GP NEWSLETTER

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Partner

Neither of our medical sector managers, Alison and Emma, were able to attend the annual AISMA (Association of Independent Specialist Medical Accountants) conference this year, so responsibility for a summary of events has fallen to me.

The morning sessions were devoted to the current state of GP practice. The key note speech was delivered by a representative of NHS England's GP section, and offered a variety of proposed measures to improve the current situation, both in terms of extra finance and greater use of IT in particular to ease GPs workloads. Perhaps it is the cynicism that comes with age but I am afraid my reaction was to question how many of the proposals outlined would actually come to fruition. I was reminded of other similar presentations I have heard over the years, for all sorts of businesses, where the landscape that developed has proved rather less rosy than that which was predicted.

The second session was from what might be termed a poacher turned gamekeeper, a former NHS executive now providing consultancy services to general practice. Although the message was in many ways a familiar one, that there are going to be major changes in the way GPs operate in the next ten years, there was some interesting comment on the perceived ways in which that change will come.

For example, the mega practice idea was dissected in some detail, with pros and cons given equal consideration. A particular comment was that although the average list size of practices needs to rise, a figure around 20,000 may be the optimum figure, rather than something up around the 50,000 mark. This higher level can give more problems in terms of human resources in the widest sense; partners become remote from each other and staff motivation is also more difficult. Given that general practice is very much about people, these potential problems may well outweigh the financial savings that can be achieved through economies of scale.

If mergers are not necessarily the answer, what are the alternatives? Perhaps working more closely with neighbouring practices, either through a federation or some other arrangement that is more flexible and retains a degree of independence than a full blown joining together; an entente cordiale rather than a united nations? That theme struck a chord with me; the older GPs amongst my client base will recall me for years using the analogy of agriculture as illustrating the way I feel general practice needs to change. Farmers, like GPs, value their independence and prefer to meet their neighbours on a social rather than a business basis. However, the rising cost of agricultural machinery, coupled with reduced returns, have meant many have had to change that view in order to survive; for example arrangements where major items of equipment such as combines are shared are now commonplace.

How can closer co operation take place in general practice? Another comment from this session that struck a chord was the suggestion that greater use of other health care professionals should be considered, to free up GP time so it is utilised in the best possible way. Whilst a single practice may not be able to bear the cost of a physiotherapist to assist with diagnosis, an alliance of neighbouring practices might well be able to.

The speaker's experience was that there is a general opposition to change within GP practices. It was clear that an independent pair of eyes, from outside the practice, with no pre conceived ideas, had greatly benefitted the GPs he had worked with. In many cases, the tried and trusted is the best way, and change for change's sake is wrong, but a different view can often bring benefits. Our website gives details of the GP trouble shooter service we are offering to GP practices, whether existing clients or not. I came up with the idea following the experience of one of my clients last year, when they needed assistance at short notice when their finance manager went on sick leave. The post was filled by a former finance director of a subsidiary of a FTSE 100 company, who as well as being able to fulfil the practice's needs in terms of the financial function, was able to utilise the experience of many years in industry to provide some valuable comment of the way in which some of the practice's procedures might be improved.

Clearly an independent review comes with a cost. However, the testimonial from the senior partner of my client included on our website shows the potential benefits. It may be that the review will conclude that a merger is the best way forward.

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The first afternoon session covered the always topical subject of pensions. The detail of the current situation with the annual and lifetime allowances was covered in detail in Emma Wood's newsletter following the AISMA pensions course last autumn so I will confine these comments to a few specific points. The trend for many GPs to become deferred members due to factors such as the tapered annual allowance was noted, but with a word of warning about the benefits that can be lost if there is early retirement due to ill health, particularly one that falls with tier 2. Continuing to pay added years is not generally beneficial because of the lifetime allowance, although there can be specific situations where it can help. All members should make sure they have registered to receive an annual Total Rewards statement, a copy of which should always be passed to us to assist with the tax implications of the pension scheme membership.

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Finally, we were given the results of the AISMA survey of GP practices dealt with by member firms for the year ended 31 March 2016. The general trend was that net incomes were very similar to the previous year, but the factors such as net income per patient are continuing to fall year on year. Whilst the conclusion that net income did not fall significantly is good, these result are now over twelve months old and so of limited value given the rate of change within general practice. It is also debatable whether they will encourage new partners into GP practices, one of the major issues facing the profession, given other concerns over matters such as work load and pensions.

My fellow medical sector partner Debbie Wakefield also attended the second day of the conference, where the first session dealt with the changed tax position of locum GPs, arising from a change in the way HMRC are dealing with IR35, specifically requiring public authorities to review services from sub contractors that are provided via the sub contractor's personal service company. The IR35 rules deal with situations where the reality of the arrangement between the two parties is one of employer and employee and so the amounts paid to the sub contractor should be taxed under PAYE. The view was expressed at the AISMA conference that GMS or PMS contract holders are public authorities and so need to apply the new rules. Assuming the arrangement falls outside IR35, it is important there is a written contract between the GP practice and the sub contractor's company but if not as a minimum a letter to the sub contractor's company setting out the practice's understanding of the working arrangements. We are happy to advise on specific situations.

The final Friday morning session of the conference dealt with mega practices; Debbie's view is that these may be appropriate in some circumstances but are not a fit all solution, confirming the thoughts from the previous day.

If you think this information might be useful to a friend or colleague, please pass it on.

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