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New GP Contract: 6 top tips to changing your partnership agreement

Introduction

With 1 April 2004 fast-approaching, it is vital that those practices without a partnership agreement enter into one as soon as possible. It makes no sense whatsoever to rely on the "gentleman's agreement" that you have because the PCO contract obligations are too onerous. If your solicitor does not have a thorough knowledge of the 2004 regulations, the new SFE, the PCO contract and the published guidance on both GMS2 and PMS then look for a specialist solicitor to assist you. Definitely don't fall into the trap of tinkering with the agreement yourself.

Is your existing agreement valid?

If you have an agreement, you may be blissfully unaware that the document is no longer valid. If your agreement has not been updated since 1997, then you almost certainly need a new one! If you have introduced at least one new partner without formally updating your agreement then it is no longer valid. This means you are practising as a partnership-at-will which is the most unstable business relationship that exists.

Practice Insurance

Since the new GP contract is entered into with the practice, it will force all practices to consider taking out comprehensive practice insurance as a "top-up" insurance to each individual doctor's clinical cover. This will especially be the case if you have admitted a non-clinical partner or you are thinking of doing so. Whilst doctors currently secure 100% indemnity insurance in respect of clinical claims, non-clinical partners will not be covered. See my article in the January 2004 issue of Medeconomics on this topic. Who pays the medical defence subscriptions? If each doctor pays his/her medical defence organisation fees, then it would be wise to consider funding the subscriptions from the practice account in the first instance. You can always deduct the cost from the income profits of each Partner but at least you know that the fees are paid and the insurance is in place. Also, think about holding the benefit of any insurance proceeds as part of the partnership capital so that they can be applied directly towards the practice.

Declaration of Trust

If some partners own the surgery but others have no share in it at all (be it leasehold or freehold) you would be well-advised to remove the property from the partnership agreement altogether. Clearly there are tax consequences associated with this, which you need to discuss with your accountant but from a legal point of view, this is certainly the safest route. Why? Because if your partnership agreement lapses for any reason then the clauses regarding the property also cease to be binding. Why risk this happening? Since the surgery is likely to be the partnership's most valuable asset (aside from any dispensing rights you may have and wish to sell to an approaching chain!), you do not want to be in a position where a non-owning partner can assert rights to the property when he/she never formally bought in. The property-owning partners can then consider whether to enter into a lease or a less formal licence with non-property owning partners. Whatever, you do, don't let a non property-owning partner practice from the surgery or branch surgery without any

formal documentation. After as little as six months such a partner could claim a right to remain in the surgery even if you wish to terminate your partnership with him/her.

Phased quality payments
How are you going to deal with quality monies that are paid to the practice after a partner has retired? I am firmly of the view that a standard apportionment under GMS1 principles simply will not stand. What about the IT partner who steers the practice through the use of the read codes and without whom the achievement of the quality standards and payments would not be possible. Why should such a partner be denied his share of the quality income just because he/she had to retire from the practice earlier than expected on the grounds of ill-health? The partnership agreement needs to include a valuation mechanism for dealing with such circumstances. I recently acted for a partner who was denied his share of the practice preparation money on the grounds that he had not been pulling his weight and assisting in the quality preparation work. Unfortunately there was no partnership agreement so make sure you have a clear valuation mechanism set down in your partnership agreement.

Decision-making
In partnerships of two, both partners take all decisions. No one partner should be able to take decisions unilaterally without the authority of the other partner. If your practice still recognises one 'senior' partner as having a casting vote, this 'inequality' between the partners could be construed as a sale of goodwill and the prohibition on sales of NHS goodwill in the NHS Act 1977 are repeated in the draft 2004 regulations.

Practices with three or more partners generally take managerial 'day-to-day' decisions by way of a majority vote and decisions on matters of policy by way of a unanimous vote. In view of the new GP contract, the policy decisions need to be reviewed. I would recommend that all the partners should agree the following decisions:

- Provision of enhanced services
- Opting into health service body status
- Signature of the PCO contract
- Opting out of out-of-hours cover
- Opting into PMS
- Opting back into GMS2 if you are PMS

Voluntary or Compulsory retirement
If a partner leaves the practice of his own volition or he/she is expelled, the requirement to give notice in the partnership agreement must dovetail with the notice provisions in the PCO contract otherwise you risk finding yourself in breach of contract. At the time of writing this article clause 473 of the draft PCO contract contains a very stringent indemnity provision whereby the practice must indemnify the PCO for all losses, including legal expenses incurred by the PCO because of a breach of contract by the practice. The new GP contract requires that practices must give six months notice to the PCO to terminate the PCO contract. Whilst the PCO contract does not terminate if a partner leaves the partnership (because the contract is with the practice and not with any single individual) if the practice is no longer able to provide certain services because of the departure of that partner, there is likely to be a breach of contract. Practices that have no partnership agreement can be terminated without notice by one dissenting partner, which could also put the practice, including the dissenting partner, in breach of contract if the PCO contract services cease to be provided. Practices whose agreements provide that partners can leave by giving three months notice might wish to extend this notice period to six months.

Restrictive Covenants
Restrictive covenants (also known as “restraint of trade” clauses) protect the goodwill of the partnership. From 1 April 2004 there will no longer be personal medical lists because patients are registered with the practice and not with an individual Doctor so restrictive covenants that refer to a partner taking his own medical list must be carefully redrafted to refer to the practice list. PMS practices should amend their agreements likewise. These clauses require bespoke drafting taking into account the location of the practice and the practice area that you have agreed to service with the PCO. The drafting of these clauses is crucial to their enforceability since to be enforceable, they must be reasonable with regard to both (i) their geographical limitation and (ii) their duration. Whilst you may not feel the need to include such restrictive covenants at the moment, it is wise to incorporate them so that you at least have a choice to enforce them in the future.

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PARTNERSHIP AGREEMENT CHANGES

- Partnership Capital – include PCO contract and practice insurance
- Practice insurance – consider group cover since GMS2 contract with PCT is a practice contract rather than individual cover
- Payment of insurance – consider making payment a practice cost that can be charged to each partner’s individual account if necessary rather than an individual cost
- Declaration of Trust for property to protect property-owning partners
- Phased quality payments – how will you apportion achievement income for an outgoing partner who leaves before the payment date?
- Decision-making – consider making certain GMS2 decisions unanimous, eg. OOH, opting into health service body status, enhanced services
- Notice periods to voluntary retire and to expel a partner – do these dovetail with the practice contract with the PCT?
- Restrictive covenants – revisit these to delete references to personal lists. Consider their application in circumstances where a partner resigns due to a difference in practice ethos