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Should your Partnership Agreement be altered in light of GMS2?

Is your partnership agreement up-to-date and does it give you the protection you may need in the event of a partnership dispute? GMS2 has certainly brought into focus the need to have a robust partnership agreement in place so what areas of your agreement do you need to review?

Although the GPC Guidance hopes that every practice (GMS2 and PMS) has an effective partnership agreement in place, the absence of an agreement cannot prevent a PCO awarding a practice a PCO contract. In the absence of a partnership agreement the provisions of the Partnership Act 1890 will apply will all the disadvantages this involves.

Decision-making

GMS2 is all about capitalising on the “skill mix” in your practice but with this comes greater scope for divergence of views on how the practice should be run. Are all your day-to-day decisions passed by a simple majority vote (50%+) and then certain unanimous decisions are specified? Does it still make business sense that one partner can effectively “block” a unanimous decision? Maybe a “special majority vote of 75% or 80% of the partners would better serve your purposes? Should one partner delegated with a certain service also be delegated sole decision-making powers in that area? What about a partner who is ill or on holiday when a decision is placed on the agenda? Can he/she leave a “proxy vote” or will this be used as an excuse not to turn up to practice meetings? Review the following decision-making processes in your partnership agreement:

- Provision of additional and enhanced services
- Contracting out of additional services (on a temporary or permanent basis)
- Opting into health service body status
- Signature of the PCO contract
- Opting out of out-of-hours cover
- Delegation of certain services to other third party providers
- Opting into PMS if you are GMS2
- Opting back into GMS2 if you are PMS
- Opting into or out of health service body status

Partnership Capital

Does your agreement make it clear which assets form partnership property (referred to in your agreement as “partnership capital”) and which assets the individual partners own

personally? If any assets are “off balance sheet”, such as a GP limited company to ring-fence the surgery mortgage, is this clearly documented and do you understand this arrangement? Also, think about holding the benefit of any medical defence insurance proceeds as part of the partnership capital so that the proceeds can be applied directly towards the practice in the event of a claim. On the subject of partnership capital, think about holding the benefit of the PCO contract as partnership capital so that an Outgoing Partner cannot claim any benefit in the PCO contract on his departure.

Practice medical defence insurance

Under GMS2, patients are registered with the practice not with individual Doctors and the PCO enters into a PCO contract with the practice. Have you considered taking out practice insurance to deal with this change in liability? If you have admitted a non-clinical partner or you are thinking of doing so, then you would be wise to explore the all-inclusive practice quotes that are presently on offer from the various medical defence organisations. Whilst doctors currently secure 100% indemnity insurance in respect of clinical claims, non-clinical partners will not be covered.

Payment of medical defence subscriptions

Who pays the medical defence subscriptions? The practice? Or the individual partners? Generally it is better to fund the subscriptions from the practice account in the first instance. You can always deduct the cost from the income profits of each Partner at the year-end but at least you know that the fees are paid and the insurance is in place.

Mechanisms for dealing with under-performing partners

The “old” definitions of full-time partners, three-quarter time partners and half-time partners no longer exist so it is crucial that your partnership agreement sets out the commitment of the partners, perhaps by reference to the number of sessions undertaken each week. Utilising the “skill mix” it is no longer necessary for all partners to be achieving parity within three years as under the Red Book regime which means that partners are not tied to equal profit shares. Should a “star” partner who exceeds all his targets be rewarded with a “bonus? Likewise should an under-performing partner or a partner on long-term sabbatical leave suffer a reduction in his/her drawings? So far, practices appear to be taking the view that the PCO Contract targets are practice targets but how long will this last?

On the subject of under-performing Doctors, are your expulsion clauses up-to-date? Does the Partnership agreement provide for the ability to suspend a partner while the partners explore how best to deal with the situation or prior to the partners exercising their expulsion rights? “Green socks” or “purple hair” clauses provide for an immediate expulsion without the establishment of any grounds, i.e. you don’t like the colour of a partner’s socks/hair! Under GMS1, such clauses were usually only recommended for practices of four or less due to the instability which they can create. With GMS2, perhaps now it is time for all practices, no matter what size, to consider the inclusion of a “purple hair” clause due to the difficulty of “fitting” an under-performing partner precisely into the defined expulsion grounds in the partnership agreement.

Voluntary or Compulsory retirement

The PCO contract requires that practices must give six months notice to the PCO to terminate the PCO contract. Note that a “termination” under GMS2 is treated differently from a “variation” of the PCO contract. The PCO contract does not necessarily terminate if a partner leaves the partnership because the contract is with the practice and not with any

single individual. However, if a group of partners leave together then the practice is unlikely to be able to provide certain services and it will therefore find itself in breach of the PCO contract. Similarly 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. To avoid being sued, ensure your partnership agreement has a clause restricting the number of partners that can retire at any one time, no matter how inflexible this may appear. You can always relax the provision at a later date if appropriate by unanimous agreement. The temporary default provisions that the PCT may impose if a practice splits in this way may not be satisfactory and would undoubtedly result in loss of income for the continuing partners.

Phased quality payments

How are you going to deal with achievement payments that are paid to the practice after a partner has retired? On the “accruals basis” of accounting which I see in most partnership agreements, whereby the achievement payments accrue evenly over the year in which they are earned, an under-performing partner is set to benefit financially if he/she is replaced in the same accounting period by a high-achieving partner whose efforts are largely responsible for, say, exceeding the aspiration goals. Maybe in time the specialist medical accountants will suggest a fairer way of dealing with such apportionments but it is tricky because what if the partner was under-performing through illness? In the meantime, I come back to my suggestion for rewarding such a star partner with a compensatory bonus.

Conclusion

With the advent of GMS2 and practice budgets it is increasingly common for specialist medical solicitors to draft GMS2 and PMS partnership agreements for a fixed price. These legal costs pale into insignificance when compared to the legal costs incurred in a partnership dispute where there is either no partnership agreement at all or the agreement is out-of date. Definitely don't fall into the trap of tinkering with the partnership agreement yourself unless you have specialist knowledge of the GMS2 regulations.

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