HUMBERSIDE LMCs

The professional voice of general practice

Updating Partnership Agreements

Practice Management

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Over the few years there have been substantial changes to the terms and conditions of practices not only in the Regulations/ contracts to General Medical Services (GMS) or, Personal Medical Services (PMS), but also by virtue of the introduction of the Health and Social Care Act and the development of "Federations".

Agreements should now be amended to reflect the significant changes to practice working arrangements. This is to prevent the practice falling into a partnership at will and to prevent or mitigate any disputes.

Contractual changes

The changes to the GMS/PMS contracts which reflect the obligations of practices to cater for patients over the age of 75 and to have a named GP available should be reflected in the agreement. The responsibility will be that of the practice to ensure that internally there are mechanisms in place to ensure that this is satisfied and that the practice has put into place the relevant safeguards in the event that the "named GP" is unavailable.

CQC registration requires a practice representative to ensure that conditions required to be satisfied are in fact in place and that there is an individual that will be responsible for liaising with CQC to ensure that any issues whether outstanding or not are resolved via that person. That individual does not have to be a partner, but if it is, then the agreement should reflect that and place the obligation upon that partner to ensure that he does not place the practice at risk of non-compliance.

The Health and Social Care Act 2012 introduced and created Clinical Commissioning Groups (CCGs) and as a result core contracts were amended to reflect the fact that practices were to be members of CCGs and that each practice would have a representative at CCG meetings. The obligation to have a practice representative and to name that individual should be reflected in any partnership agreement. Furthermore, since any practice representative may well be casting a vote on behalf of his practice at CCG member meetings, somewhere in the agreement there should be a process by which the partnership as a whole agrees how that member will cast a vote on any particular issue and, place an obligation on that representative to not only attend meetings of the CCG when required, but to feedback accurately and regularly any issues in respect of CCG business.

It is likely that the CCG representative may not always be available to attend CCG meetings so the provision of, and process to nominate a proxy is sensible and should be reflected in the agreement. The practice in those circumstances should ensure that the CCG is informed of any proxy beforehand and the nomination of any proxy should be in writing. A copy of any proxy nomination should also be submitted to the CCG before any substitution – although it is likely that provision is made for this in any CCG constitution so practices should check their CCG constitution beforehand and at the very least familiarise itself with the contents.

Federations

This is probably the most important change for GPs and practices emerging out of the changes to the healthcare system. Federations or local network provider organisations are being established in a variety of forms all over the country. The speed at which the organisations are being created and the complexity and size of the structures have somewhat overtaken any thought of how partnership agreements MUST be changed to reflect the practice membership.

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Whether the network organisation is a formal entity or a super-partnership, the success of the structure is dependent on the strength of its members. Its members will be practices in the locality. It makes abundant sense therefore that the structure of practices are strengthened by having a robust partnership agreement that minimises disputes (which places core contracts at risk) and also caters for the relationships and obligations that the practice will now have vis a vis its network provider arm organisation.

If, for example, the provider arm organisation is a company limited by way of shares, then the partnership agreement needs to reflect how the shares are held, who holds them (whether individually or on trust), how dividends are to be distributed and what happens when the practice no longer qualifies to hold shares or wishes to leave the federation.

If shares are held on trust then perhaps the trust deed (which must be in place), should be an appendix to the main agreement.

A network provider organisation is going to rely on its members to deliver under any contracts which the network is successful is acquiring, so practices and federations should be focusing on how to ensure practices are supported and how practices can be strengthened by ensuring that they have taken contractual precautions in ensuring that they are robust internally.

ALL practices should have an up to date partnership agreement in place. Those that do but do not have the above amendments in place can add the required changes by way of an addendum to the main agreement.

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