

April 2014

# GPC

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General Practitioners  
Committee

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# Partnership Agreements

Guidance for GPs

BMA 

## IMPORTANT

This guidance applies to practices in England, Wales and Northern Ireland Partnership law in Scotland differs in some respects from the provisions that apply in the rest of the UK. Scottish partnership law is therefore covered in a separate guidance document.

In general there are only slight differences between GMS and PMS in relation to partnership agreements, any differences relevant to this guidance are noted in the appropriate places.

**Please note it is not part of the BMA service to provide commercial/management advice to practices or GPs. This guidance is for general use only and mainly concentrates on how partnerships should be considered in the light of any GMS/PMS/APMS contract/agreement together with the basic elements of partnership law. Practices/GPs are strongly urged to seek the specialist advice of accountants and independent lawyers in their relevant country in relation to the more detailed aspects of their partnership agreements, including drafting and the application of tax and accounting. This is especially important where advice is required on whether the arrangement is appropriate to an individual GP or practice's needs.**

**A partnership agreement is a contract between the partners and should be kept up to date at all times in order to be valid and thus effective.**

Further information is available to BMA members through the BMA and to LMCs through GPC.

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## List of abbreviations

APMS	Alternative Provider Medical Services
BMA	British Medical Association
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
GMC	General Medical Council
GMS	General Medical Services
GPC	General Practitioners Committee
HEE	Health Education England
HMRC	HM Revenue and Customs
LAT	Local Area Team
LHB	Local Health Board (Wales only)
LLP	Limited Liability Partnership
LMC	Local Medical Committee
MAP	Mutual Assessment Period
MDO	Medical Defence Organisation
MPIG	Minimum Practice Income Guarantee
NHSBSA	NHS Business Services Authority (Pensions)
NHSE	NHS England
PMS	Personal Medical Services
SFE	Statement of Financial Entitlements
TMA	Taxes Management Act

## Basic elements of a partnership

Whether a partnership exists depends on the relationship between the parties involved. A relationship does not become a partnership simply by calling it one. Under section 1 of the Partnership Act 1890, a partnership is defined as “the relationship which subsists between persons carrying on a business in common with a view of profit”.

In English law (unlike in Scotland) a partnership is not an entity distinct from the partners who at any time may compose it. The partnership itself cannot acquire rights nor can it incur obligations. A partnership also cannot hold property (eg buildings). The rights and liabilities of a partnership are the collection of the individual rights and liabilities of each of the partners. Therefore the relationship between partners requires the highest degree of trust and good faith. This is because partners are usually jointly and severally liable for their own and each other's actions; for example, if one partner commits the partnership to incur a debt of £10,000, the partners may be sued jointly for the recovery of that debt, or any one partner may be sued individually for the whole debt (even though he or she was not the partner who entered into the contract).

## Implications of the GMS contract

The GMS contract was introduced in 2004 and provides greater flexibility in the way its contractors are structured. Contractors can be single-handed GPs, partnerships or certain types of limited companies. This means that GMS contracts are now mostly held between practices (known as contractors or providers) and NHSE. **This is very different from the previous arrangements**, where contracts were between the relevant primary care organisation and individual GPs (known as principals). The implications of this fundamental change, and its effects on their partnerships, **must** be understood by all partners in a practice, as well as intending partners.

### Non-GP partners

The GMS contract also makes it possible for practice partnerships to include non-clinical members, e.g. Practice Managers/nurses. Although at least one of the partners must be a medical practitioner whose name is included in the GP register.

When drawing up partnership agreements with non-GP partners, partners will need to consider, among other issues, the following:

- whether there are any aspects of decision-making which should be specifically reserved for the health professional partner(s) or categories of health professional partner(s)
- what mechanism will be appropriate for determining profit share given:
  - (i) that the nature of the work of the GP partner(s) will be different from that of other partners
  - (ii) the relative ability of the various categories of partners to influence the income and business prospects of the partnership.

### PMS Agreements

Although there are many PMS practices that operate as partnerships and hold open 'one' PMS agreement, it is clear that the PMS agreement is signed by each individual GP, each of whom has an individual agreement with NHSE to provide PMS. The fact that they choose to operate as a partnership is relevant in as much as the agreement will normally specify those arrangements, but this is not part of the PMS Regulations and any change to the means of delivery of the services may require the agreement of NHSE.

## **APMS Agreements**

Alternative Provider Medical Services (APMS) contracts allow NHS England to commission primary care services from a wide range of providers. They can be used to provide essential services, additional services where existing (GMS and PMS) GP practices opt out, enhanced services, out-of-hours services or any one element or combination of these services.

Commissioners can contract for primary care services with commercial providers, voluntary sector providers, mutual sector providers, social enterprises, public service bodies, GMS and PMS practices (through a separate APMS contract) and NHS Trusts and NHS Foundation Trusts.

## **Contractual obligations**

A partnership agreement entered into for the purpose of providing services under a PMS, GMS or APMS contract should take into account the obligations under that contract. The terms and conditions of any partnership agreement should therefore be consistent with those obligations where applicable, whether or not the contracting party is the partnership or individual partners. It is important to note however that the partnership agreement cannot override the PMS, GMS or APMS contract. Some of the key considerations for GMS and PMS contracts are outlined later in the guidance.

## **Types of partnership and related entities**

### **Partnership at will**

A partnership without a written agreement is a partnership at will, ie one which subsists at the will of the partners from day to day. This means that relations between partners are governed by the Partnership Act 1890. **A partnership at will is an unstable business relationship as it can be dissolved on notice by any partner.** Such notice may be served by one partner on the others without their prior knowledge or consent and will take immediate effect, unless it can be proved that a notice period has been agreed. No reason need be given to justify such notice. In addition the notice and any consequent dissolution may result in the forced sale of all partnership assets (including the surgery premises) and the redundancy of all staff, incurring potentially large financial liabilities.

During the lifetime of a partnership at will, all partners are deemed to have equal profit shares unless there is clear evidence to the contrary having been agreed and most decisions are made by simple majority. A written agreement will reduce significantly the potential for serious disagreements and instability.

**The BMA strongly advises that all partnerships have a written, up-to-date partnership agreement signed by all partners at the commencement of the partnership which is always updated on the admission of a new partner.**

## **Partnership with a written partnership agreement (Deed)**

Partnerships with written partnership agreements will have been able to largely 'override' the provisions of the Partnership Act in their written agreement and thereby make their own provisions as to the rules and other terms governing their association. Clearly a written agreement is preferable.

## **Limited Liability Company (limited by shares)**

It is possible for practices to be set up as limited liability companies. This is a similar concept to the 'qualifying body' provided for in Section 93 of the National Health Service Act 2006, persons wishing to enter into GMS contracts is dealt with in Section 86 of that Act). The ownership rules for GMS limited companies are that:

- (i) all shares in such a company must be legally and beneficially owned by a person who could lawfully enter into a GMS contract as an individual or as part of a partnership
- (ii) at least one share must be legally and beneficially owned by a medical practitioner whose name is included in the GP Register (or is suitably experienced) and any share which is not so owned is legally and beneficially owned by a person who is either an NHS employee or other healthcare professional
- (iii) any other shares owned by a medical practitioner must be so owned by a medical practitioner whose name is included in the GP Register or who is employed by NHSE, a Local Health Board, an NHS trust (including an NHS Trust in Scotland), an NHS foundation trust, a Health Board, or a Health and Social Care Board.

Further detail of these arrangements lies outside the scope of this guidance. Likewise this guidance does not go into any detail in relation to Limited Liability Partnerships (LLPs). One reason for this is that such entities are not generally recognised for purposes of the NHS Pension scheme.

## **Terms of a partnership agreement**

### **Parties**

The agreement must start with a list of the names and addresses of the parties. This will include any non-health professional parties (see above). It should also be stated that there must be compliance with any applicable Companies Act legislation. This requires the partnership to disclose the name of each partner on the business letter head or any correspondence. The address that appears for each partner in the partnership agreement must be the address to which any legal documents could effectively be served. If the partnership carries on under a different name from those of the partners, this should be specified in the agreement and on the business letter head.

### **Definitions**

It is always helpful to have a list of definitions of certain terms of the agreement, for example, bankers, accountants, practice name and area.

### **The business**

It is vital to specify the nature of the business because this limits the extent to which each partner can, in his or her capacity as partnership agent, bind the other partners. This is important since

otherwise liabilities arising from any other business activity of any partner might inadvertently be shared by all the other partners.

## **Dissolution, retirement, death and expulsion**

**It is essential that the partnership agreement is kept up to date, particularly when there are changes to the membership of the partnership.**

Many problems encountered in respect of partnerships relate to termination of partnerships either through dissolution, death, retirement or expulsion. The duration of the partnership agreement should be defined. The partnership will usually be declared to exist during the joint lives of the partners, or any two or more of them and the agreement will usually state that if any partner leaves for any reason it shall not determine the partnership between the remaining partners. Exceptionally, a partnership may be entered into for a fixed period of time. There should be adequate provision in all partnership agreements for how a partnership is terminated. Part 8 of the GMS contract regulations covers this eventuality to a certain extent where partners have entered into a GMS contract. However, PMS providers should note that there are no equivalent provisions for PMS on partnership splits, although there are specific provisions regarding variation.

### **Dissolution**

The dissolution of a partnership brings the partnership to an end. This is distinct from the termination of a partnership as regards a specific partner by other means, such as retirement, death or expulsion (sometimes called a 'technical dissolution'). The agreement should consider the position of dissolution of the partnership and the circumstances in which this may arise. The agreement would ordinarily specify that a unanimous vote would be needed to dissolve the partnership. Time spans should be considered carefully in any dissolution, mainly to give the partnership time to divide assets and cater for any liabilities. It would be prudent for the agreement to state that dissolution should not take effect until such time as the terms of dissolution have been agreed between the partners.

### **Retirement**

The partnership agreement needs to provide for what happens to a partner and to the partnership on retirement with regards to both assets (including premises – see below) and the relevant NHS contracts. Regulation 108 of the GMS contract requires that NHS England (the Board) is given three months notice of an individual medical practitioner terminating their contract.

Partners under a GMS contract may consider the inclusion of a clause requiring any outgoing partner to nominate the others to succeed to the GMS contract, whatever the circumstances of his or her leaving (e.g. retirement, expulsion etc).

### **24 Hour retirement**

If partners wish to seek advice on the option of 24 hour retirement, please contact the BMA, telephone number: 0300 123 1233 or e-mail: [support@bma.org.uk](mailto:support@bma.org.uk)

A basic point to note is that any partner wishing to take 24 hour retirement needs to get the consent of his partners for it and approval from the relevant health authority, such as NHS England. In the event that it is a single-hander wishing to take 24 hour retirement then he may wish to take on a partner before doing so or in any event speak to the NHS England Local Area Team regarding his proposal to take such retirement.



## **Death**

Where a partner dies the remaining partner or partners should notify NHS England of the death. A GMS contract would normally continue with the remaining partner or partners (except for example where the surviving partner is not a medical practitioner). Consideration should be given to what happens to a deceased partner's share of partnership assets, otherwise, on death, the assets may be retained by the surviving spouse or civil partner.

## **Expulsion**

A specific list of grounds for expulsion should be set out within the partnership agreement, which could specify that any notice served should take effect forthwith or with a fixed period of prior notice (obviously bearing in mind that the partners will not want to breach the terms of their medical contract and a period of time would be necessary to deal with a division of assets). Grounds for expulsion would usually include for example the maximum period of time a partner may remain absent from the partnership on grounds of sickness (see 'sickness and incapacity'). However, partners should be aware that it can be difficult and expensive to prove that any such ground has been adequately met. For this reason agreements sometimes include an expulsion or compulsory retirement clause which does not specify the need for any grounds to be satisfied but which instead allows for the service of notice simply on the basis that the other partners no longer wish to be in partnership with the individual concerned. It can be argued that such a clause (often referred to as a 'green socks clause' and further mentioned below) undermines the stability of the partnership. However they seem to be increasingly common and some legal advisors now positively recommend them, especially for larger partnerships (where they are more suitable). Partners should be aware of possible discrimination claims resulting from decisions to expel. Expulsion clauses must apply equally to be enforceable and any expulsion notice must be signed by all other partners to be valid.

Partners should also be aware that, in GMS partnerships, any expulsion or compulsory retirement, unless concluded amicably, may result in problems with NHSE and may have a detrimental effect on the status of the contract as well as the partnership (see non-amicable splits below). Where PMS is concerned, although there are no detailed clauses regarding partnership splits or death in the regulations, it is advisable that fundamental changes to a partnership which may affect the delivery of services under PMS are communicated to NHSE.

## **Expulsion without reason**

An expulsion without reason under a "green socks" clause is defined as a provision allowing for a decision of the partners to expel another partner without a stated reason. Such a clause may undermine a small partnership (for eg 3-5 partners) but may be more relevant for larger partnerships.

It is essential that partnerships remember that despite the inclusion of a "green socks" clause they are still obliged to comply with all anti-discrimination legislation. Failure to do so can easily result in inconvenience and unpleasantness as well as potentially expensive legal costs and compensation.

All such clauses may be scrutinised with regard to possible abuse and the consequent hardship of expulsion. Generally a partner may not be expelled, even if the wording of the clause permits it, if the expelled partner can show that his or her co-partners have not acted in good faith.

### **Other determinations of a partnership**

Where a contractor consists of two or more individuals practising in a partnership and for whatever reason that partnership is terminated or dissolved, a GMS contract will only continue with one or more of the remaining partners if that partner or partners is nominated in writing and if this nomination is agreed and signed by all the partners (hence the need for partners under GMS to consider inclusion of a clause requiring outgoing partners to nominate the others to succeed them in the contract).

As PMS contracts are silent with regard to amicable splits, the above rule will not necessarily apply to PMS contracts and these splits may instead be treated as a variation.

Problems usually arise where the dissolution or split of the partnership is non-amicable. The GMS contract does not detail actions to take in this eventuality. However, partners must be careful to note the following consequences for their GMS contracts if a non-amicable split occurs.

In the event that a contractor is aware that the partnership is in dispute and is likely to dissolve, or when there is to be a substantial change to the composition of the partnership, there is a duty upon the contractor to provide NHS England with six months notice in writing. From the partnership point of view, regulating as far as possible the manner in which dissolution or splits occur within the Partnership Agreement, this will be a deciding factor in whether or not NHS England terminates or allows the contract to continue.

Although the notice period is not always specified, the longer the notice period the more beneficial it will be to the partnership as a whole. Once NHS England receives this notice, it will assess the ability of the contractor to fulfil its obligations under the contract. NHS England may terminate the contract forthwith or may allow the contractor to continue for a period up to six months in order to assist the contractor in providing clinical services by employing or supplying another GP(s). This is why it is important for a contractor to ensure that adequate notice of any major change is given to NHS England and this obligation must be reflected within the partnership agreement.

In the event of dissolution, or a non-amicable determination, the practitioners may be in the position of having to reapply separately for individual GMS contracts with no guarantee of obtaining these. Parties will be required to submit separate business cases to NHS England setting out robust reasons supported by sufficient evidence as to why they are able to continue to deliver essential services, including sufficient experience, staff and premises.

Where there has been a split between two partners there have been occasions when neither partner has been granted a GMS contract. Obviously, single-handed GPs may be more costly to maintain than a group of partners, but what NHS England decides to do will be wholly dependent on its individual attitudes, local requirements and budgets. In some instances the individual doctors might be offered a position within a health centre run and owned by NHS England. In the interim they may be granted temporary accommodation in order to continue providing services to patients until a position becomes available. In any event, there are no guarantees.

There appears to be nothing in the regulations that prevents the above rules from applying equally to PMS practices, although it should be emphasised that unlike GMS regulations, PMS regulations contain a termination by notice provision which allows NHS England as well as the contractor to terminate simply by serving notice in writing on the other.

## **Termination periods**

Whatever an individual partnership agreement might state in terms of notice periods for termination, Regulation 108 of the GMS contract requires that NHS England is given six months notice before termination takes effect in the case of a partnership or company and, in the case of an individual medical practitioner, three months notice. So, although disputes may lead to partners wishing to dissolve the partnership quickly, the obligations under the GMS contract must be adhered to, failing which NHS England may consider termination as a result of breach by the contractor and instead of terminating the contract forthwith, could impose a contract sanction. A sanction could include withholding or deducting money otherwise payable under the contract. These provisions are similar for PMS.

## **Effect on premises**

It is important to note that in the event of one partner leaving a practice, there may be a knock-on effect with respect to premises funding where property is leased by the partnership from a third party and the rent is funded by NHS England. In these circumstances, NHS\_E will send a surveyor to review the premises and re-evaluate the actual space being used to deliver essential services under the contract. This may well result in a cut in funding owing to the fact that following a partner's departure, not all of the premises are being used to deliver services under the contract. This inevitably results in practitioners/partners having to fund the difference out of their own pockets.

It is therefore important that the occupation of the practice premises is carefully defined in the partnership agreement. This will be dependent on the circumstances of each partnership. It may be that each partner has a legal interest in the premises in which case they must be advised to seek both conveyancing advice from a solicitor and financial advice. Special consideration must be given where one or two of the partners own the premises and lease the premises to the partnership. Appropriate clauses should be inserted within the partnership agreement to ensure that, if the owner decides to leave the partnership and terminate the lease, any remaining partnership has sufficient time in which to find new premises or make alternative arrangements. The same will apply in respect of any tenancy agreement and GPs are advised to seek advice from a specialist in property law.

## **Factors to consider when appointing a new partner**

In a situation where a Practice is seeking to appoint a doctor to support the delivery of medical services there are 3 options:

### **1. Appoint a Partner**

The appointment of a Partner, in the true sense will require in the first instance, the agreement of the terms applicable to the incoming partner and the terms governing the operation of the partnership; and secondly for the Deed of Partnership to be signed to create an effective, valid Partnership.

The BMA does not recognise salaried partners or fixed share partners as true partners. Furthermore Her Majesty's Revenue and Customs (HMRC) take a dim view of such arrangements as they see anything less than a true Partner as a tax avoidance measure.

In the absence of a signed Partnership Agreement the partnership will be deemed a partnership at will which may be dissolved at any time by any partner.

## **2. Appoint a locum**

Normally this would provide for a post to be covered for a short term temporary period, where the appointee would be deemed as self employed, therefore remuneration would be paid as a gross amount. The Locum would not enjoy the benefits afforded to an employed doctor and would be responsible for payment of his/her own tax and national insurance.

## **3. Appoint a salaried GP**

Since April 2004, GMS Practices have been obliged to offer a written contract to salaried GPs in accordance with the BMA Model Salaried GP contract, or on terms which are no less favourable.

It is worth noting that it is a statutory requirement of the agreement between the GMS Practice and NHS England to offer no less favourable terms than those of the Model Contract. If a GMS practice fails to comply with this requirement then they will be in breach of their contract with NHS England. As a result the ultimate sanction may be the withdrawal by NHS England of the practice's GMS provider contract.

When taking on a new partner, it is essential that their status is clear. A Period of mutual assessment (i.e. a period of 'probation'), usually of 6 or 12 months duration subsequent to the signing of the partnership agreement, following the admission of a new partner, is recommended.

Partners must therefore ensure that a prepared draft of the partnership agreement is available to show prospective partners, which draft will usually provide for the period of mutual assessment. During this period, either the existing partners or the new partner are able to give notice to terminate the partnership of the new partner – often a period of one month. Such notice would not, however, end the partnership between the existing partners.

**Note: It is important for practices to confirm the status of the incoming GP. The BMA does not recommend the appointment of salaried GPs 'with a view to partnership'. Such appointments may result in confusion relating to the status of the individual GP and whether he or she is employed or is a partner. If a salaried GP is appointed, this does not necessarily constitute a genuine partnership and if he is actually an employee that GP should be appointed under the terms of the salaried GP model contract, until such time as a decision is made regarding partnership status. Genuine partners are self-employed. Similarly the term 'fixed-share' partner can give also rise to confusion. Regardless of the term used the question is always what their actual status is in reality and whether they are either employed, or self employed as partners.**

**Note: partners usually take an equity share in the partnership, but those who are subject to a fixed share can be genuine partners if the other indicators of true partnership are there.**

The agreement should take into consideration how any new partner will buy into the existing partnership, making clear that the sale of goodwill for NHS services is prohibited and is not included in the valuation, and should make arrangements for determining his or her profit share.

### **Changes within the partnership**

Any change in the constitution of a partnership (specially the addition of a new partner) should be dealt with under the terms of a partnership agreement. Otherwise, a partnership at will could arise, with all its disadvantages. It is important to remember that having a mutual assessment period on the introduction of a new partner does not change the fact that there is a new legal partnership from the first day.

### **Bank accounts**

It is advisable to limit the financial powers of individual partners so that expenditure over a certain amount must be authorised by 2 or more individual partners for security reasons. There should also be some provision for signatories if partners are on holiday or leave. There should be arrangements for any partnership credit card use. All bank accounts of the partnership should be identified by bank, branch and account number.

### **Assets**

#### **Capital**

Details of partnership capital should be included in the deed, particularly where not all capital assets, especially property, are held by all members of the partnership. This is important because the initial divisions may also be subject to change in the future and sometimes, with a separate deed recording capital, a change may be effected without altering the main body of the agreement. Capital assets may consist of, for example, surgery premises (see further below), drugs stock, furniture, equipment and/or money. It is worth checking to see whether or not there are certain occasions where individual partners may be required to provide equipment at their own expense (for example, a mobile phone or car). Items can only be regarded as partnership capital if they are owned jointly (in whatever proportions) by all the partners.

#### **Property**

Where the practice premises are owned by some or all partners, the arrangements pertaining to the property should ideally be contained within a separate deed drafted by a solicitor specialising in property law. The BMA has arrangements with external lawyers for property related work under which BMA members will receive preferential rates. Those firms are Gateley LLP and Silverman Sherliker LLP Sols. Contact the BMA for more information regarding affiliated law firms. Telephone number 0300 123 1233 or e-mail: [support@bma.org.uk](mailto:support@bma.org.uk)

A separate deed will regulate the rights and obligations of the partners with respect to those premises.

Where some or all of the partners own the premises as part of partnership assets or capital, then the partnership deed can make limited reference to how the share of premises held by any partner may be retained within the partnership on the death or retirement/expulsion of that partner.

### **Tax and accounts**

All the partners are entitled to have access to the books of account of the partnership and supporting documentation without exception. The partnership will be responsible for maintaining proper books. There will also be a requirement for all the partners to sign the annual accounts once approved. One partner should be nominated to file a Partnership Tax Return with HMRC. Each partner should warrant that their expense claims are reasonable, accurate and complete and they may warrant that they have supplied the partnership accountant with all relevant information.

Partners who incur late filing penalties and interest may agree to indemnify (reimburse) the other partners in respect of such penalties. Agreements will typically include a general and mutual indemnity for all partners against the debts and liabilities of the others, including tax debts.

## **Pensions**

Partnerships should consider the implications of a pension provision in the partnership agreement. Usually all partners and staff, unless already in receipt of an NHS Pension are eligible for automatic entry to the NHS pension scheme and need to opt out if they do not wish to contribute. The practice is responsible for all employer contributions, currently (2013/2014) at the rate of 14% in England & Wales, 13.5% in Scotland and 13.3% in Northern Ireland. This applies to partner or staff income. Individuals currently pay between 5% - 13.3% (depending on their income level) contributions from their salary or drawings.

Practices should be aware of their liability to fund locum pension contributions.

In the case of partners' pensions, pensionable pay is defined as NHS Profits and these are determined following the production of practice accounts. It is therefore necessary to include provision for paying contributions after the closure of the financial year for any late earnings that relate to that year. Any partner who leaves a practice will have outstanding contributions to pay on any outstanding payments and the practice will have outstanding employer's contributions to pay.

Practices should nominate one person to be responsible for pension matters. Partners and staff would normally be eligible for membership of the relevant NHS pension scheme for their nation and help and training is available for employers from the pensions agencies.

There is an element of funding for pensions costs included in GMS practices' Global Sum or MPIG. Funding for pensions for PMS practices should have been added to their baseline. Practices should ensure that any additional work they consider is paid at a rate appropriate for all costs. Any shortfalls in contributions may have to be picked up by the practice. This should be clearly set out in the agreement.

GPs are required to sign an annual return, which tells NHS England how the profits of the partnership are to be divided among the partners. This is used by NHS England to allocate pensionable income among the partners according to their share of the profits. Special arrangements may be made in respect of pensionable income received by a partner from other NHS employment.

## **Partnership income**

The definition of partnership income and the manner in which it is distributed should be stipulated in the agreement, for example, whether or not each partner may be allowed to keep private patient income. nb: Seniority payments are applicable to both GMS and PMS. However, seniority payments are being phased out under the 2014/15 contract arrangements. They will be reduced by 15% per year until they are completely abolished in 2020. Also, any new entrants into general practice will not be eligible commencing 31 March 2014.

Partnership agreements should also consider how any earnings from other NHS or non NHS sources are dealt with by the partners. Under GMS and PMS, there are many different streams of payment available to practices and each one must be catered for in terms of division of profit. The same principle will apply to expenses.

Partners should clearly define what should be treated as partnership income as distinct from personal income. There may also need to be a provision about who receives any insurance proceeds and who pays for locums.

The agreement should state that the division of profit can be reassessed should the duties of the partners change.

## **Leave**

### **Holidays - Study Leave - Parental leave - Sabbaticals**

It is up to the partnership to decide how much leave an individual can take. Provision must be carefully agreed to cover additional costs of the leave and to ensure equality and prevent any breach of statutory provisions on sexual discrimination. This is particularly important in small partnerships where the strain of one partner being away is greater for the others. It may also be necessary to consider whether profit share and any cost of the employment of locums paid for by the partnership will be affected.

### **Maternity Leave**

A pregnant partner must be given reasonable time off for ante natal appointments.

It is advisable to have some form of notice requirement before commencing maternity leave so that the partnership can plan in advance for the partner's absence. This might cover both the commencement and termination of leave, including return to the practice. In the case of maternity leave such periods of notice should be reasonable having regard to the circumstances of the practice. 21 days minimum notice in either case will generally be reasonable, but where there are particular known difficulties in obtaining locum cover, for example, a longer period might be reasonable.

Return to practice after maternity leave. Compulsory expulsion from the partnership on failure to return after the agreed period of leave should be considered so that the partnership is not left in limbo should the partner simply fail to return. It should be made clear that the partner's right to sick leave is in addition to the right to maternity leave so that if maternity leave is followed by a period of sickness, then the expulsion provision will not apply until the maximum period of absence through incapacity is exhausted.

Where maternity leave is concerned, partnerships should be careful about imposing stringent conditions regarding division of profit and take specialist legal advice regarding any clause in this respect. It is advisable for practices to agree a defined period of maternity leave as to do otherwise may leave that practice open to the risk of sexual discrimination.

Arrangements for maternity pay for partners can vary widely between practices because partners are not subject to all the provisions of employment law. It is however advisable that these do not vary from sickness and incapacity pay because of the possibility of a discrimination claim arising. Prospective partners should carefully check the arrangements in place before signing.

Reimbursement to cover maternity costs may be claimed under the SFE. Such reimbursement applies to medical partners only and would not apply to non-medical partners, e.g. practice managers.

### **Adoption Leave**

It is recommended that the arrangements for adoption leave mirror those of maternity leave.

### **Compassionate Leave**

It is recommended that a defined period of compassionate leave be included in the agreement.

### **A note on discrimination**

It is unlawful under The Equality Act 2010 for any partnership to discriminate on the grounds of any protected characteristic being: sex (including pregnancy), sexual orientation, gender reassignment, disability, marital status, race, religion or religious belief, ethnic or national origins, and age e.g.

- when advertising for a new partner
- when appointing a new partner
- in the terms on which a new partner is offered a partnership
- by refusing, or deliberately neglecting, to offer a partnership.

In addition, if someone is already a partner it is unlawful to discriminate:

- in the way he or she is afforded access to any benefits, facilities or services
- refusing, or deliberately neglecting to afford access to those benefits, facilities and services.

It is also unlawful to discriminate during dissolution of the partnership or when determining the expulsion of a partner.

### **Sickness/Incapacity**

Consideration should be given to whether it would be appropriate to engage the services of a locum, especially where the period of sickness is lengthy. It could be considered whether a long period of sickness would give the other partners the right to terminate the sick partner's membership or the right to seek a medical report on a sick partner.

It is common for a practice to hold locum insurance but individual locum insurance is also an option.

### **Duties of partners**

Provision should be made within the agreement to include details of the partners' obligations to the various regulatory bodies, namely, CQC, CCGs, GMC, etc. It should be considered whether or not there should be restrictions on the right of each partner to take up other employment, self employment, voluntary or public office work or membership of committees or councils which may detract from the business of the partnership. This is a matter for the partners to decide and agree. As referred to above, partners should also decide whether fees or honoraria and financial loss allowance payments received through committee work should be paid to the practice or kept by the individual, and whether the individual should meet the cost of providing cover during absences.



As there is a requirement for all practices to belong to a CCG, consideration should be given to the implications of this on the relationship between the CCG and the partners as regards their participation and representation in the CCG.

### **Restriction on a partner's authority and decision making**

This is an important section of any agreement. The agreement should cover the calling of partnership meetings, both urgent and routine. It might be necessary to consider restricting the voting rights of any partner on long-term leave (holiday or sickness) so that the general running of the practice is not inhibited. It should also be clearly set out what the duties of a partner are and what that partner is prohibited from doing on his/her own in terms of binding the partnership to any liability or agreement. It is wise to insert an indemnity clause in this respect so that the other partners are protected. In effect, any liability incurred by the partnership by an individual partner acting without authority vis a vis the partnership will be indemnified by that partner. Following from this, each partner should be properly insured.

### **Suspension**

NHS England has powers to suspend GP performers from the Medical Performers List. Any GMS GP performer suspended on/or after 1 April 2004 may be entitled to payments directly from NHS England under the Secretary of State's Determination – Payments to Suspended Medical Practitioners 2013 (Regulation 13 (9) (b) Performers List regulations) or the practice may be eligible for payments under section 11 of the SFE. These payments are made in order to preserve the performer's earnings or provide financial assistance to the contractor under the GMS contract in respect of the cost of engaging a locum. The reimbursement given to the practice (under the SFE) may not necessarily be the maximum amount payable under the SFE. It is normal for NHSE to determine whether or not it is in fact necessary to engage the locum depending on the circumstances of the practice (paragraph 17.4 of the SFE). The GPC has produced separate guidance on the suspended GP and specific advice is available from LMCs, medical defence organisations and the BMA, telephone number: 0300 123 1233 or e-mail: support@bma.org.uk

The partnership agreement should contain clauses to cater for the provision of locum cover in order to protect the income of both the suspended partner and the other partners. There are, broadly speaking, two ways of doing this:

1. the partnership agreement can stipulate that the suspended partner will essentially continue to receive their normal share of profit but that they will indemnify the other partners against (net) locum expenses, such that the indemnity is deducted from any monthly drawings. Alternatively however the partnership may pick up excess locum costs after any SFE reimbursement monies are received
2. payments under the determination the partnership agreement could stipulate that the suspended doctor will **not** receive at least 90% (100% in Scotland) of their normal drawings, and that (usually therefore) the partnership will be responsible for locum expenses.

It is particularly important that non-GMS contracted GP partnerships contain such clauses because the provisions in the SFE for NHS England support for locums during suspension do not apply automatically to non-GMS practices. Further information on suspension can be found in the GPC guidance, *The Suspended GP* available on the BMA website.

Finally, the partnership agreement should clarify that where one partner is suspended they should not be precluded from carrying out normal administrative and non-NHS responsibilities subject to any conditions imposed as a result of the suspension, but that the remaining partners shall have the power to prevent the suspended partner from such activities as they reasonably believe will be detrimental to the partnership.