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AISMA Doctor Newsline

At the heart of medical finance...

GP practices fight to keep staff

As GP practices fight to keep staff amidst a cost-of-living crisis - plus low pay awards and superannuation rate rises - **Sally Sidaway*** looks at what they can do to help ride the storm

We are surrounded by news of the cost-of-living rise and its pending effect, especially on employees at the lower end of the pay scale.

Against this, GP practices face an ever-increasing workload as they strive to recover from the pandemic, coupled with probably the greatest workforce crisis in NHS history.

The government has accepted the NHS Pay Review Body recommendations, awarding a 4.8% annual increase for Agenda for Change staff and around a 4.5% rise for salaried GPs.

This is much higher than the 3% budgeted for in the contract and primary care is so far being left to fund the additional costs of practice staff despite calls for this to change. Meanwhile the deepening workforce crisis really questions the government's commitment to recruit an additional 6,000 GPs and 20,000 other key primary care workers by 2024.

An average GP practice could be around £35,000-£40,000 worse off due to these unfunded increases but, if it cannot match pay

rises in secondary care, the ability to retain staff will be undermined. If we see partners' profit shares reducing, we face an even bigger risk to GP numbers.

The expanding budget for Additional Roles Reimbursement Scheme (ARRS) staff carries with it doubts over their availability and there is uncertainty too about the longer-term future of the PCN DES and what PCN funding beyond 2024 will really look like.

So - the perfect storm is upon us! What can we do to mitigate the severe cost pressure of rising practice staff costs?

Maximise use of ARRS staff roles

Practices must engage closely at PCN level to make sure they can take maximum advantage of ARRS staff who are largely, if not wholly, a paid-for resource.

It is now vital for PCNs to do all they can to find, train and make use of these individuals. All practices must make their voices heard at the PCN and ensure sharing of these staff benefits all.

Care co-ordinators, for example, are a relatively low-paid reimbursed staff category who can be used within the practice for a wide range of duties within the allowable remit. Look carefully at admin teams and be innovative in beefing these up over time with care co-ordinators carrying out all duties relating to patient care co-ordination.

Clinical ARRS staff may need training to really improve GP workload but, when this is made to work well, it is invaluable. We have moved beyond the time when GPs and senior clinicians can be afraid to delegate, and we must embrace change within the day-to-day working of general practice.

Salaried GP time

We see differing rates of salaried GP pay per session from a regional perspective as well as job description variations.

It is important that practices ensure salaried GPs are paid an appropriate rate for work carried out. Some practices are, however, looking at different categories of salaried GP with greater and lesser levels of responsibility in terms of clinical and administrative responsibility.

Interestingly, when practices merge there are differing expectations of salaried GP work patterns and practices need to look carefully at the appropriate levels of pay for 'differing roles.'

In the overall staff budget salaried GPs are going to be the highest individual cost. Be willing to consider with any staff role, as natural wastage occurs, if a like-for-like replacement is the best and most efficient way forward for the practice.

"...talk to your AISMA accountant as to how you compare with other practices..."

Can the workforce be rearranged so that salaried GPs are able to delegate an element of their work to another senior clinician such as a paramedic, physician assistant or clinical pharmacist?

Is an additional advanced nurse practitioner actually a better way to spend some of the staff budget? Of course, a willingness to train and change is needed to maximise the ability of these individuals to take some of the strain off the GPs.

Retainers

I am a great believer in this scheme. Look at using it to encourage GPs towards the end of their careers to stay longer with the added support of additional education. On top of the salary supplement, the practice will also receive, for example, £16,000 for four sessions' worth of this valuable expertise. It is time-limited, but we need all we can get right now.

GP registrars

If you are not a training practice then consider if any of your GPs would be prepared to become a trainer, and give them the time and support to do this. The pay-back in time, after the initial training period in terms of work and continuity at the practice, really can make a huge difference.

GP fellowship scheme

Look at this scheme. It is available to all newly qualified GPs and nurses working substantively in general practice as a two-year fellowship programme of support with reimbursement of up to one session per week salary cost.

Staff time

Always remember your staff team is your greatest asset.

Practices need to award pay rises in accordance with the pay award recommendations but also in consideration of both the cost-of-living crisis and the competition you face as an employer. Without getting this right we face a huge exodus from general practice, one that will cost far more than the cost of getting the pay rise right now.

I would urge practices to look at different areas of their workforce in different ways and pay particular attention to staff who will suffer most from the current economic threats.

Despite this, practices have a finite budget to spend so practice and finance managers face a challenge.

Look at different staff groups and talk to your AISMA accountant as to how you compare with other practices for staff cost per patient in different staff groups.

Non-clinical staff

These have been averaging a cost of £35-£38 per raw patient. If you are significantly above this, excluding ARRS staff, then this needs to be reviewed.

Areas to look at:

- Unfunded PCN management time - does the practice need to charge the PCN for this, from some of the £1.50 per patient? Be aware of VAT on all PCN staff recharges - talk to your accountant (see VAT article on page 12).
- Overtime costs, particularly on reception - can this be better controlled with changes to rotas?
- Can care-coordinators take some of the admin burden and allow rearranging of duties as a funded resource?
- Split sites will be more expensive, but can you look at differing use of clinic times at different surgeries to reduce reception time needed?
- Extended hours times will need non-clinical time but maximise what work can be done in those times by those being paid.

Nurses and HCAs

This staff group covers a multitude of clinicians ranging in skill sets and pay scales. It is vital that you consider right person, right job.

We see averages of about £15 per raw patient but some significantly lower than this. If you are on the lower end this could mean a lack of delegation from senior clinicians which may be costing more than is sensible in the current

Helping lower paid staff

There may be some ways in these hard times practices can help lower paid staff:
Bonuses can be non-pensionable and, where paid to staff, will attract tax relief for partners within the practice accounts.

A bonus accrued and paid via payroll within nine months of an accounting year end attracts tax relief for that accounting period. These have been popular during Covid but beware habitual bonus patterns that could be then linked to an annual requirement. Bonuses could be used to supplement pay rise levels during the high inflationary period.

Consider the lowest paid staff carefully. Practices of course look at minimum and living wage rates, but these could still take you to an hourly rate below that paid by a local supermarket. The attraction of the bigger NHS pension is simply not going to help those employees for whom the cost-of-living crisis threatens day-to-day living.

Non-cash bonuses can be considered, such as vouchers not exchangeable for cash. Talk to your AISMA accountant about the rules and limits but these are proving attractive to some practices and should be explored.

Staff recruitment will be a challenge. Be innovative in flexibility around term time and part year workers but be careful not to fall foul of Working Time Regulations in terms of annual statutory holiday.

Salary sacrifice schemes – these may have a place. Childcare vouchers and cycle to work schemes are particularly useful.

Staff expenses claims – where relevant make sure these are paid in a timely fashion.

Staff parties and other social functions, together with trivial benefits and small gifts, can all add to the wellbeing of a workforce and your AISMA accountant will be happy to discuss the HMRC rules.

primary care market.

For example, take chronic disease management and phlebotomy, both areas that bring extra practice income outside core funding. But profitability from these very much depends on the right level of staff being trained and trusted to carry out this work.

Clinical pharmacists

We see a mixed bag of opinion as to how well this works. I believe they can work extremely well where GPs are happy with an area of their workload redirected.

Training and peculiarities of list will remain a boulder to overcome but it is worth striving for.

Low level pay grade staff retention

To my mind this is the most acute of your current staff problems. The increase of 1.25% NICs has added both to employers and employees an additional extra unfunded cost. The current proposal is to reverse this from November which will help.

Lower scale pay rate full time employees also face an increase in employee's superannuation rates from October 2023.

Take time to explain to your staff why this has arisen; the worst outcome in net take home pay is a nasty surprise staff were not expecting. *(See box above.)*

"In all discussions with partners, it is important that they remember any additional cost for staff will attract tax relief"

So, we have some solutions and some alleviations to the pain in what is a very difficult economic time for practices. In all discussions with partners, it is important that they remember any additional cost for staff will attract tax relief, so for most the maximum actual cost would be 60% of the pay rise, bonus, or additional cost.

GP partners are facing huge tax bills and also, for some, annual allowance tax charges, so the cost may not be as high as it seems!

I think it is vital for practice or finance managers to prepare a detailed staff budget and compare to actual throughout the year as things change. Locum and staff overtime use should be particularly carefully controlled.

We have no magic wands, but careful thought and measured control will help keep good staff teams in place.

Bite the bullet now - and give your practice better financial data

OPINION

Sue Beaton,** AISMA board member

Several contributors to our summer *AISMA Doctor Newsline* referred to the need for practices to look at how they operate.

The focus largely concentrated on ways to maximise quality delivery of medical services, to tighten up and better control claims and to streamline clinical work processes for greater efficiency.

But a related aspect of examining processes and how practices work is the accounting and finance function, including when and how their income and outgoings are recorded and what is done with that information.

There are some excellent and high achieving practices who still have not fully geared up their financial record-keeping to get the most from their financial reporting.

Several would not currently be fully ready or compliant for the start of Making Tax Digital (MTD), which, for medical partnerships with individuals as partners, commences in 2025-26. This will require quarterly reporting of financial information to HM Revenue and Customs (HMRC) using accredited software packages approved for this purpose.

A surprising number of practices still use outdated, limiting accounting software. And some even still maintain records via Excel spreadsheets which are updated infrequently, mainly when the information is requested by accountants to compile the year end accounts.

These practices could gain so much more timely insight into how they are doing financially if they invested in cloud-based accounts software as soon as possible, even before MTD makes it necessary. Authorised users can access the records from anywhere.

A bank feed gives access to live information, enabling approved users to regularly monitor transactions. Ledgers can be set up with a little more training.

A sales ledger enables you to keep a continual record of claims and outstanding invoices such as solicitor or medico legal reports, which clear down once the money is received. Aged debtors' reports give a clear statement of who owes what to the practice at any one time and how long these amounts have been outstanding.

Similarly, a purchase ledger enables the logging of outstanding amounts payable to suppliers which, again, clear down as they get paid. At the touch of a button, assuming the data has been entered correctly, the practice can see how much it owes to suppliers at any given time.

Profit and loss statements and balance sheets for specified periods can be run and, provided the entries recorded in the system are accurate, can prove valuable tools in helping the practice see its performance and compare with previous quarters, 12 months or even several preceding years.

Figures in the system can be drilled into to see underlying details, supporting invoices and notes. Files or working papers can be uploaded into the records too.

Likewise, information can be downloaded in various formats, including Excel. Even practices who already use cloud-based, MTD-approved software could benefit from these aspects.

These tools can provide a deeper understanding of the day-to-day finances, cash flow can be more closely monitored, and budgeting and monitoring refined.

In these challenging times, with spiralling inflation and rising interest rates, having appropriate and up-to-date financial systems and software that is fit for purpose is very important for a practice's efficient running.

Having access to timely and accurate financial information is a crucial part of operating a more commercially savvy business.

There are likely to be many practices whose current financial internal record-keeping leaves something to be desired.

They can be as smart as they like with the patients and the clinical work. But if their underlying accounting data is not properly recorded or reconciled, is slow to be updated, and is using outdated products, they will never be as good as they could be.

Making changes is never easy but compliance with MTD is not far away so looking at systems, biting the bullet and having access to better financial data now will bring the chance of being more financially aware and better equipped to run a tighter practice.

Time to get familiar with other types of contracts

Understanding what psychological contract exists for every individual in your practice can help motivate, engage and retain your team members. Fiona Dalziel explains

There has never been a better time to understand motivation.

Why do people work? What do they expect to get back for their efforts? Is money going to make people stay in a demanding job?

Money is only a short-term motivator but you will know if you are familiar with Maslow's hierarchy of needs (see link below) that if a worker's security is threatened then they are unable to move ahead until the threat disappears.

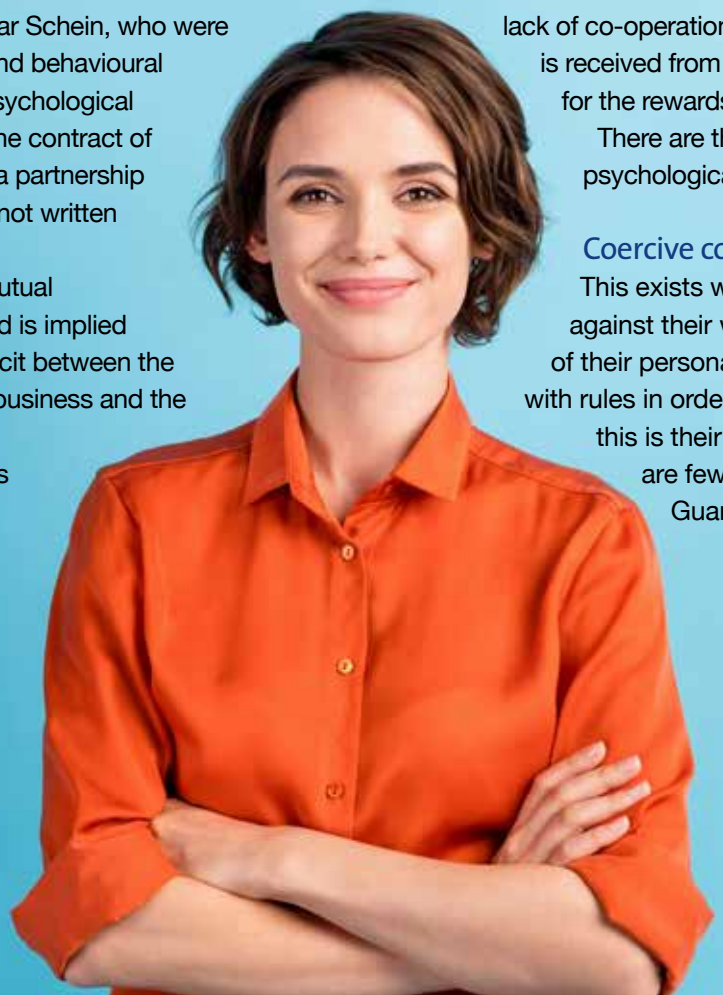
Staff worried about paying for food, heat and childcare will prioritise this before they can rise to new challenges. Taken by itself, this is not very encouraging in the current financial climate.

What should we be thinking about? What will help us understand everyone's motivation when our hands are pretty tied financially in terms of rewarding people?

The concept of 'Psychological Contracts' appeared in the 1960s in the work of Chris Argyris and Edgar Schein, who were organisational and behavioural theorists. The psychological contract is not the contract of employment or a partnership agreement; it is not written down.

It is a set of mutual expectations and is implied rather than explicit between the organisation or business and the individual.

What does this mean in reality?



On both sides, on the side of the practice as a business and also on the side of the employee (or partner), there exists a bargain or psychological contract.

How much we as individuals expend in terms of our time and energy depends on whether we see the bargain as reasonable to us. The practice as a business also has a set of expectations in terms of what it is willing to give as a 'reward' (for example pay, annual leave, promotion, training) in return for our efforts.

Working harder or longer for no more reward may not, but can, be perceived by individuals as reasonable. Asking for more reward in return for no increase in input may not be perceived by the business as reasonable.

A perception of inequality in the bargain leads to stress and conflict. The individual feels exploited if the business expects more than the individual wants to offer. The business may feel there is a lack of co-operation if it expects more than is received from the individual in return for the rewards it offers.

There are three different varieties of psychological contract:

Coercive contract

This exists where individuals are held against their will. They are deprived of their personal identity. They comply with rules in order to avoid punishment; this is their motivation. There are few or no rewards. Think Guantanamo Bay.

"...a lack of understanding of everyone's individual psychological contract with the practice will lead to conflict"

Calculative contract

This is the most common psychological contract and is entered into voluntarily in exchange for an explicit set of expectations on both sides. In exchange for 'x' effort, the employee will receive 'y' reward.

Management retains control of activities and rewards. If management seeks something for nothing, then the employee will adjust their behaviour accordingly.

Spotting adjustments in behaviour can be quite difficult, as they may not be directly related to the change in expectation. For example, the senior receptionist requests a change in hours. The request is dealt with fairly but is refused.

Everything seems fine until a couple of months later you discover that the Christmas party has not been arranged. No booking made, no plan.

The senior receptionist usually jumps at the chance to sort out social events. What on earth has happened? Her expectations were not met and she adjusted the amount of energy she was willing to expend.

Cooperative contract

If a cooperative psychological contract is in existence then the individual identifies strongly with the goals of the business.

Management allows the individual to work independently without much direct control and the employee (or partner) has discretion to make decisions and solve problems without reference back up a chain.

The individual will often expend far more effort in pursuit of goals than is expected in the contract of employment. This may manifest itself as working additional hours, taking work home and not leaving worries at the door. The divide between work and home is more blurred.

Not everyone wants this level of engagement and pressure. A cooperative contract cannot be imposed and is easily damaged, in which case it reverts to being calculative, with an attendant loss of 'extra' effort being expended by the individual.

Let's look at an example. Shirrin was recruited from another practice as practice manager. She was already a competent administrator but required management training, which was provided.

She flourished in the role and developed a cooperative psychological contract. She was willing, dedicated and enthusiastic, regularly attending evening meetings and sometimes taking work home, but not taking the time back.

She requested a week's additional annual leave. This was refused. She now keeps a careful note of all the personal time she spends on practice business and takes the time back, as her contract of employment allows her to do.

Her psychological contract has become calculative because she expected her efforts to be recognised and rewarded. Her employers could not understand why her motivation took such a dip.

Thinking about it

Each individual in every practice will have a different psychological contract. You may find that some lower paid staff have a cooperative contract and some partners a calculative one.

This may not be what you expect, and a lack of understanding of everyone's individual psychological contract with the practice will lead to conflict.

Where there is dissonance between their expectations of the practice and vice versa, staff or partners will work less well. Hoped-for results may not materialise and valued individuals may leave.

Plainly, this does not answer the question of how to motivate, engage and retain staff when more pay is what they want but the hardest thing for the practice to offer.

However, an understanding of what psychological contract is in existence for each individual will go a long way. Are you a leader in the practice? Then you need to work this out.

Find out more

Maslow's Hierarchy of Needs
https://tinyurl.com/53hawu9e

Fiona Dalziel runs DL Practice Management Consultancy

ASK AISMA!

GPs' questions about how their money is eaten up by taxation, and the value of recording personal expenses, are answered here by **Abi Newbury**[***]

You can ask a question by contacting your local AISMA accountant or messaging us through Twitter @AISMANewsline

HELP ME UNDERSTAND WHERE ALL MY EARNINGS ARE GOING

Q **I thought if I was a 40% taxpayer in England I just paid 40% on all my income – but it seems that's not the case. Can you explain what tax do I pay at various levels of income?**

A I can see why you might think that you'd be paying a flat 40% on the top slice of your income. But it is more complicated than that and it is worth understanding how it works as your income increases:

- 40% is the marginal rate (or rate on the top slice) of your income.
- Many people will have a tax-free allowance - currently £12,570 - so effectively the first 'slice' of income is tax free. However, this disappears for higher earners (*see more below*).
- The basic rate band will cover the next £37,700 and will be taxed at 40%. Then it gets more complicated.
- If you earn between £50k and £60k, are the higher earner of a couple (married or not) and claim child benefit, then that starts to get reduced by way of a tax charge until at £60k all your child benefit would be recouped.
- If you earn £100k then your personal allowance tapers off – until at £125k approximately you lose the whole allowance. This means that you pay an effective 60% tax on this slice of income.
- Also, £100k is the limit for the tax-free childcare scheme. Under this scheme you can get up to £2,000 a year towards childcare (as well as the 30 hours free childcare scheme), but you must have income below £100k after pension deductions.
- Then at £150k of taxable income you start paying the additional rate of 45%.
- If you get as high as £200k and if your

pension inputs take this over £240k, then your £40k pension annual allowance starts to get tapered – right down to £4k – so your annual allowance charge will be much higher.

And don't forget that on top of tax, as a partner or self-employed individual, there are further liabilities:

Class 2 NIC - currently £3.05 per week
Class 4 NIC - currently between £11,908 and £50,270 at 10.25%, over that at 3.25%.

You might also have student loan repayments at 9% (the starting level depending on the type of loan you have).

And then you need to consider NHS pension tiers which is beyond this question.

Hence the need for a specialist accountant to make sure you don't hit any unnecessary cliff edges and pay more taxes than you need.

HOW IT PAYS TO PROPERLY RECORD PERSONAL EXPENSES

Q **Every year my accountant nags me to send information for my expenses claim. Is it really worth the hassle?**

A With the pressures GPs are under it is quite understandable that they don't want to waste time hunting out receipts or payments to make a personal expenses claim.

After all, how much difference does noting course costs, personal use of mobile phone and landline and other ad hoc expenses make?

If just £1,000 of expense is claimed for a 40% taxpayer then that would currently save tax and

National Insurance of at least 43.25%. It would also save you superannuation of perhaps 13.5% (less tax relief) = 8.1% net.

So that might save £513.50 every year. Over a 30-year career that could be more than £15,000. Worth a little bit of organisation each year I would say!

Add to that the possibility of those expenses also dropping you under a limit to perhaps claim more personal allowance – in which case the total saving would be 63.25% - or it might even drop you under a superannuation tier – and save you 1% or more on your total pensionable earnings.

Collating the information needed can be a much easier task if records are kept through the year.

Using a simple month-by-month spreadsheet, or a separate bank account or credit card account for work related expenses and downloading the statement monthly, will not only avoid the dreaded year end panic but it will get you ready for Making Tax Digital (MTD) for partnerships when it comes in.

Once you are in the habit of recording expenses, it won't be so difficult. And you might be very glad you put a system in place to provide a relatively small amount of information that could have a potentially big effect on your liabilities.

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AISMA Doctor Newsline is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK.
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To lease or to licence?

The difference between a lease and a licence to occupy should be understood at the outset. Stewart Gregory explains about the lease licence dilemma, your rights and the vulnerabilities

How best to document the short-term occupancy of a particular party in healthcare property is an important consideration.

A licence can seem a quick, easy way to grant a right to occupy property, but problems can be created by its inappropriate use.

To see if a lease or licence is more appropriate for a particular occupancy, let us look at first principles.

A lease is the grant of a right to the exclusive possession of land for a determinable period of time. Note 'exclusive possession': the key element of a lease in this context.

Someone is said to have exclusive possession if they can enjoy the property as though they were the landowner and exclude both the landlord and third parties from the property. A lease therefore creates an interest in land, a licence does not.

A licence simply gives permission to a licensee to do something on the licensor's property that would otherwise be an unlawful trespass. It is therefore a personal contractual right or permission and does not give the licensee the right to exclude the licensor from the property.

A tenancy at will is another possibility for a short-term occupancy arrangement and can be very similar to a licence. A tenancy at will exists where there is a tenancy on terms that either party can bring to an end at any time.

It is again a personal relationship between the original landlord and tenant and cannot be transferred. It is useful where parties are in negotiation for the grant of a lease and want to document a short-term occupational arrangement while the lease is negotiated and completed.

Great care is needed: if not properly drawn up it can instead create a periodic tenancy, which can have serious consequences when it comes to terminating the arrangement.

Labelling a document a lease or a licence has little bearing on what it actually is: if exclusive possession is granted by the arrangement a lease can come into existence. Cases over many years have debated the distinction.

The leading case is a decision of the House of Lords in Street v Mountford, 1985. To summarise:

'If the agreement satisfied all the requirements of a tenancy, then the agreement produced a tenancy and the parties cannot alter the effect of the agreement by insisting that they only created a licence'.

That decision has been reinforced in recent cases. The effect is: 'If the arrangement has the characteristics of a lease, then it is a lease, irrespective of what you have called it'.

But why is all this important?

The crucial issue is the occupier's security of tenure. When properly drawn up, a licence and a tenancy at will do not give the occupier security of tenure.

Generally, a tenant who occupies property under a lease for the purposes of its business has statutory rights to renew its tenancy at the end of the term. The landlord can only oppose that renewal on certain limited statutory grounds.

A lease can be granted that does not give the tenant security of tenure, but this can only

be done either by:

- 'contracting out' the lease from the security of tenure provisions before the lease is granted, or
- by granting a lease that is exempt from those provisions - which, in healthcare, really means only granting certain tenancies for not more than six months.

This can make licences and tenancies at will seem attractive when the occupier wants a short-term arrangement.

What happens if a tenancy inadvertently arises from the arrangement?

A lease can only be contracted out of security of tenure before it is entered into. If the parties believe they are only entering into a licence they will not go through the statutory required procedure to contract that arrangement out of the security of tenure provisions.

If it is subsequently held to be a tenancy, because the occupier actually enjoys exclusive possession, the tenant will have security of tenure, making it difficult for the landowner to terminate the arrangement.

Can a licence ever be safely used?

It might seem not, but remember, a court will look at all the landowner's rights and powers when determining whether an arrangement contains a grant of exclusive possession. While they are not conclusive, here are examples of provisions in documents that courts have interpreted as meaning only a licence had been granted:

- provisions preventing the occupier from interfering with the owner's right to possession and control of the premises. Such a provision is inconsistent with the grant of exclusive possession;
- provisions allowing the licensor to make alterations to the premises. That would require a significant degree of physical control over the premises inconsistent with an occupier's exclusive right to possession;
- the absence of a right for the landowner to enter the property. If it is a licence then the landowner retains control of the premises at all times, so no need for a right to enter;
- provisions entitling the owner to require the occupier to transfer to other property selected by the owner. This has been held to negate the grant of exclusive possession; and
- provisions that restrict the use of the property to certain hours or only part of a day.

These can all be used to drive a document towards being a licence, but if in reality the occupier enjoys exclusive occupation, to the exclusion of the owner, then no matter how many are used, the arrangement will have been the grant of a lease.

Adverse tax consequences can also arise from inadvertently creating a tenancy. Tenancies at will and licences are exempt interests, outside the scope of SDLT (LTT in Wales), so no SDLT or LTT is payable, and no return is required.

However, the grant of a lease is not an exempt interest: if the arrangement is in fact a lease, it may be subject to SDLT or LTT.

Adverse VAT implications may also arise if not properly considered and dealt with in the arrangement.

Conclusions

A lease gives a tenant certainty as an occupier, and the landowner a secure period of income.

If the lease is properly contracted out (or is of a certain type for not more than six months), the landlord will be entitled to possession of its property at the end of the term, with protection from spurious claims from the tenant. If flexibility is required, a mutual rolling break clause can be used.

Leases usually take longer to negotiate than licences, costing more to produce.

No matter what the document is called, if exclusive possession is granted, the owner risks the arrangement being challenged by the occupier.

A licence cannot be terminated 'at will', giving a licensee more security than a tenancy at will: the circumstances in which the owner can terminate a licence will be set out. There is generally no SDLT or LTT payable on a licence and, if properly constituted, it does not attract security of tenure.

Finally, if a tenancy at will is appropriate, it can be prepared quickly and cheaply because it is a short document. Properly drawn, it will not attract security of tenure and allows the landlord to get the property back immediately at any time.

However, it offers no security of income for the landlord as the tenant can also terminate the agreement immediately at any time.

Getting the right arrangement for any set of circumstances is crucial to avoid unforeseen issues.

Stewart Gregory is a partner in the real estate team at Hempsons. For more information on real estate services contact him on 0238 098 3009 or email him at S.Gregory@hempsons.co.uk

VAT, the ARRS and PCNs

Jonathan Main[****] provides commentary on a confusing issue which emerged over the summer: VAT and its application to the ARRS and PCNs

A PCN, acting through its member practices, provides medical care and welfare services to its patient population and its funding comes from the NHS via a nominated lead practice/ fundholding entity based on its total patient numbers.

But the PCN fundholding entity is not necessarily the employer for those in the Additional Roles Reimbursement Scheme (ARRS) required by the PCN.

The key VAT issue is to determine the VAT liability of the service provided by the employer of the additional role to the GP practice members of the PCN.

Medical care

Medical care provided in support of a PCN is exempt from VAT if it is provided by or supervised by a qualified healthcare professional employed by the service provider.

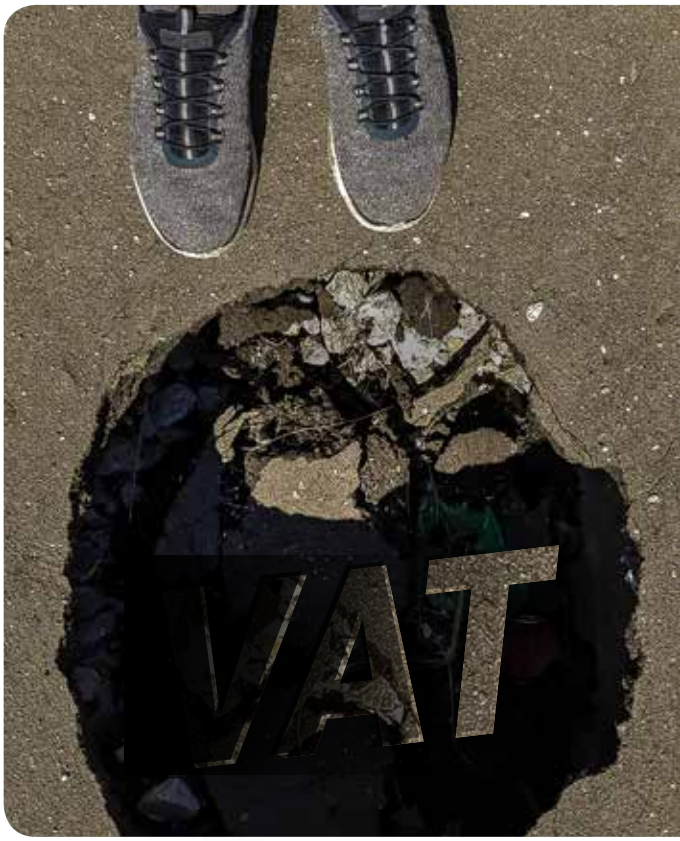
HM Revenue and Customs (HMRC) requires the healthcare professional to be a medical practitioner or medical practitioner with limited registration, a qualified nurse, midwife or nursing associate, or aligned to The Health Professions Order 2001.

Medical care must also be provided or supervised by someone qualified for the procedure in question. If provided by a clinical pharmacist it must be wholly performed by someone registered as such. Medical care supervised by a clinical pharmacist would not confer VAT exemption.

Medical care HMRC guidance

HMRC's view of the VAT exemption for medical care is best summarised by the following extract from its guidance:

- *The services are within the profession in which the person is registered to practice, and use the knowledge, skills, judgment, and experience acquired in the course of their professional training; and*
- *the primary purpose of the services is the protection, maintenance or restoration of health of the individual concerned.*



Welfare services

In addition to the VAT exemptions for medical care, the services provided by a PCN may also fall within the welfare VAT exemptions.

Welfare services have a different route to VAT exemption. The service itself must first constitute:

- *The provision of care, treatment or instruction designed to promote the physical or mental welfare of elderly, sick, distressed or disabled people, or*
- *The care or protection of children or young persons.*

The service must be provided by a:

- *Charity;*
- *state regulated private welfare institution or agency; or*
- *public body.*

For a state regulated private welfare institution or agency, both the entity and the service itself must be subject to state regulation.

"If the GP federation does provide healthcare, it will also need to confirm whether it qualifies for VAT exemption"

Examples of welfare services from the ARRS list may include the services of a social prescribing link worker, health and wellbeing coach, or care coordinator.

The VAT exemption puzzle

To solve the puzzle of VAT exemption, the PCN will need to deal with the following challenges:

- The nature of the service and whether it qualifies for VAT exemption. As discussed, there is a different criterion for a nurse compared to a clinical pharmacist.
- Identify the service provider for a welfare service and whether that entity and the service in question is subject to state regulation, the CQC, Ofsted or the devolved equivalents.
- Identify the employer of the ARRS and whether that entity is responsible for the provision of a healthcare service or is merely acting as an employment business and providing resource to the GP practice member of the PCN.

The ARRS employer

I have covered the first two challenges, the third relates to the ARRS employer, which will be one of the following:

- A third-party provider (including NHS trust, local authority, charity, and commercial provider)
- A GP federation
- A PCN corporate body
- The lead GP practice
- A PCN member GP practice
- A single practice PCN
- A personal service company (PSC)

A PCN corporate body employs staff, with each GP practice remaining responsible for the underlying healthcare service, as a member of the PCN. The PCN may outsource healthcare delivery to the PCN corporate body.

The PCN may in fact outsource/sub-contract the entire provision of healthcare as a service to be delivered by one of the above providers, say a GP federation. In that case, the GP federation will also be the provider of the healthcare service. This supply of services may qualify for VAT exemption, as a GP led provision of healthcare services.

If the GP federation is providing additional roles, not the outsourced delivery of the PCN's services, it will need to consider whether that is a provision of healthcare or just staff resource.

Staff resource cannot be the provision of healthcare. If the GP federation does provide healthcare, it will also need to confirm whether it qualifies for VAT exemption.

The cost sharing exemption

A GP federation is typically a corporate entity limited by shares in which each GP practice holds a single share, being held on trust by a partner in the GP practice.

The structure and ownership of a GP federation can lend itself to the successful operation of the cost sharing exemption (CSE). The CSE allows services from a GP federation (or PCN corporate) to its shareholders to be exempt from VAT.

To successfully operate the CSE, the GP federation must satisfy five tests. The first requires the identification of a cost sharing group entity (CSG), such as a GP federation or PCN corporate body, which is independent of its members. The CSG and its shareholder members must satisfy the following:

- The CSG must be an independent entity supplying services to its members.
- The members must carry on activities which are either exempt from VAT or non-business.
- The services must be directly necessary for the members exempt or non- business activities.
- The CSG must only recover the exact cost of the services from its members.
- The application of exemption must not cause a distortion of competition.

In my experience the operation of a GP federation or PCN corporate body alongside the PCN can satisfy the above criteria but would need detailed consideration.

Key takeaways

Are as follows:

- Who employs the ARRS?
- Does that employer provide resource or subcontracted healthcare?
- Does the healthcare qualify for VAT exemption?
- Can the CSE provide an alternative route to VAT exemption?