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1. Lockharts Partnership Deed Tick Box Test for Doctors and Dentists

Many practices are putting off updating and renewing their partnership deeds saving what they see as non-essential expenditure. However this can be one of the real false economies in a partnership business. There are many reasons to keep your Partnership Deed up to date and it is always sensible if an annual review is carried out in the practice to see that the Partnership Deed accurately reflects the arrangements that the partners have and the way that the practice is being carried on.

If there is no effective Partnership Deed the partnership is a Partnership at Will and is governed by the provisions of the 1890 Partnership Act, which has a number of unfortunate effects, including the fact that the only way a partner can be expelled from the partnership is to bring about a dissolution of the partnership. A Partnership at Will automatically ends on the death,

retirement or bankruptcy of a Partner. Under a Partnership at Will, any partner can choose to end the partnership immediately without giving notice to the other partners and without any obligation to give reasons for doing so. This can put a practice's contractual arrangements with PCTs at risk, especially if there is an acrimonious dispute.

We have also noticed an increase in partnership disputes where tensions between partners, which may have been swept under the carpet when there was plenty of money to go round, are surfacing as a result of the increasing squeezing of income available to practices. Many practices either have no Partnership Deed or an old Deed which has become obsolete. The costs of partnership disputes can be very expensive indeed.

We have prepared a Lockharts' Partnership Deed Tick Box Test which we have provided to the specialist medical or dental accountants with whom we work. This will enable them to take GP/GDP practices through a number of simple questions whilst they are visiting to discuss the year's accounts. Do ask your accountant about this simple test.

If your accountant needs a copy of the test, please get them to email "Tick Box Test" to csd@lockharts.co.uk.

If it becomes apparent that your Partnership either does not have a Partnership Deed or has a Deed which requires updating, we specialise in this work for GPs/GDPs, including the preparation of Partnership Deeds. We would be very happy to talk to practices about the terms upon which we prepare Partnership Deeds or how we carry out a 'Health Check' of any existing Deeds. For further advice about partnership deeds, in the first place please contact either Bhavika Shah, bs@lockharts.co.uk (Medical) or Puja Patel, prp@lockharts.co.uk (Dental).

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2. BMA requesting revalidation answers

Doctors are urging the Government to take action over their concerns regarding revalidation proposals. The BMA is calling for intervention and clarification as aspects of relicensing and recertification begin to be piloted around the UK.

Some of the issues on the list drawn up by the BMA that are currently being considered by the Department of Health and the NHS Revalidation Support Team, include general concerns over funding and workload as well as technical questions on the practicalities of revalidation for prison doctors, military specialities and forensic medical practitioners.

The BMA has also warned that some doctors fear the revalidation process may put undue pressure on individuals to conform, and has called on clarification of safeguarding mechanisms to prevent this from happening. Further questions have been raised by the BMA equal opportunities committee regarding the arrangements for monitoring the quality and diversity impact of the pilots, especially with regards to the proposals for multi-source feedback and peer-led review processes.

The UK Revalidation Programme Board announced that pilots of some aspects of the whole system would be running until 2010, and consequently revalidation may not actually start until 2011. Doctors leaders have also said that all primary care organisations need to ensure that doctors are appropriately informed and that a network of responsible officers needs to be in place before revalidation can begin.

For more information about revalidation and the license to practise please visit the GMC website at:

www.gmc-uk.org/doctors/licensing/index.asp

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3. PBC budgets: Time to get real?

As we commence the fourth year of Practice Based Commissioning, overall progress on participation remains largely mixed. Whilst at one end of the spectrum there are parts of the country where PBC never got underway; consortia at the other end of the spectrum are now being given the opportunity to take the next big step and manage real PCT budgets.

Previously, practices were given 'indicative budgets' based on historical use and against which they could make savings by better performance through effective service redesign. The freed up resources created by successful consortia were not profits but practices/consortia could use a percentage of these savings for reinvestment for the benefit of patients. Thus, for the entrepreneurial consortium, the opportunity to take hold of real budgets and to share in the profits of effective service redesign may be irresistible.

However, there will be a large number of practices for whom PBC itself has appeared more indicative than real.

We have assisted consortia around the country with tailoring inter-practice agreements and company/LLP documentation. With a willing group of practices, the development and finalisation of this process has largely been in the control of the participants. However, for consortia, attempts to ensure that similarly comprehensive contractual arrangements are in place between the consortium and the PCT have proved an uphill struggle.

The consequences of not setting out the parties' obligations and rights have ranged from disputes over the use of freed up resources to disputes over the way in which indicative budgets were calculated. On the use of freed up resources, practices have found the goalposts have been moved on several occasions, particularly with requests for to use savings on premises redevelopment.

Some practices have also been faced with problems where PCTs have set budgets when in 'special circumstances' and now, after

having restored financial balance, are continuing to base future budgets on budgets calculated when in financial difficulties. Other complaints focus on top-slicing of PBC budgets leaving many practices overspent at the end of the year.

It must also be noted that controlling real budgets will be a double edged sword. The promise of a share in the "profits" is offset by an obligation to share the risk and any losses.

The above concerns should not detract from the opportunity being presented to GPs. Greater control in commissioning may allow practices and consortia the prospect of ensuring that the Framework for procuring External Support for Commissioners does not drown out the voice of GPs in commissioning. However, those practices who are ready to take the step, should learn from the difficulties that have been noted above and ensure that appropriate contractual arrangements are in place to protect practices/the consortium's exposure to liability.

For further information and contract documentation please contact our Mark Jarvis at mj@lockharts.co.uk

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4. "Any Willing Providers" and Procurement

Procurement routes that any PCT may take in the commissioning of new services under Practice Based Commissioning include developing services through existing primary medical services contracts, using the 'Any Willing Provider' ('AWP') model or putting a particular service out to tender.

The Department of Health publication – Practice Based Commissioning: practical implementation (published on 28 November 2006) provided 'clarification of the procurement rules for services commissioned through practice based commissioning and the need for tendering, along with the scope for local tariff flexibility'.

Paragraph 3.35 – 3.37 of the publication reinforced the principle of free choice of provider for patients for routine elective services and the opportunity for AWP to supply services.

The AWP model, in effect, was intended to be a procurement route to encourage competition within a range of services rather than for them. It is described in paragraph 3.36 of the publication as a 'local approval process' enabling PCTs to approve any number of willing providers for routine elective services on the condition that the providers in question could demonstrate that they met all necessary quality criteria and standards as set out by the Healthcare Commission (the Healthcare Commission, along with the Commission for Social Care Inspection and the Mental Health Act Commission, ceased to exist on 31 March 2009 and the Care Quality Commission is now the health and social care regulator in England).

Under the AWP model, there are no guarantees of volume or payment in any contract awarded. As stated in paragraph 3.37 of the publication, 'for providers looking to supply a routine elective service, including those developed through PBC, tendering is not required'. This was reiterated in paragraph 3.42, 'where the PCT is granting permission for any willing provider to operate in their area rather than purchasing an exclusive service from a single or limited number of providers, then...tendering is not required'.

The 1st October 2008 saw the launch of a national website called Supply2Health. Supply2Health was developed by the Department of Health with the NHS Purchasing and Supply Agency and it was intended to provide a single source of information for providers looking for advertisements for Part B clinical services where the PCT is the main contracting authority.

Health Minister Ben Bradshaw, in his speech on 16 September 2008 at the Laing and Buisson Independent Healthcare Convention, described Supply2Health as 'an online procurement portal'. From 30 September 2008, it became mandatory for all PCTs to use Supply2Health and all NHS

commissioners are now required to post information about tendering opportunities and contract awards on the website, with the intention of making it easier to track down single opportunities and understand exactly what PCTs want. According to Ben Bradshaw, Supply2Health will 'help commissioners to meet their legal requirements, reduce the number of requests for more information from bidders and increase the response to their adverts'.

Under the Department of Health publication – PCT Procurement Guide for Health Services ("the Guide" published in May 2008), the AWP process for the award of contracts can either be open or managed. In an open process, PCTs are willing to accept proposals from providers at any time. In a managed process however PCTs award contracts at discreet moments for particular purposes. The managed process has been described in the Guide as being run as a 'simplified procurement and may be appropriate to address local issues such as demand for specialist services or to deal with performance issues'.

In accordance with these new rules, bidders are now obliged to comply with the 'simplified' procurement process which includes much of the documentation included in a full tendering and procurement process. This includes the Memorandum of Information which outlines the procurement process, the Service Specification which details the requirements of the service, and a Questionnaire which comprises of documents which must be completed as part of the AWP assessment process and in accordance with the guidance contained in the Memorandum of Information.

Although the new system may have been embraced by some as simplifying the search for new contract opportunities and enabling providers to track new contract award announcements on a regular basis, in reality it seems the AWP process of bidding for and being awarded a particular contract requires compliance with a procedure that is no more than a shortened form of the full tendering and procurement process.

For further details and information please contact Victoria Wheeler in our New

Enquiries Team at vw@lockharts.co.uk or 020 7383 7111.

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5. NHS Pension Scheme 'Choice Exercise' Approaching

Since 1 April 2008, two NHS pension schemes have been operating, one under the NHS Pension Regulations 1995 and the other under the NHS Pension Regulations 2008.

The first scheme, operating under the 1995 Regulations (with some updated rules and benefits from 2008) continued as a final salary scheme with a retirement age of 60. This is known as the NHS Pension Scheme (Updated).

Alongside the NHS Pension Scheme (Updated), a new NHS pension scheme was created on 1 April 2008. This was a new final salary scheme for anyone who joined for the first time on or after 1 April 2008 and has a normal retirement age of 65 as well as a different set of rules and benefits. It is known as the New NHS Pension Scheme.

Members of the updated NHS Pension Scheme will be offered the choice, for a limited period, planned to run from 1 July 2009 to 30 June 2010, of moving their pension into the New NHS Pension Scheme, something that may better suit some members' retirement plans. This gives members a year to make their choice and this choice will be for past and future pensionable service only.

Employers will also have an important role to play in delivering the Choice exercise and strategic practices and procedures will be needed.

Should you require any information or advice on the above, please contact Victoria Wheeler in our New Enquiries Team at vw@lockharts.co.uk or 020 7383 7111.

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6. Normal Expenditure out of Income Rules

An under utilised exemption from IHT is gifts that qualify under the normal expenditure of income rules. For those taxpayers with relatively high income (or business owners who have an element of discretion as to whether to retain profits, within the business, or pay out as annual dividends or salary); it can be advantageous to apply this useful exemption.

A gift, out of net income, should qualify for this exemption if (it complies with certain conditions):

- The gift was part of the *normal expenditure* of the donor; and
- (*taking one year with another*) it was made out of *income*; and
- that after allowing for such transfers forming part of normal expenditure the donor was *left with sufficient income to maintain his standard of living*.

Some commentary is required on these conditions; the criteria are subjective in nature. The question of whether a gift constitutes "normal expenditure" must be answered according to all the facts and circumstances of each particular case.

Two examples may highlight the subjective nature of this test:

A widow with children grown up, frugal tastes, no mortgage and regular pension income (from late husband's pension provision), will probably save a high proportion of this income; it appears she could give away this proportion (to her family) and it be treated as part of her normal expenditure.

Compare to:

Another individual - albeit with higher income, but with relatively large family commitments and outgoings (including mortgage) and no history of savings - may find it difficult to establish any gifts (out of income) as normal expenditure, as such gifts would reduce his standard of living.

A pattern of gifting must be established, but the payments need not necessarily be repetitive. Regularity is an essential character of any payment under these rules; HMRC acknowledge there is no set time limit for the purpose of demonstrating a habit of giving but a span of "three to four years" would be reasonable.

How do you determine "normal" expenditure? HMRC regard normal as "habitual" (i.e. according to the "norm" of giving which the donor has established). It was held by the Court (Bennett v IRC) that "normal expenditure" accorded with a settled pattern of expenditure. This could be either:

- Reference to a sequence of payments by the donor out of past expenditure; or
- Proof of a prior commitment adopted by the donor regarding future expenditure (e.g. regular premiums to be paid under a pension or insurance contract or instalments for the benefit of another individual).

"Out of Income"

There is no specific requirement for such gifts to be made after tax is deducted from income. However, in practice PAYE is deducted from employment income and, for those individuals with investment income (which is usually received net of tax at source); any additional tax liability invariably is paid out of income. Thus, taking income after tax merely reflects the available income.

However, if an individual is based abroad, for say three or four years, suffering reduced tax deducted; then he does not have to take tax into account.

Between spouses, it can be advantageous to transfer income producing assets for income tax purposes (say from husband to wife). This practice could enhance the wife's ability to make normal income gifts.

Are there any snags? The capital element of a purchased life annuity and withdrawals

within the 5% allowance of an investment bond are not treated as income for IHT purposes.

Record keeping: no requirement for such (income expenditure) gifts to be returned to HMRC; nevertheless it is eminently sensible to keep a record of such gifts, in case the donor's personal representatives are required to provide evidence on the donor's demise.

Donors would be wise to maintain careful records (of income/ expenditure) not only for the year in which such income gifts are made, but in several years before and after to ensure a pattern can be proved. If the income tax year is adopted (6th April to following 5th April), this will make it relatively straightforward to match available income against expenditure.

It is perfectly acceptable to resolve to establish a pattern of gifts (say quarterly) – provided the donor will live long enough for such regularity to be established. A specific written declaration of intention would assist and an individual's own financial plan would be a good starting point.

In summary, this is a most useful method of IHT planning and one which can be applied easily and simply in the appropriate circumstances.

For further information please contact Associate Solicitor Andrew Murdoch at am@lockharts.co.uk

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7. Protecting a Dental Business After Death

During their working lives, dentists will have to contend with a variety of issues concerning their business ranging from contractual compliance, to ensuring that their businesses and goodwill are protected. In doing so, dentists will need to develop a business plan and seek relevant specialist advice, where necessary, to ensure that this is the case. Those who have prepared wills should know that planning for the future of

the business, will also involve planning for the consequences of their death.

It is likely that their businesses will have generated goodwill during their working lives. Ensuring that this is realised and that their partners/children are catered for is likely to be at the top of dentists' minds.

Sole practitioners need to be alert to the danger to their contract and goodwill which will arise on death and be conscious of the steps that need to be taken to protect them.

The NHS Act provides that certain qualifying persons may hold a GDS Contract or PDS Agreement. The GDS/PDS Regulations make specific provision for the death of an individual contractor and this information can be found in Schedule 3, paragraph 63 of the PDS Regulations and Schedule 3, paragraph 65 of the GDS Regulations. Generally, these paragraphs provide where the NHS contractor is an individual dentist, the contract/agreement will terminate at the end of a period of seven days following death unless the Primary Care Trust ("PCT") agrees in writing with the individual's personal representatives ("PR's") that the contract should continue for a further period (not exceeding three months). Furthermore, in order to obtain this agreement the PR's will need to confirm in writing that they are employing or engaging another dentist or dentists to assist in the provision of dental services.

It is entirely understandable that, in the seven days following the death of a spouse or parent, the family will wish to grieve and dealing with business matters may be the furthest thing from their mind. However, given the prescribed period, this is exactly what must be done in order for the NHS Contract and associated value to be maintained. Consequently, the Contractor will need to inform their PR's, spouses/children of this time period and the need to notify the PCT as soon as possible. Dentists should either also advise their PR's of the need to seek immediate advice on their death from the local LDC, the BDA or an experienced dental law solicitor who will be able to assist in what will be a difficult time for the family. It may well be that family solicitors are to be involved in the winding up of the deceased's estate but very

few will have any detailed knowledge of NHS Regulations.

Following the agreed extension to the NHS contract, the NHS regulations also provide that the PCT may agree that the contract/agreement can continue for an extended period of up to six months following the end of the initial three month period. This will only be the case where the PCT is of the opinion that another individual may wish to enter into a contract/agreement to provide the services. However, this does not indicate an automatic mechanism for the PR's to sell the practice directly to a purchaser and they will need to work with the PCT about the future of the practice.

It must be noted that allowing the contract/agreement can continue with the personal representatives is entirely at the PCT's discretion and both the GDS and PDS Regulations state that these provisions for continuation will not affect any other rights to terminate the contract which the PCT may have. In GDS, the most pertinent will be termination on the grounds that the Contractor is no longer a dental practitioner.

The above narrative sets out the basic position under the NHS Regulations. However, there are a number of other considerations that must be taken into account. The NHS contract may contain negotiated terms and this will be more likely with PDS than GDS. Although the NHS contract cannot be contrary to the NHS Regulations, it is entirely possible that the NHS contract provides alternative arrangements which are more favourable to the contractor. Ideally, a dentist should investigate the position as part of the planning process and they should consider seeking legal advice. As above, if this is an issue left for the PR's to resolve with legal advice or otherwise the time limits will be a concern.

Other concerns may be whether the will left by the dentist makes adequate provision for the PR's to continue the business in their stead and this is something dentists will need to consider when drafting their wills. Specialist legal advice is recommended to ensure that all these bases are covered.

It must also be remembered that given the discretionary nature of these post death arrangements, the attitude of the PCT will be decisive. A receptive PCT may take a far more relaxed approach to the contractual issues and this will obviously favour the PRs. Conversely, PRs dealing with a hostile PCT may find it impossible to protect the contract and its value, with the PCT allowing the contract to expire and re-tendering to alternative providers.

It is for this reason that Contractors should be considering alternative methods of protecting their contracts including incorporation or partnership to ensure that their share of the business is realised on death. There will be other considerations that need to be considered in taking these steps and contractors considering these options should seek specialist legal and accountancy advice.

The Dentists Act 1984 sets out restrictions on those who can carry on the business of dentistry and this will be particularly pertinent to private practice. The Act makes express provision that where a dentist dies, the restrictions will not operate to prevent the dentist's PR's, surviving spouse or children from carrying on the business in continuance during the three years beginning on the date of death.

For further information please contact our Mark Jarvis at mj@lockharts.co.uk.

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8. Lockharts Company Secretarial Services

As you may be aware, private limited companies are no longer required to have a company secretary. In the absence of a company secretary, the directors must fulfil the company secretarial functions. Failure to comply with statutory filing requirements can carry serious (and, in some cases, criminal) penalties. Whether or not your company has a company secretary, our service (below) is designed to relieve you of the administrative burden of meeting statutory deadlines and complying with filing requirements. This leaves you to concentrate

on your business of providing healthcare services.

Complimenting the range of services that Lockharts already offer, we have launched a company secretarial service, specially tailored for NHS provider companies. We have identified a need for a specialist service which meets the particular and complex requirements of incorporated NHS providers.

We are offering two separate packages addressing different levels of need. However, if you require a tailored company secretarial service we would be happy to discuss your specific requirements and build a proposal around your company's needs.

In the first instance please contact Neha Shah on ns@lockharts.co.uk or Michael Barrett on mb@lockharts.co.uk.

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If you would like to receive previous issues of the Lockharts Newsletter please contact Kabir Savjani at csd@lockharts.co.uk.

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