Myth busting questions on Partnerships for GP Trainees

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You are about to or may have recently completed your GP training and are now freely able to enter the exciting world of general practice. You're fully trained in the clinical aspects of being a GP - but what sort of career are you looking for?

At this stage, trainees and newly qualified GPs are often looking for more information on the options available. In particular, questions tend to be asked about what it means to be a partner, and critical to your future is the current debate about the future of the partnership model. Hopefully this document will help you gain a greater understanding about partnerships and dispel some of the myths we frequently hear.

The following questions have been posed by a number of trainees and answered by experienced GPs, with specialist advice from medical accountants, surveyors and lawyers. The views presented are based on their own experiences. They should not, of course, be the sole basis of any decisions, but we hope they serve as a helpful starting point going forwards.

1. What are the potential benefits of being a partner?

There are many strengths to the GP partnership model, and therefore to being a partner:

- **Autonomy** – and self-determination. This includes the autonomy to set up your working day/week, in conjunction with agreement from your partners.

- **Portfolio career** – as a partner you automatically have a portfolio career with clinical, financial, management and employer responsibilities, but the opportunities to develop are endless. It is a varied and challenging role that can bring huge personal satisfaction. Quite often one partner takes the lead on management issues, so everyone doesn't have to know everything.

- **Income** - usually beneficial, although it is a business, and so profits can vary from practice-to-practice/year-to-year. As a partner you have the opportunity to make decisions about how to run your practice, and can directly see how these changes impact on income. Income can be derived from numerous sources and monitoring expenditure is important. Partner income is usually more than what salaried GPs earn, and should reflect the additional responsibility.

- **Stability** – whilst general practice has continued to evolve, it remains the primary building block that serves the local population and will continue to do so for years ahead. There are many GP partnerships continuing to thrive and move forward in the changing landscape of the NHS. The potential development and investment in clinical

services that support practices at a local level, with general practice taking a leadership role, will become more important and help with the sustainability of general practice. Primary Care Networks (PCNs) will be creating additional opportunities, and it will be the constituent practices with partners determining how these develop.

- **Freedom to advocate for your patients/independence** – you are not accountable to an employing body in the same way as a Trust employee is, and therefore you have greater freedom to act as your patient's advocate with less risk of organisational pressure. It should be remembered that within partnerships there will be agreed clinical pathways and the partnership will hold an NHS Contract, and therefore will have a degree of accountability to the CCG and NHS England who commission services from general practice.

- **Connected and accountable to your own community** – most practices form an important part of the local community, and as a partner you tend to feel a particular sense of responsibility and accountability to the area you serve, which can be hugely rewarding.

- **Freedom to innovate** – practices are agile and responsive organisations with streamlined decision-making processes. This means they can develop services and implement changes quickly and effectively. The responsibility of the partnership role enables one to enact positive change.

- **Desire to succeed as a business** – it is your practice, and so there is an inherent incentive and drive to make positive changes for the benefit of patients and the community.

- **Decision maker** – as well as making hugely positive changes to your own practice, you can also help to disseminate the good practice learned from your practice across your locality (including to other practices, hospitals and community services).

- **Education and training** – as a partner you can also be responsible for supporting the education and training of other GPs and health care professionals, by creating a positive and supportive training environment in your practice. This also forms part of succession planning, by helping to train a workforce for the future. You can also be a trainer if you are a salaried GP or a GP Retainer.

- **Flat hierarchy** – all partners should have an equal say in their partnership. It is also important that all staff are valued, and this is especially true regarding salaried GPs.

- **Property owning opportunity** – for some this is seen as a risk, but in the past it has provided an opportunity, and as a partner you may have the option to become a part owner of your surgery.

- **Continuity of care** – one of the most important aspects of being a GP, which has been shown to improve patient morbidity and improve GPs satisfaction with their role. Being a partner gives you greater opportunity to influence how you deliver continuity of care to your patients.

- **Leading member of a team** – as a partner you are a leader. You may not be the chair or managing partner but you will have the opportunity to lead, and these opportunities will increase as you gain experience.

2. What are the risks to me personally if the practice doesn't do well financially?

As a partner you are jointly and individually liable. This means you share all profits and losses, management authority, and risk for the business. Partnerships do carry the potential for financial risks, but this needs to be balanced against the benefits cited above. A well-run practice will be able to foresee likely financial downturns, and decisions can often be made early to address this with solutions. As a partner you will be party to such decisions, and you will have clear guidance on your liabilities within the partnership agreement.

3. What are drawings?

As a partner you are self-employed, and therefore will receive a 'drawing' as opposed to a salary. This is a share of the profits, which is calculated by taking the practice expenses away from the total practice income.

Most practices will work out a budget for the year knowing roughly what their income and expenditure will be. They will then agree what the partners' drawings will be each month.

Some practices will set this level such that it will share the expected 'profit' out monthly, and therefore there will be little additional money during the year. Other practices will set the drawings at a slightly lower level, and during the year there may be some additional payments or 'share outs'.

In some practices Tax and National Insurance Contribution (NIC) are held back and paid by the practice, but this is not always the case and should be carefully understood. It is vital to clarify what arrangements are in place in consultation with an independent medical accountant.

4. What does ‘parity’ mean?

As a partner you are self-employed, and therefore your income is dependent on the ‘profit’ that is available to share between the partners after all the expenses have been paid. In 2015/6 the average full-time partner earned £101,000 (after expenses).

Parity means that if, for example, you have a 4-partner practice and the full-time partners earn £100,000 a year, and you are full time and have reached full parity, you would earn the same.

In the past, it was normal for partners to start on 70% of a full share (parity) and then over a period of time (normally 2 – 3 years) that share would incrementally increase until reaching full parity (full share). This reflected the fact that you were joining an established business, and although you were qualified to work clinically as a GP it would take some time before you were able to fully participate in all aspects of the business and partnership.

Over the years, the time to parity has reduced - now it can be as little as 1 year, or even given fully on joining a practice.

5. Could I earn less than a salaried GP?

Theoretically yes, and this has happened in a small number of practices. Normally GP partners will earn more than the salaried GPs working in the practice, reflecting the additional responsibilities and roles they hold. Depending on how the practice use their income, it is possible that a partner could earn less than a salaried GP, but if this was the case the practice would find it virtually impossible to recruit new partners. It would therefore be important to find out the reason why – for example, is it due to the number of staff employed, money owed to the practice, or is the practice not viable?

6. What does ‘goodwill’ mean?

Goodwill is the value of a business over and above the value of its tangible assets such as premises, equipment, stock, net debtors and bank deposits. The sale of the goodwill of a medical practice which has a list of registered patients is not permitted under any circumstances. This is detailed in NHS Regulations.

7. Premises - what are the options? Do I have to buy in? If you don't own the surgery what are the alternatives?

Ownership – this could be by one or more partners or by the partnership. Normally the partners or practice act essentially as the landlord, and they will receive 'market rent' from the NHS. This rent will normally more than cover the cost of the loan to purchase the property.

Practices either own their premises or rent them.

There are a number of options:

- **All partners own a share of the building** – so after you join a partnership you purchase a share of the building. Banks will facilitate this through a loan which will not affect your personal mortgage. When you leave the practice, you can then sell your share of the building. If the value of the building has increased you will make a 'profit' which is then subject to capital gains tax, but equally if the value of the premises falls then you may lose some money.

- **Some partners own the building** – in which case you may not be required to 'buy-in', or you may agree to buy in after a set period of time.

- **The partnership take on the loan** – as a new partner you are not required to take an individual loan, but become part of the practice loan.

- **Reimbursement for the costs when you are the owner of the building** - a practice will either own their premises or they will rent them from a 3rd party. The NHS will reimburse the practice for the cost of the premises. This will include the market rental costs, the business rates and the cost of collecting clinical waste. Normally the amount reimbursed will be agreed between the NHS and the practice. Where the GP owns the building, this is known as 'notional rent'. Where the GP are paying off a mortgage, this is known as 'cost rent'. Where the GP is a tenant in a building owned by an NHS landlord or a private owner, they receive leasehold cost reimbursements.

  Premises owners

  Cost rent - As the name suggests, this form of reimbursement is designed to cover the costs of a loan taken out by the practice for the purchasing, building or significantly refurbishing its practice premises. Cost rent should only be in place for a finite period of time; once the mortgage has been repaid, the practice is no

longer eligible for Borrowing Cost Reimbursements and should notify the Area Team and switch to notional rent.

Notional rent – this is based on the current market value of the premises.

- **Rental and leases** – many practices work from buildings that they do not own and are instead rented from the owners. This is done via a lease which lays out an agreement between the occupiers and the owners. Leases are normally for a 20 year period and will sometimes have a break clause after 15 years, although the length of the lease and the possibility of break clauses will largely depend on the quality of the premises. There are different types of leases depending on what you are responsible for. The NHS will assess the premises and agree a level of reimbursement which would normally cover the cost of the lease but not cover things such as heat, lighting and cleaning.

8. What are the tax implications of being a partner?

You will need to register with HMRC as self-employed - this is a very simple exercise. You will be responsible for submitting an Annual Self-Assessment Income Tax Return. Your accountant will do this for you, who will usually be the practice accountant too.

If you are self-employed, you will pay National Insurance Contributions (NICs) as well as income tax.

This currently includes Class 2 NICs (all self-employed people pay this at a flat rate) and then based on the profits made you pay some Class 4 NICs.

How much NIC do you pay?

Class	Rate for tax year 2018 to 2019
Class 2	£2.95 a week
Class 4	9% on profits between £8,424 and £46,350 2% on profits over £46,350

These NICs pay for benefits such as the:

- The State Pension
- Maternity Allowance
- Bereavement Benefit.

As partners are self-employed, you will have to pay your own tax (due at the end of January and the end of July). The amount you have to pay will be based on your previous year's self-employed earnings. The practice accountant will normally tell you what this figure will be. The practice year end and your start date at the practice will affect when you first pay tax, but it is vital that you, or the practice, start saving for tax as soon as you start receiving drawings from the practice.

As stated above, some practices save tax on behalf of their partners and will then pay the tax owed on their behalf in January and July each year. Both of these methods lead to exactly the same tax payable, it is purely a different mechanism for saving for the tax. Obviously if you are paid gross of tax (i.e. before it's taken out), your drawings will be higher than if the practice withheld tax and saved it for you.

Student loan repayments (if due) are also collected via your income tax return annually, so you will need to make sure you tell your accountant about your student loan position.

A practice may also be registered for VAT. This is a practice liability not a personal liability. It is based on practice earnings which are deemed to be subject to VAT and the practice reaching a certain threshold. Practices who dispense medications to their patients, known as dispensing practices, are likely to be VAT registered.

As a self-employed individual you are able to claim tax relief on certain expenses which you may incur personally, such as business motor expenses, professional subscriptions, business computer and mobile phone costs. Your accountant will be able to help you with this, so that you can maximise the tax relief you can claim and reduce your tax bill. Tax relief for expenses incurred personally is more generous under a self-employed status than under a salaried status.

9. What is 'working capital'?

For any business to run it needs an element of cash flow, and a GP partnership is no different.

When you become a partner, you will be asked to build up a working capital current account balance which is like a small loan of cash that you lend to the practice. This

money remains under your individual name. You may be asked to build this up over a specified amount of time, for example by a small deduction from drawings over a two-year period from joining. The amount will vary depending on a number of factors, including the number of sessions you are going to work, size of the partnership etc. This will come out of your drawings, and the amount is negotiated between the individual and the partnership and would not normally require the new partner to take out a loan to meet the requirements.

You would withdraw any working capital current account balance on retiring or leaving the practice.

10. Am I legally and financially responsible for staff?

As a partner you employ your staff, so as the employer, you and your partners are legally and financially responsible for your staff and must therefore comply with employment law, health and safety etc.

This is one of the reasons why it is so important to have a good Practice Manager who will ensure that all of these aspects are covered - but ultimately the partners hold the responsibility.

11. What are the pension contributions?

If you are an employee and part of a pension scheme, your employer will pay a fixed contribution and you as the employee will make a fixed contribution.

In the past, a partner would contribute to their pension based on their income (profit) and the NHS would also contribute. In 2004 this arrangement stopped, and the NHS's contribution was added to the income received by practices so that now the individual partner has to meet the total cost. Each year your accountant will issue a certificate of pensionable profits.

It is worth remembering that the current NHS Pensions are not as generous as they were in the past, but are still better than most private pensions. If you are thinking of opting out of the NHS Pension Scheme, take independent financial advice first. Also remember that by being part of the NHS Pension scheme not only do you receive a pension on retirement, but it also gives your family death in service benefits, as well as ill health retirement cover.

The current employer contribution rate is 14.38%. All GP partners in the scheme will pay at this rate.

The current employee contribution rates are tiered based on pensionable earnings levels as follows:

Up to £15,431.99	5%
£15,432.00 to £21,477.99	5.6%
£21, 478.00 to £26,823.99	7.1%
£26,824.00 to £47,845.99	9.3%
£47,846.00 to £70,630.99	12.5%
£70,631.00 to £111,376.99	13.5%
£111,377.00 and over	14.5%

For example, a partner income over £111,377.00 will pay 14.38% (the employers' contribution) plus 14.5% (the employees' contribution) i.e. 28.88% of their income.

12. What is the difference between GMS and PMS practices and what is APMS?

The **General Medical Service (GMS) Contract** is the contract between general practices and the NHS for delivering primary care services to local communities.

The current GMS contract was introduced in 2004 and covers three main areas:

- The Global Sum – covers the costs of running the practice and delivering essential services.
- The Quality and Outcome Framework (QoF) – a quality initiative focused on public health and clinical areas such as diabetes, hypertension etc.
- Enhanced services – which covers additional services that the practice may choose to provide, for example minor surgery and extended opening.

These contracts can only be held by a Contractor or Contractors (defined as an independent contractor (i.e. GP). The contract is held by a Contractor or Contractors in perpetuity (i.e. there is no time limit on the duration of the contract).

The Personal Medical Service (PMS) Contract was introduced in 1998 and allowed practices to have greater local flexibility than the GMS Contract. This contract can be held

by a GP or GPs or Nurses but not by an external organisation. With NHS reforms the difference between GMS and PMS is significantly less than it used to be.

Alternative Provider Service (APMS) Contracts were introduced in 1998 and are normally primary care contracts that are provided by outside organisations. These contracts are normally awarded for a period of 5 – 10 years.

13. What is MPIG?

This is the Minimum Practice Income Guarantee. Following the introduction of the new GMS Contract in 2004, a new formula called the Carr-Hill Formula was introduced to calculate the funding each practice would receive. This formula took account of a number of factors - age, sex, morbidity, mortality, deprivation for example. Shortly before the new Contract started each practice received its budget for 2004/5, and many found that rather than increasing they lost funding - for some this was very significant. The NHS therefore introduced additional funding for all the practices who would be net losers, and this was called a Correction Factor (CF) which when added to the Global Sum made up the MPIG.

This is being removed from practices over a seven-year period and re-invested into the Global Sum, so that by April 2020 all GMS practices will be funded at the same global sum payment per weighted patient.

A similar process is happening in PMS contracts to remove any funding seen as additional when compared to GMS practices. This funding is being re-invested in GP services locally. By April 2020 all GMS and PMS practices should be paid the same per weighted patient.

14. What are my employment rights as a partner?

As an employee, your employment rights are covered under employment law.

As a partner, you are not subject to the same employment laws as an employee. For example, ‘unfair dismissal’ as covered in employment law is applied to employees, but does not apply to partners. It should be remembered that partners are still subject to discrimination laws (for example in relation to sex, race, disability and age).

Partnerships are governed by the 1890 Partnership Act. It is therefore essential that all partnerships should have a partnership agreement in place that is up to date. A partnership agreement is a contract between partners in a partnership. It details the terms

and conditions of the relationship between the partners, and would normally include details of, for example:

- Duties of a partner;
- How decisions are made – for example, voting for minor and major decisions;
- How profits are divided;
- Holiday entitlement, parental and compassionate leave;
- Details of tax, accounts and pensions – and how these are addressed;
- Dissolution of the partnership, retirement etc;
- Premises.

You should go through any partnership agreement carefully and consult independent advice before joining a partnership. Your Local Medical Committee (LMC) can help you with support and advice.

15. What does ‘last person standing’ mean? Is that a risk?

This is a term used whereby partners have left the practice and the practice has been unable to recruit replacement partners, and the full liability of the partnership sits with one remaining partner.

There are ways to reduce this risk - for example, ensuring there is a robust partnership agreement which prevents all the partners leaving in quick succession. Normally such a stipulation would mean that only one partner can leave every 6 months. Practices could keep a contingency fund that would cover the liability and hence protect all partners.

The partners of the practice should be open about their plans for length of time they intend to work in the practice, so as to enable the practice to plan for the future and have a succession plan.

Secondly, if the practice is forward looking, has a positive attitude and is profitable, this is much more attractive to new partners, which in turn negates the risk of ‘last man standing’.

Vulnerable practices need to identify themselves early and look for potential solutions which could include merging with another practice or getting support from the LMC or your local GP Federation.

16. Is it true that joining a partnership is like a marriage?

Your practice can be like a second family - it is a big commitment, but you also get out of it what you are prepared to put in. All practices have ups and downs, and relationships require time and investment. It can be very rewarding as everyone is committed to the team - but you have to work through those highs and lows together like any family!

If you are seriously considering joining a practice as a partner, you should expect to be able to see their partnership accounts for the previous 2 years. That then gives you the option of gaining an expert view on the financial state of the practice.

Ask how soon you would be expected to build up your working capital.

You should ask to see their current partnership agreement.

17. What's the future of the partnership model?

We believe that the partnership model is here to stay and offers unrivalled advantages in delivering patient care in an effective and cost-efficient way.

General practice will remain as the foundation of the NHS and a gateway into most NHS services. Primary Care Networks are developing in England, based on communities of about 30-50,000 people, and led by practices working together. These networks will allow practices to benefit from additional services and resources to improve the care of the population they serve. More details will become available over the coming months.

For the tax payer, partnership offers the most cost-efficient way of delivering general practice services.

The challenge will be in identifying how to best support the partnership model so that it can thrive within a rapidly changing landscape, without losing the current benefits of partnership in continuity of care and staff productivity.

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