging environment by reviewing proposed collaborative models. This is in order to equip GPs with information about alternative forms of collaborative provider models to meet the challenges we have outlined in 'Meeting the Challenge' particularly the development of sustainable collaborative provider arrangements.

Achieving transformational change in the way general practice is delivered must be focused on the needs of patients. It must encompass and build on the strengths of primary care particularly the holistic and continuous care approach focused on patient outcomes and personalised care. To address this, practices all over England (with some examples in London) are grouping together using various arrangements, in order to maximise their quality and efficiency.

Collaborative Provider Models

Over the last year much has been published on collaborative provider models and the different options. We have reviewed the literature on these proposed collaborative provider models. There is no one size fits all. We set out our review findings in appendix one and comment on the aspects of the models which GP practices need to contemplate when considering collaborative working with other GP practices or health care providers.

We have identified that these models broadly fit into three key forms (see appendix one):

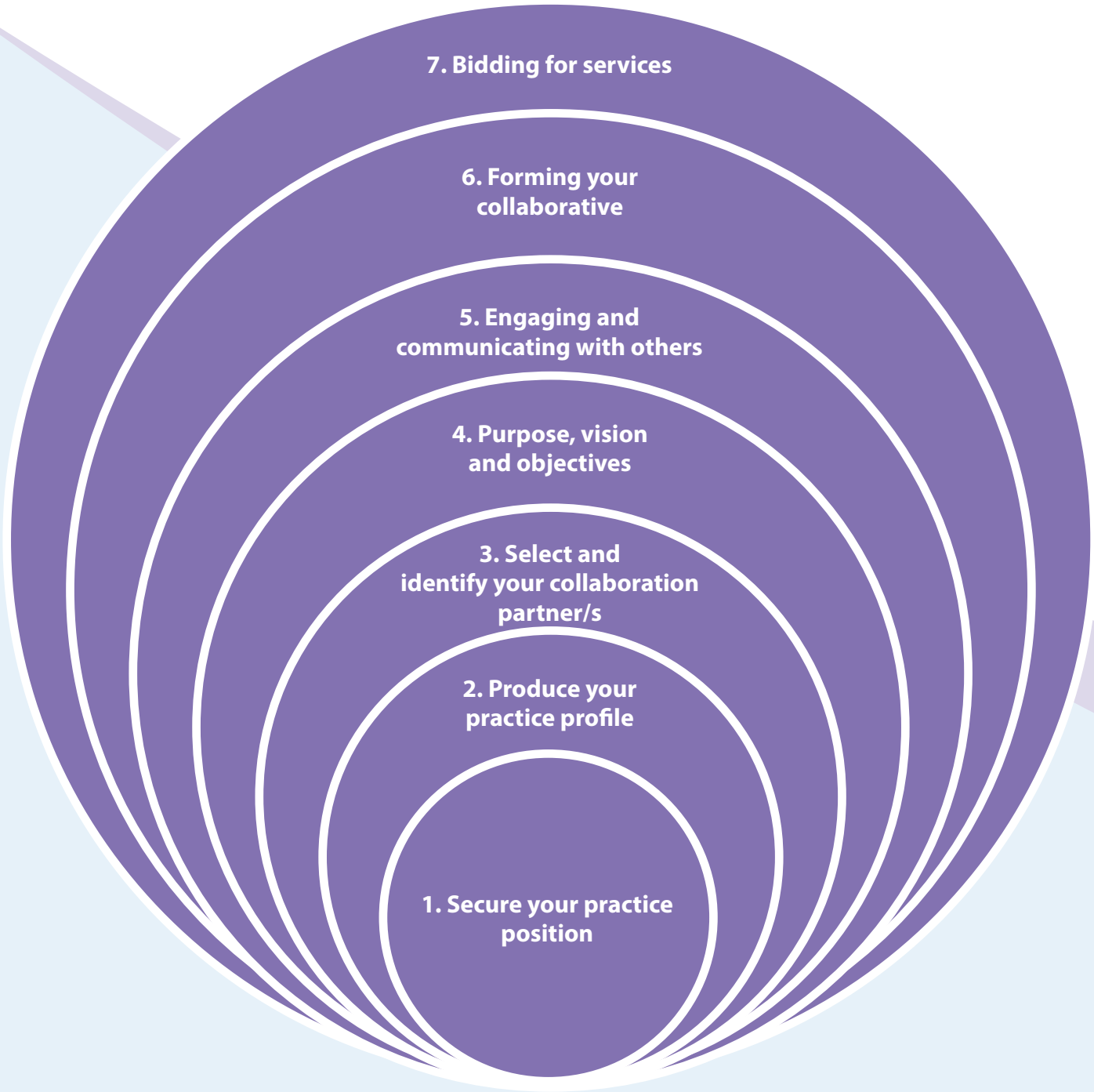
1. Collaboratives (loose eg networks/alliances; structured eg cooperatives/federations/social enterprises)
2. Super-Partnerships
3. Integrated Organisations

Form	Collaborative	Super-Partnership	Integrated Organisation
Suggested Models	Alliances GP Cooperatives Networks Federations	Partnership mergers	Regional and national multi-practice organisations Integrated Practice Units
Key Benefits	Retains local knowledge and existing patient-doctor relationship Flexible arrangements between practices	Retains local satellite practice Economies of scale	Retains local satellite practice Economies of scale
Key Disadvantages	Limited to specifc services Loss of local accountability	Risk to continuity for patients Requires clinical and financial investment	Risk to continuity for patients Requires clinical, managerial and financial investment

Further information about the formal corporate structures that could support these forms are outlined and explored in appendix three.

We have developed a seven step process (see 2.1) that practices should use when considering the above three forms of collaborative working:

1. Secure your practice position
2. Produce your practice profile
3. Select and identify your collaboration partner/s
4. Purpose, vision and objectives
5. Engaging and communicating with others
6. Forming your collaborative
7. Bidding for services



Collaborative Provider Model Steps

1. Secure your Practice Position

The practice's core contract for the provision of primary medical services (GMS, PMS, APMS) is completely separate from any contract or arrangements that are in place or in development to provide extended, enhanced or additional services. Therefore, it is important that the practice does not conflate its individual practice contract with any of the contractual developments and agreements that are made when working with collaborative partners.

2. Produce your Practice Profile

Key to the success of working with collaborative partners across organisational boundaries is to have a clear practice profile before you start to negotiate any form of joint working. The practice profile is important in informing how practices can collaborate effectively, efficiently and economically in order to achieve the aims and objectives defined from a vision and strategic direction when working with others in order to meet patient and practice population need. Core functions and priorities, with a detailed understanding of the profile for any collaborative group will inform how resources can be deployed, and inform the organisational structures and processes.

The detailed information should be easily accessible to form a practice profile. A suggested list of areas in producing a practice profile is listed below. It is not expected that practices work their way through the entire list. These are areas that practices may consider when contemplating what would be important for their practice in working with others.

Practice population

- Age/sex register
- Birth rate
- Ethnicity
- Disability registers
- Death rates for heart disease, cancers, COPD
- Disease registers for long term conditions
- Immunisation rates
- Hospital SUS data

Practice management

- Opening times
- Clinical sessions
- Policies - HR, Data sharing, Child protection
- Age profile of workforce, succession planning
- Skills/interests
- IT systems

Practice premises

- Premises survey outcomes and ratings
- Clinical space
- CQC requirements

User information

- GP survey outcomes
- Patient Participation Group feedback
- Patient referrals
- Use of health facilities

Supportive information and data resource

- Public Health - comparative health data
- Disease prevalence
- Disease projections
- Birth rates
- Death rates
- Local Authority- population data and projections
- Disability registers
- Housing
- Education
- Regeneration proposals

3. Select and identify your collaboration partner/s

It may be useful if potential collaborative partners agree a standard set of information to collect and share through a two stage process:

1. Understanding your practice
2. Developing understanding amongst your partners

The practice profile will help to identify collaboration partners/stakeholders that have a similar vision and values and where you can work together in delivering services to patients.

4. Purpose, Vision and Objectives

a) Purpose, Vision and Objectives

It is absolutely essential that all practices within a collaborative grouping develop a clear vision that will form the basis of any agreement. The vision needs to set out the principles, values, purpose, aims and desired outcomes for any alliance either formal or informal. It is crucial that the values are aligned with all collaboration partners to ensure effective working.

It is useful when coming together as a group that the service objectives are defined including what is to be achieved along with the management of implementation. It may be that there is a range of possible service objectives that require negotiation as part of the establishment for the possible benefits of collaboration. A first step would be for practices to share some of their strengths and challenges to identify where collaboration would provide added value.

Being explicit about the outcomes for the service along with interim markers of success are also helpful (Bardsley et al., 2013). Included within this must be mechanisms for undertaking an evaluation of the services provided, as part of the collaborative provider model, in order to assess whether the desired outcomes have been achieved (Bardsley et al., 2013).

b) Profile of services and resources

Considering equity for the population and the context of the local collaborative provider model along with working out what you already have is very important (Bardsley et al., 2013). The group profile will continuously develop to reflect the changing local needs of the population and the services, as they evolve, to meet those needs.

The foundation of the collaborative group profile will be an amalgamation of all the practice profiles. Collating robust baseline data as part of an overall profile for all the collaboration partners involved is essential. This should include a description of the current infrastructure of services, staffing, and premises available which will also inform areas of expertise and gaps for the group of providers. It is important that plans are based on an agreed statement of current and future resource requirements, and that key gaps and issues are identified at an early stage.

The information data set could also include wider information available within the health and social care stakeholder community as outlined in step two. The amalgamation of the information will demonstrate the range and depth of current resources and highlight any gaps for example: workforce ie clinical and managerial expertise or from the estate ie under used capacity within premises that could immediately facilitate the delivery of additional services.

You will need to plan for a sustained investment in providing staff and contractors with the skills needed to innovate, and supporting them when they do (Goodwin et al., 2013; Timmins and Ham, 2013). It is our intention to support you to have the relevant resources directed to your practice and collaboration partners.

c) Business plan

As part of this vision and strategy it is imperative that a business plan for the group is developed that will plan the future work of the collaborative group (Rosen and Parker, 2013). There are many template business plans available but it is suggested that you consider including the following areas:

- Vision and mission statement
- Aims of the collaborative group
- Context and environment
- Outcomes and benefits
- Finance and resources
- Delivery
- Risks
- Structure/arrangements for the collaborative group
- Marketing and communications
- Reporting and monitoring
- Review and evaluation

5. Engaging and communicating with others

One of the key opportunities for practices working as a collaborative provider group is the scope and potential to develop and deliver services in partnership with a wide range of professionals and support staff, which will enable practices to address current NHS agendas such as integrated care. The collaborative provider group may cover a large population base with services provided by a diverse workforce that will span many organisations, including community service providers, local authorities, private and voluntary organisations. It is vital that existing partnerships are built on whilst establishing new links within the wider primary care workforce to support the redesign of care.

The following list includes local stakeholders that could be engaged by the group:

- Patients and Healthwatch
- Clinical Commissioning Groups
- Local Authority/Social Care
- Third Sector providers, local sub sector organisations, including carers organisations
- Public Health (part of the Local Authority)
- Community Service Providers, District Nurses, Health Visitors
- Acute Sector
- Mental Health Trust
- Other primary care providers e.g. pharmacies, dentists, optometry
- Health education bodies

In summary, by engaging and collaborating within an extended healthcare setting the collaborative provider group can:

- Access a wider range of skills and expertise within the workforce to best meet the patients' needs as new services are provided, and care pathways redesigned
- Access larger capacity, through economies of scale, to support bids to provide integrated health care across the local population
- Provide opportunities to employ shared staff with other organisations for example, Clinical Nurse Specialists
- Access information that will support the holistic approach to the health and wellbeing of patients in order to support the services delivered across the group
- Enable access to premises both clinical and non-clinical eg Local Authority owned premises that provide services to a wide population base
- Opportunities for training and development of staff across a multidisciplinary team within the wider area eg clinical staff and managerial staff across organisations

At the outset of development it is vital to ensure that patients and users are involved and engaged in service development and should be a core principle in collaborative working between providers. Patient and public engagement and involvement should be actively encouraged and will inform and enhance service improvement and development. Patients and the inclusion of lay membership in the development and structure of collaborative provider groups will be key to the assurance of the governance for the organisation.

It is important to ascertain the level of patient and public involvement that is already established within the provider group area. This information will be available as part of the profile and will include practice patient groups and expert patient groups. The local authority user groups that have a health focus, voluntary organisations (for example Age UK) and the statutory organisation that represents the public, Healthwatch, are all crucial in bringing expertise to strengthen the engagement with patients and service users in engaging with the public.

6. Forming your collaborative

There is no single legal model for a collaboration of practices and other providers. These can range from a loose alliance of practices to a highly managed single corporate entity. "Developing service models to integrate care for patients does not necessarily mean developing integrated organisations" (Bardsley et al., 2013). The key thing is the need to agree a collective vision and values to enable the process to run quickly, efficiently and cost effectively. The vision should be documented as a basis for moving forward.

Practices are not required to change core contract arrangements as part of any approach to collaborative working and you should consider carefully the long term implications of any suggestion that individual practices should do so.

If opting for a collaborative form the autonomy and 'commercial' independence of individual GP practices can be maintained whilst at the same time encouraging service integration, shared values/single culture, efficiency and economies of scale.

It is essential that appropriate management is identified for the collaborative provider group. This could be by filling management gaps identified in the profile by appointing appropriate management consultants/support or by using existing expertise in the local system. Without this support it is unlikely that the collaborative provider group will succeed as the setting up of the collaborative provider group will require expertise in workforce management, accountancy, legal issues and project management. It is important that the collaborative provider group is set up with an agreed vision and within a framework as a GP provider unit. Lead personnel in each practice should be identified to ensure that all member practices are represented for robust communication between practices. Initial and on-going costs and budgets/funding for management shares should be agreed at the beginning.

Ways of working together should be clearly identified and agreed from the outset. Function and purpose will define the size, legal framework and processes for a larger range of services and/or services for larger groups of patients. Although provision of a larger range, and/or services for larger groups of patients may require a larger organisation with more complicated decision-making and risk-sharing arrangements, there are a number of important principles that will apply to collaborative provider groups.

Ways of working together should include systems and processes that support:

- Focus on purpose and outcomes
- Promoting and supporting agreed values and behaviour
- Supporting informed, appropriate and transparent decision-making, including identifying, managing and mitigating against risks
- Developing and supporting skills, capability and capacity within the organisation
- Engaging and communicating with patients and key stakeholders
- Financial balance

It is important to note, in healthcare, that innovations and new ways of working in care are given considerable time to "bed in" as organisational models before objectives can be achieved (Goodwin et al., 2013).

7. Bidding for services

To successfully bid and win contracts consideration needs to be given to:

» Networking and partnering with other organisations that will save on costs and resources as well as demonstrate the ability to work with others in order to improve quality of care to patients

» Checking the Supply2Health website (https://www.supply2health.nhs.uk/default.aspx) on a regular basis for vacancies or invitations to tender

» Remembering that competitive bidding is likely

» The cost of putting a bid together including resources, workforce skills and knowledge

» Know what goes into a good bid – low price is an attractive element but if you can demonstrate that you have delivered this service well then past performance is likely to be taken seriously

» Cost effectiveness and viability of providing the service

» Cover your costs while remaining competitive

» Demonstrate your ability to deliver the core service specification

» Timing and length of contract

» Penalties/get out clauses

» Understand the bidding process (see section on process for procurement and tendering for services)

» Consider the risks fully for providing or not providing the service

The procurement processes open to commissioners are outlined below:

Single Model: Some legal considerations

Where a single provider can supply the services, a commissioner may, in exceptional circumstances award a contract to that provider without going through a full procurement process.

Similarly, where a service is already being provided by a single provider then, if the provider is performing to a required standard, there may be a justifiable reason to keep the contract with that provider.

In reaching a decision to retain a single provider, the CCG must ask itself a number of questions. For example: Can the service be improved? Can the quality be improved? Is the service value for money? A full report would need to be compiled (which would then need to be discussed and minuted at CCG board level). If there is another provider who could improve the current service then the CCG would be strongly advised go out to full tender.

Please note that when bidding for any contract via any of the above models, the provider must at all times ensure that it holds appropriate CQC registration in respect of the services to be provided.

Competitive Procurement

This is where the commissioner puts a contract out to tender, where the value of the contract is greater than £111,676 (from 1 January 2014) and the commissioner receives a number of bids from different companies. This could include large private healthcare companies or small GP-led provider arm companies.

In submitting a tender, due care must be afforded to the documentation. Even though there will be a willingness to appear more capable, popular, cheaper, etc than competitors, it is imperative to ensure that all calculations, statistics and projections promised are not only attractive to a commissioner BUT are also manageable and realistic.

Process for procurment and tendering for services:

Stage One

- The process starts with the advertisement which should contain enough information to enable a prospective bidder to decide whether or not they are interested
- Expression of Interest - potential bidders are usually provided with a template of the Expression of Interest document to fill in when they wish to participate in the process
- Pre-Qualification Questionnaire (PQQ) - this consists of a series of questions for the bidders to answer. It also contains guidelines on how to answer the questionnaire along with more information on the tender
- Bidder day - there may be more than one day allocated and there may also be a series of speakers that address potential bidders. This offers the opportunity for bidders to be able to ask questions in respect of the bid

Stage Two

- Invitation to tender (ITT) - those shortlisted after submission of the documentation may be asked to submit an ITT. Detailed instructions will be submitted with this to enable bidders to respond as accurately as possible. The ITT is usually a standard document which ensures consistency in responses to enable easy evaluation
- Presentation - once submitted, invitations may be sent to those shortlisted to give a presentation
- Preparation and planning is essential to success

Stage Three

- Contract award - the successful tenderer will be informed and the contract will be awarded. Unsuccessful bidders will also be informed and there are procedures where feedback and reasons for rejection can be given
- Contract signing and commencement - there is a lapse of 10 days between the award and the signing of the contract to give unsuccessful tenderers the chance to be able to challenge the award on a number of grounds, eg fairness.

Any Qualified Provider (AQP)

Under the AQP model, a provider is accredited (for a maximum of 3 years) if it can demonstrate the required levels of quality and governance to the commissioner. Hence, multiple providers can be accredited for each service.

Providers whose bids are accepted are likely to be those who can provide high quality services and attract patient referrals. The prices offered for the service by the CCG are set, and are not subject to negotiation. Also, volumes are not guaranteed, so potential providers must assess the commercial viability of being able to provide an AQP service at the prices set. This however provides real opportunities for organisations who can build relationships with referring GPs and other stakeholders.

When submitting a bid to become an AQP, a new provider, in order to fulfil the tendering requirements, may make arrangements with other providers for the use of premises, staff, equipment, etc. There is nothing to preclude a provider from entering into such separate arrangements as long as this has been made explicit in the tender documentation.

Further information can be accessed here: https://www.supply2health.nhs.uk/AQPResourceCentre/Pages/AQPHome.aspx.

Sub Contract

The CCG must be made aware of any intention to sub contract all or parts of the service. The tendering documentation needs to make this expressly clear and obviously the sub-contracting party must be able to demonstrate that they will be able to perform the service, including holding CQC registration.

It is necessary to have robust documentation between the primary contractor and the subcontractor. This needs to set out what the key elements of the service are and the standards to be adhered to and how issues are resolved in a timely and efficient manner (eg via a dispute resolution process).

In the event that the primary contactor sub-contracts the contract, this does not absolve them from liability in the event of a breach. In this respect, the primary contractor should consider whether a claim would be included under their insurance policy and insert an appropriate indemnity into the sub-contract.

Appendices

Appendix One: Analysis of evidence on collaborative models

Form	Key Feature	Benefits	Disadvantages	Authors	Models	Examples
Collaboratives	A collaborative alliance between multiple health care providers, often GP practices, either through informal linkages or formal legal contracts in order to develop and provide patient services on a wider scale in the community.	**Patient Benefits** • Could improve the quality of one or more patient services • Could create better patient access • Retains the existing patient-doctor relationship • Retains existing local knowledge and understanding of patient need • Could lead to better access to consultations provided in different sites • A wider range of tailored services • Existing local knowledge of clinical staff and understanding of patient need retained • Could lead to faster treatment and better outcomes **Organisational Benefits** • Could lead to cost savings for sharing of staff • Flexible arrangements between practices • Costs of premises could be shared • Close proximity of providers in a geographical area allows for easier and simple alliances to be arranged • Could lead to shared quality frameworks and policies due to shared staff	**Patient Disadvantages** • Limited to specific services • Limited scope of arrangement leads to short life span of available service • Negative impact for patients that may have to travel further • Reduced choice of providers for patients **Organisational Disadvantages** • Joint employment contracts can be difficult and costly to arrange • Contracts with commissioners are likely to be short term • Loss of local accountability • Premises costs can escalate due to landlord changes • Some providers may feel forced into joint ventures that they do not agree with	General Practitioners Committee, 2013; Royal College of General Practitioners, 2013; Smith et al., 2013; Rosen and Parker, 2013	Simple alliances/ joint informal and formal joint ventures GP Cooperatives Joint Premises Networks Federations	Midlands Health Network, New Zealand Canterbury, New Zealand Tower Hamlets, UK BADGER Group, UK Suffolk GP Federation Independent Practice Associations, New Zealand

Super-Partnerships	Large scale single GP partnership model that can operate from multiple geographic locations and that is often created through list growth and formal partnership mergers.	**Patient Benefits** • A wider range of services available • Enables a more comprehensive range of services to be available • Could lead to improved coordination of care for patients • Retains local satellite practice that ensures geographic accessibility • Could lead to faster treatment and better outcomes **Organisational Benefits** • Merging parties do not have to have equal viability • Significant benefits through economies of scale • Enables rationalisation of quality frameworks and policies • Career development opportunities may be clearer and more available for practice staff • Could lead to enhanced peer review and clinical governance	**Patient Disadvantages** • Risk of losing connections and continuity for patients • Reduced choice of providers for patients **Organisational Disadvantages** • Loss of local accountability • Culture and vision change required • Need to ensure good and right communication processes in place • Requires clinical and financial investment • May require property and estates support • Legal, accountancy, financial management and HR support required	General Practitioners Committee, 2013; Smith et al., 2013; Rosen and Parker, 2013	Partnership Mergers Super-partnership	The Vitality Partnership, UK Dr HM Freeman and Partners, UK Midlands Medical Partnership, UK
Integrated Organisations	Offers an extended range of local services through managing multiple dispersed practices. There is often a small ratio of executive partners in comparison to employed clinicians. Akin to some of the physician group models in the US. There is often co-location of care in some dedicated facilities. .	**Patient Benefits** • System could be less fragmented and more coordinated • Could lead to faster treatment and better outcomes • Retains local practice location that enables accessibility for patients • Extended range of specialist and community services **Organisational Benefits** • Lower costs particularly through economies of scale in resources • Could lead to secure financial viability • Standardisation of clinical and management practices • Increased opportunities for career development, education and training for practice staff	**Patient Disadvantages** • Risk of losing connections and continuity for patients **Organisational Disadvantages** • Does not have the same influence within a federation that covers an entire geographical area • Loss of local accountability • The integrated practice unit model is based on a system whereby healthcare is not generally paid for by the state in the US. It is also based on value based healthcare that requires transformation in the way in which healthcare delivery is organised, measured and reimbursed	Porter and Lee, 2013; Smith et al., 2013; Rosen and Parker 2013	Regional and national multi-practice organisations Integrated Practice Units	Cleveland Clinic, US Schon Klinik, Germany Geisinger Health System, US Kaiser Permanente, US Hurley Group, UK The Practice, UK AT Medics, UK

Appendix Two: Self-assessment collaborative working checklist

The following checklist is a guide for practices to check progress and achievement working towards collaborative working.

	Action Required	Achieved/Progress Update	Outcome
1	Does your individual practice contract remain separate from any arrangements, developments and agreements with your collaboration partners? Repeat this action after completion of item 10.	*Enter status or progress to date*	Secures your practice position
2	Have you completed a population profile relevant to your practice and any considered collaborative grouping?	*Enter status or progress to date*	Develops an understanding and awareness of who appropriate partners might be to work collaboratively with
3	Have you identified your collaboration partners?	*Enter status or progress to date*	Identifies appropriate collaboration partners based on a practice profile
4	Have you developed an agreed purpose and vision with your collaboration partners?	*Enter status or progress to date*	Ensures effective working together as part of a collaborative provider
5	Have you completed a collaborative group profile?	*Enter status or progress to date*	Develops an understanding of expertise as well as potential gaps
6	Has a business plan been developed and agreed?	*Enter status or progress to date*	Plans for the future work of the collaborative group
7	Have you and your collaboration partners engaged with all relevant stakeholders?	*Enter status or progress to date*	Potential to develop and deliver services in partnership with a wide range of professionals and support staff, which will enable practices to address current challenges
8	Do you have a communication plan for within the collaboration group and for communicating with other stakeholders?	*Enter status or progress to date*	Enables robust communication between all collaboration partners and stakeholders to ensure more successful collaborative working
9	Have you and your collaboration partners considered all the options and arrangements for forming your collaborative?	*Enter status or progress to date*	Enables the collaborative provider group to succeed with appropriate expertise, skills, functions and form
10	Do you and your collaboration partners understand how best to bid for services?	*Enter status or progress to date*	Aware of competitive environment so can be better prepared for potentially successful bids

Appendix Three: Corporate Structures

For any of the different legal forms chosen, the corporate and commercial independence of individual GP practices can be maintained whilst at the same time encouraging service integration, shared values/single culture, efficiency and economies of scale.

Information Options on different corporate structures:

Corporate Structure	Positive aspects	Negative Aspects
Company Limited by Shares	The liability of the shareholders is limited to the amount unpaid on their shares; however it is more common for the full amount to be paid when the shares are originally purchased.	Companies Act 2006 compliance – disclosure and filing requirements and directors duties.
	A very flexible, straightforward and popular model for business allowing for the articles of association to suit the shareholders.	
	For profit driven enterprises as the allocation of profits through dividends is permitted.	
	Currently, income derived from work undertaken under GMS/PMS contracts may be recognised as being pensionable by the NHS Pensions Agency, but not other CCG-commissioned work. Note that pensions rules are currently under review and specific, up-to-date advice should always be sought.	
Company Limited by Guarantee	The liability of the members of a company limited by guarantee is limited to the amount stipulated in the articles (usually one pound sterling).	Due to the absence of a dividend payable to members, this kind of model may be less attractive for investors.
	The guarantee only comes into effect at the winding up of the company in order to satisfy any liabilities that the company has at the time of winding up.	
Limited Liability Partnerships (LLP)	The liability of the members of the partnership is limited and they are not held personally responsible for the partnership liabilities (except in limited circumstances).	Complicated and costly to set up and run.
	Organisationally flexible as it has the capabilities of a partnership to decide how to share profits, the management, how to accept new members and how to cease being a member (by virtue of an LLP Agreement).	A partner continues to bind the LLP for such time until they are formally removed from the register.
		Specifically designed for large law firms and accountants with worldwide offices.
		Not currently permissible for GMS/PMS practices to form LLPs.
Community Interest Company (CIC) /Social Enterprise	Can be set up as either a company limited by shares or a company limited by guarantee. Receives public recognition more so than other corporate vehicles.	Not appropriate for any enterprise with profit for shareholders or owners as a goal as dividends are capped. Must be strictly not for profit, but can generate a surplus. The sum not destined for a (capped) dividend may be reinvested in the company.
	A defining feature of a CIC is that dividends are capped and profits that the entity makes must be reinvested into the provision of the service concerned. Emphasis on the community provision is further protected by an asset lock to prevent the assets being sold for the benefit of the shareholders at the expense of the community.	The resulting entity has to compete with all other groups going for the same tender, including companies with profit purposes.
		The restrictive nature of this vehicle means the original objective cannot be deviated from.
Traditional Partnerships under the Partnership Act 1890 (This has been included as an option, but to ensure that your core GMS/PMS work is protected, BMA Law's advice is to proceed with a separate limited liability corporate vehicle for any bidding/tendering work)	Subject to limited statutory regulation.	Partners are jointly and severally liable for their own and each other's actions.
	Flexibility.	

Additional requirements

Our suggestion is that the most suitable vehicle is a company limited by shares but you may find that other structures suit your needs.

Once a new company is up and running, has registered with Companies House and has appointed directors, there are still some practical aspects that need to be addressed, including:

- You must have a plaque outside your registered office
- Filing requirements – appointment and resignation of current and future directors and filing of annual return
- Filing accounts and changing the accounting reference date
- Bank accounts and signatories
- Disclaimers on websites/email – there is a necessity to further ring fence the liability of the new entity by including a specific disclaimer on all emails and websites

It is strongly advised that you seek independent legal advice. In addition to incorporating as a company, many shareholders may want to have their rights further enshrined and protected within a Shareholders' Agreement.

It is advisable that you also seek assistance from an accountant on all financial and tax implications.

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