LMC LAW

BULLETIN 5

Mergers and Caretaking Arrangements

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General Practice has seen an increase in the number of mergers taking place between practices and, also, of NHSE requiring urgent caretaking arrangements put into place where practices are closing down.

The rules and mitigation of risk in both these scenarios are not always understood and it is important that practices who are considering merging know why they are doing this, or have understood the benefits of doing so. Equally, practices who are being asked to "caretake" on behalf of NHSE must be clear about how they mitigate any risks associated with the caretaking arrangements.

MERGERS

Any two (or more) practices can merge. It doesn't actually matter whether you hold a GMS contract, PMS contract, or an APMS contract. It is not usually the *contracts* that merge, but the *partnerships*. This effectively means that one partnership consisting of all the partners of each separate practice, become *one* partnership holding *both* contracts.

This gives merging practices a greater flexibility in terms of keeping the contracts separate but managing the delivery of them under one entity. There are however separate rules for doing this depending on which type of contract you hold. Where partners are added to a GMS contract the regulations do not require NHSE consent, however, it is different with PMS where consent from NHSE is a pre-requisite for any change to the contract.

Practices should have a fair idea why they want to merge. Mergers take place for a variety of reasons: for example to cut staffing costs, to enable partners to offer a better service, to merge backroom services, to protect core contracts, or, to protect partners from the less flexible nature of PMS agreements where termination is concerned. Either way, mergers are a good way to protect general practice and allow for the formation of more robust entities to weather current storms.

It is important however for both merging businesses to undertake a level of "due diligence" on each other to ensure that, at the very least, the merged entity does not take on any additional liabilities that existed and were a direct cause of the practice concerned before the merger took place.

These liabilities take the form of for example, staff issues, actual or potential, or premises issues. Best practice would be for both practices to serve the other with a "due diligence" questionnaire which would help in ascertaining what, if any, each practice would be taking on after the merger. Any disclosures of a negative nature would not necessarily preclude the merger, but would give each side the opportunity to have an indemnity inserted into any partnership agreement to cover off any actual or potential liabilities that were disclosed – or indeed any that were not disclosed but should have been!

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Once the merger has taken place, a robust partnership agreement should be put into place covering these issues and reflecting the new responsibilities of the partners.

Practices should also not forget to inform CQC of the change in entity and ensure that the registration is valid.

Merging practices sometimes forget that by merging they are also creating a TUPE situation – that is, as far as the employees of both practices are concerned, they are transferring to a brand new employer. Under the Transfer of Undertakings (Protection of Employment) legislation, the terms and conditions of employees under these circumstances are protected and any dismissals/redundancies or attempts to vary terms to suit the new employer may be subject to unfair dismissal claims. The rule of thumb is to take advice first. It is not unusual for merging practices to find that they have one staff member too many or, that one set of employees are on more favourable terms than others.

It is also important that practices who merge consult with their employees before the merger takes place. Failure to do so may result in a claim for compensation for non-consultation.

Having said that, there have been some successful mergers in general practice and the rules are not as difficult as they sound. The way forward is to ensure that you know what the rules are, follow them and ensure that at the same time, you mitigate any risks.

CARETAKING ARRANGEMENTS

As general practice is placed under more and more financial pressures, sadly, there are instances where practices are forced into closing, or singlehanded GPs taking a decision to retire. In those circumstances, NHSE require a neighbouring practice to assist in "caretaking" the service delivery until a decision is made as to what they wish to do going forward. Usually because these arrangements are necessarily put together as quickly as possible to ensure patients are catered for, there is no time for the caretaking practice to ensure that it is protected in terms of what staff or problems they may be inheriting, or, what protections they need to put into place.

As a rule, most caretaking arrangements are put into place for limited periods, which are, inevitably extended as required. The employees of the closing practice will therefore transfer to the caretaking practice and will become, essentially employees of that practice, although the salary costs are met by NHSE.

There are two significant problems.

Firstly, the closing practice may either have had inherent employee issues that may materialise on transfer, or, the closing practice may have failed in its obligations regarding the closure and TUPE process. In which case, the last thing the caretaking practice needs is to inherit these problems without some form of indemnity covering any potential liability. Since the closing practice will be "closed" – it is unlikely that they will have any viable recourse in that respect, so it should be part of the arrangement that NHSE cover off these liabilities by giving the caretaking practice the indemnity required.

Secondly, it is always going to be unclear what the future decisions of NHSE are in terms of the caretaking arrangements and what they do with the patients. NHSE could either, decide to put the service out to tender and, either the current practice puts in a bid and is successful (in which case

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the employees stay with the caretaking practice, or another provider wins the bid in which case the staff transfer to the new provider.

The issue is what happens if NHSE decide that the patient list should be disbursed, rather than putting the contract out to tender. Most of the patients will have already registered with the caretaking practice, but more to the point the practice end up inheriting the staff. In these cases, it would be wise for any caretaking practice to also ensure that NHSE will, should it become necessary to cover off any potential redundancy costs.

Both indemnities need to be evidenced in writing and should be agreed before the caretaking arrangement is in place. Any wording proposed by NHSE to this should be carefully scrutinised to ensure that these liabilities are properly covered should the need arise.

For and on behalf of LMC Law

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Director

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