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AISMA Doctor Newsline

At the heart of medical finance...

Check out the GMS contract changes 2023-24

As the 2023-24 financial year gets underway, GP practices must be fully aware of contract changes and the impact these could have on funding and workload. **Deborah Wood*** gives an expert round-up and commentary

At the time of writing this article the BMA GP committee had reached a stalemate in their 2023-24 contract negotiations with NHS England (NHSE), rejecting what they described as an 'insulting' offer.

Subsequently, on 6 March 2023, NHSE published a letter setting out the contract changes to be imposed from 1 April 2023.

The letter largely confirmed arrangements in line with the previously agreed five-year framework published in 2019, together with some new proposals.

The BMA had hoped to see some additional investment to assist with practices' ongoing inflationary pressures, particularly linked to staff and energy costs. It believes the lack of support for this will

mean more practices risk being discontinued.

The existing contract framework will end on 31 March 2024, with a default position for it to be rolled over 'as is', unless anything else is negotiated meanwhile for it to be changed.

NHSE has committed to continue to work with GP leaders during the next 12 months to develop a contract that the BMA wants to see working for patients and general practice teams.

The main financial aspects of the core contract, with specific reference to changes implemented for 2023-24, are:

Practice level funding

The practice contract baseline funding will increase by 2.7% based on predicted inflation rates in April 2019. Clearly inflationary pressures are much greater at the current time (**see Table 1**).

The uplift to the global sum payment from £99.70 per weighted patient has not been announced as I write but is expected to be in the order of £3 per patient. The out of hours adjustment is expected to remain at 4.75%.

Core global sum funding in 2022-23 included £20m to support workload costs for Subject Access Requests. It is not yet known if this funding will continue or be removed.

"The practice contract baseline funding will increase by 2.7% based on predicted inflation rates in April 2019"

The £237m uplift to the contract is intended to cover pay rises at 2.1% for practice staff and GPs and practice expenses.

The new to partnership premium funding is due to end on 31 March 2023.

The weight management directed enhanced service will continue at £11.50 per referral.

Table 1	2019-20	2020-21	2021-22	2022-23	2023-24
	£	£	£	£	£
Practice contract baseline	8,116m	8,323m	8,576m	8,792m	9,029m
Cumulative increase	109m	207m	253m	216m	237m
% Annual increase	1.4%	2.6%	3.0%	2.5%	2.7%

Table 2	2019-20	2020-21	2021-22	2022-23	2023-24
	£	£	£	£	£
Additional role reimbursements baseline	110m	257m	415m	634m	891m
Further funding		173m	331m	393m	521m
Total available	110m	430m	746m	1,027m	1,412m

Additional Roles Reimbursement Scheme (ARRS)

The available funding will rise from £1,027m to £1,412m (**see Table 2**).

At 31 December 2022 there were 25,262 additional full time equivalent staff in the scheme, with the target of 26,000 expected to be achieved by 31 March 2023, a year earlier than anticipated.

Several changes to the scheme have been announced:

- The number of advanced practitioners per PCN is increased to three where list size is under 100,000, and to six if more than 100,000.
- PCNs will be reimbursed for the time that first contact practitioners spend in education and training to become advanced practitioners.
- Apprentice physician associates is added to the list of reimbursable roles.
- All recruitment caps for mental health practitioners are removed and they are eligible to support first contact activity.
- The clinical pharmacist description is amended to clarify that they can be supervised by advanced practice pharmacists.

NHSE will review the scheme during 2023-24 and staff employed through it are confirmed to be considered as part of the core general practice cost base to assist with offering permanent contracts.

Quality and Outcomes Framework (QOF)

Disease register indicators will be income protected for 2023-24, with funding based on 2022-23 performance paid monthly to practices once the outturn is finalised. The number of indicators will reduce from 74 to 55.

£36m for 30 new points for cholesterol indicators is added to the QOF, together with a new mental health indicator.

This funding is recycled by retiring a rheumatoid arthritis indicator and reducing the value of an annual dementia review target.

Indicator AF007 will be retired and replaced with the former IIF indicator CVD-05 (as AF008). There will also be other small changes to indicator wordings and values in 2023-24.

Details relating to the points and values and relative list size have not yet been published as I write.

The Quality Improvement modules for 2023-24 will focus on workforce wellbeing and optimising capacity to meet demand.

GP retention scheme

The previous relaxation of the four-session cap has been made permanent.

Investment and Impact Fund (IIF)

This is a reward for PCNs meeting the NHS Long Term Plan objectives and GP contract requirements. Money derived from the IIF must be used for workforce expansion and primary care services.

The IIF indicators are reduced from 32 to five. The remaining ones relating to flu vaccinations, learning disabilities, cancer referrals and waiting times for appointments retain a fund of £59m.

As a result, the freed-up funding will be moved into the Capacity and Access Fund. £172m will be paid monthly to PCNs as a continuation of the support payments introduced in the Autumn of 2022.

£74m will be paid out under the assessment by Integrated Care Boards (ICBs) against an access improvement plan to be agreed in quarter one, and paid out at the end of March 2024, as a local support payment.

Delivering PCN specifications

Practices can opt out of the PCN DES for 2023-24 during the period 1 April 2023 to 30 April 2023.

There have been no service specifications added for the coming year.

NHSE will review enhanced access requirements in 2023-24.

Vaccinations and immunisations

There are some changes to vaccinations and immunisations to reflect updated JCVI guidance covering HPV and shingles. The other programmes remain unchanged.

Childhood immunisations

The repayment mechanism if a practice achieves under 80% coverage is removed.

Lower thresholds are reduced to 81%-89% and the upper threshold is uplifted to 96%.

Some clarification of wording will be made in the Statement of Financial Entitlements relating to item of service fees.

Other 2023-24 changes

The GMS regulations will be updated to clarify that a patient should be offered a needs assessment or signposted to an appropriate service at first contact.

The deadline for full implementation of patient access to their online records is extended to 31 October 2023.

Contract regulations will be amended to remove the 'medical cards' reference relating to registration.

Practices will have to procure their telephony solutions only from the Cloud Based Telephony NHS Framework as current contracts expire. A Better Purchasing Framework (BPF) has been developed by NHSE to provide recommended suppliers and assure value for money.

NHSE will review dispensing fee scales alongside general contract changes for 2024-25.

Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS)

Any changes announced to the core GMS contract are expected to be mirrored via PMS and APMS.

Please note: all the above information relates to contracts in England only.

Northern Ireland/Scotland/Wales

Information can be obtained from your local AISMA accountant.

What now

As ever practices must be fully aware of these changes and their impact on practice funding and workload.

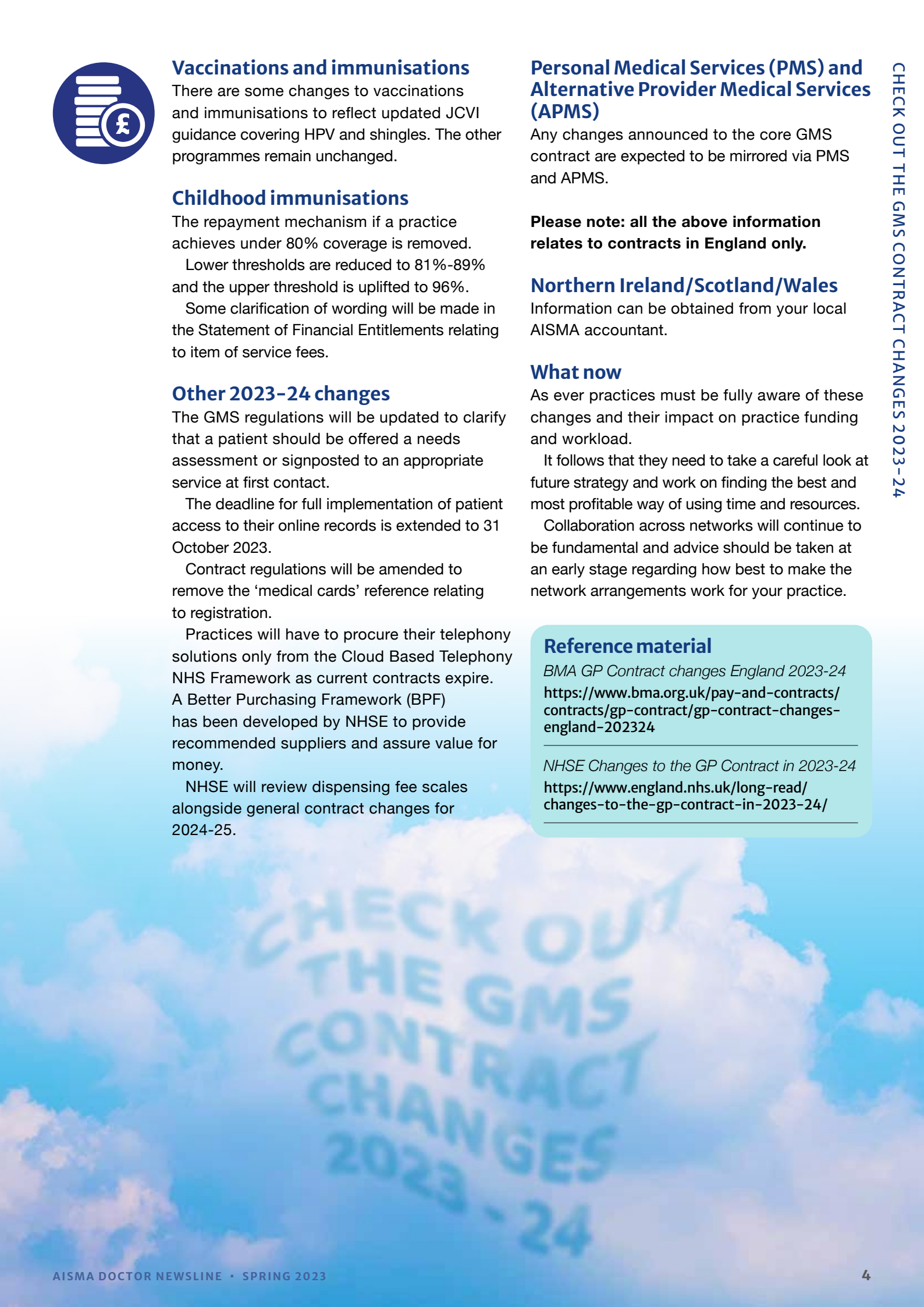
It follows that they need to take a careful look at future strategy and work on finding the best and most profitable way of using time and resources.

Collaboration across networks will continue to be fundamental and advice should be taken at an early stage regarding how best to make the network arrangements work for your practice.

Reference material

BMA GP Contract changes England 2023-24
https://www.bma.org.uk/pay-and-contracts/contracts/gp-contract/gp-contract-changes-england-202324

NHSE Changes to the GP Contract in 2023-24
https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2023-24/



Helping practices through the squeeze

OPINION

Deborah Wood*
AISMA chairman

Spring is usually a time to look ahead with optimism as we emerge from the winter darkness. But it is difficult to maintain a sunny outlook when considering the issues facing our general practice clients.

In preparation for this article I looked back at the one I wrote for the Spring 2022 issue of *AISMA Doctor Newsline*. Unfortunately things have not changed a great deal.

Once again NHS England has imposed core contract changes effective from April (see our front page story) without recognising the inflationary pressures and workload demands that general practice teams face daily.

Clients are seeking advice from their AISMA accountants on business cashflow crises and sustainability issues, looking for help with budgets and forecasts, and trying to understand where the resources are to meet patient needs.

The GPs, who are responsible for their practices and their patient care, are deliberating on the extent to which their own drawings must reduce before the balance of workload and reward is eroded completely, and contracts are handed back.

Despite increased investment via primary care networks, the funding available does not appear to be reaching the coal face of general practice.

And the almost 26,000 new healthcare professionals employed via additional roles funding do not appear to be reducing GP workload or increasing patient access sufficiently to see the pent-up post-Covid demand reducing.

Cost of living pressures in the wider economy mean that the small increases on offer for pay awards will not meet the needs of the workforce. Retention is set to become an extra hurdle to overcome.

With continuing falling numbers of GPs across primary care and below inflationary increases in contract sums and pay awards, I expect you, our clients, are not looking ahead with confidence to the new financial year.

Practice finance will be squeezed in all directions:

- below inflationary uplift in contract sums
- increasing staff costs
- rising energy bills
- heftier finance costs, and
- increased pressure to deliver additional appointments while working more collaboratively across PCNs and finding out how to fit into the new integrated care landscape.

AISMA accountants will soon be working with their practice clients to prepare the 2023 annual accounts. The reduction in one-off Covid-19 related income streams and aligned costs, together with the general cost pressures and below inflationary contract award will have had an impact on profitability and cashflow.

This has a knock-on effect to tax and pension payments which will fall due just as the funding issues noted above start to come into play for 2023-24.

Collaboration across the PCN footprint and wider federations is ramping up again. Practices need to ensure they are part of these plans and have control over, and access to, the funding deployed centrally to benefit their own patients, practice staff and resources to deliver contract requirements.

AISMA continues to work with many organisations such as PCSE, NHS Pensions, NHS England, the BMA and HMRC to try to ensure GPs and practices are receiving relevant and up-to-date information to assist them to manage their affairs on a timely and efficient basis.

There are still backlogs of unprocessed pension certificates, missing service, uncollected contributions, and unreconciled seniority payments, and we do keep pressing for the expected improvements to systems to eventually start to make an impact.

Our member firms are also looking ahead to refreshing knowledge and sharing best practice at our annual conference in May.

There, we will no doubt give thought to how the proposed tax system changes for practices with a non-March accounting year end will impact not only on the tax take but also on pension contributions and associated pension tax charges.

We will also be compiling greater knowledge about NHS Pension Scheme changes and the ongoing ramifications of the McCloud judgment.

I sincerely hope the political turmoil, industrial action, and resourcing issues soon start to give way to a brighter economic outlook that recognises the level of investment needed at practice level. It should be a great deal more than the £145 per patient available from April 2023.

Budget springs a pension surprise

Chancellor Jeremy Hunt's 2023 Spring Budget delivered a couple of big wins for doctors, with changes on pensions widely welcomed by the BMA and others. **Joanna Boatfield**** provides an easy-to-read analysis

This was a budget focused on getting people back into work, with changes to pensions and to the childcare system both designed to break down some of the UK's barriers to employment.

Aside from pension reforms, the other tax changes were relatively muted, with changes to corporation tax rates and income and capital gains tax exemptions and tax bands unchanged from earlier announcements.

Pensions

The Chancellor's surprise announcements, aimed at incentivising doctors to remain in the workforce, were the abolition of the pension lifetime allowance and an increase in the pension annual allowance from £40,000 to £60,000. Both changes will apply from 6 April 2023.

The lifetime allowance

The pension lifetime allowance was introduced in 2006 to limit the total amount of pension savings which can be built up without facing additional tax charges. Since that date successive governments have reduced it down to the 2022-23 figure of £1,073,100.

Large pension pots in excess of this allowance have been subject to additional tax at rates of either 25% on top of normal income tax when taken as a pension or 55% when taken as a lump sum, discouraging further pension saving.

Although the headlines are that the lifetime allowance has been abolished, there are a couple of provisos:

- The 25% tax free lump sum remains restricted to 25% of the existing lifetime allowance – so £268,275. For those without lifetime allowance protection, amounts in excess of this will be subject to tax at their marginal tax rate (reduced from 55%).
- These changes only apply from April 2023 – so small comfort for those who may have recently retired and suffered lifetime allowance charges.
- Perhaps most importantly, Labour has already announced that it would look to repeal or alter these changes if it gets into power.

For those close to the lifetime allowance limit, the question remains as to whether the limit will be brought back at a later date and whether this uncertainty will encourage early retirement for those with large NHS pension pots.

"For those medics operating through companies this means that strategies for withdrawing profits from the company may need to be reconsidered"

There are further questions for those who have taken steps to preserve higher allowance limits through the various forms of lifetime allowance protection. Advice from financial advisors will be important over the coming months to weigh up the options available.

The annual allowance

The pension annual allowance is increasing from £40,000 to £60,000, with the adjusted net income limit (which can determine whether the annual allowance is tapered down to a lower figure) increasing to £260,000 from £240,000. The minimum tapered annual allowance is increased back up to £10,000 from £4,000.

Although the annual allowance itself has increased, for many of the highest earning doctors a cliff edge remains based on their taxable 'threshold income' so that if they have taxable income of over £200,000, their allowance can be tapered down, while those with taxable earnings just under £200,000 retain a full £60,000 allowance.

This does retain an incentive to doctors with around £200,000 of taxable earnings to limit taking on additional work.

One big positive is that changes to the timing of pensions revaluation have now been confirmed which will remove pension growth from the annual allowance charge to the extent that it reflects prevailing inflation rates.

The mechanism for correcting this also means that for 2022-23 only, revaluation of NHS pensions has been removed from the annual allowance charge calculation altogether - a welcome reprieve for those expecting large inflation-based annual allowance charges in 2022-23.

Corporation tax

As expected, it was confirmed in the budget that from 1 April 2023 the corporation tax rate will be increased to 25% for those companies with profits over £250,000. Where profits are below £50,000, the tax rate remains at 19% and on profits between the two limits companies face a marginal rate of tax of 26.5%.

For those medics operating through companies this means that strategies for withdrawing profits from the company may need to be reconsidered.

In recent years it has almost always been better to take the bulk of profits out as dividends rather than salary or a bonus. Moving forwards this may not always be the case. Detailed calculations are needed to check the position for 2023-24 onwards.

Remember in this context that the 0% dividend allowance is reducing from £2,000 to £1,000 in 2023-24 and then to £500 for 2024-25.

Further tax breaks were introduced for companies purchasing new plant and

"Many more will fall into the 45% rate of income tax, which it was confirmed will apply to income over £125,140 from April 2023"

machinery from 1 April 2023 until 31 March 2026 with an unlimited 100% first-year allowance for 'main rate' expenditure, and a 50% first-year allowance for 'special rate' items, benefiting companies spending more than the £1m annual investment allowance.

This won't apply to individuals or partnerships - which will prevent GP practices carrying out capital expenditure of more than £1m from benefiting.

Childcare

The other leg to the Chancellor's plan to encourage people back into work is an increase in the availability of free childcare for younger children.

The main measure reduces the age at which children are eligible for up to 30 hours of free childcare.

Initially, from April 2024, working parents of two-year-olds will be able to access 15 hours of free childcare per week. By September 2025 up to 30 hours is available for children from nine months old.

Funding paid to childcare settings for these free hours will increase, along with an increase in staff to child ratios, all changes designed to support the finances of the UK's struggling childcare system.

It does, though, remain the case that free childcare is in most cases not available to those earning over £100,000 – another cliff edge which may incentivise a reduction in working hours for some medics.

Other measures

There are a number of other measures which may impact on those in the medical sector:

- In an attempt to ease pressure on GPs, from May 2023 the VAT exemption for healthcare will be extended to services carried out by staff who are directly supervised by registered pharmacists in the UK. Zero-rate VAT is also extended to prescriptions for medicines supplied through patient group directions from Autumn 2023.
- Many more will fall into the 45% rate of income tax, which it was confirmed will apply to income over £125,140 from April 2023.
- It was also confirmed that, as announced last year, there will be a reduction in the annual exempt amount for capital gains tax to £6,000 in 2023-24 and then again to £3,000 in 2024-25.
- The Energy Price Guarantee for individuals will be retained at the current level until the end of June 2023 – with prices being capped at £2,500 for the 'average' household.
- The annual investment allowance, which allows 100% tax relief for qualifying capital expenditure, has been retained at an annual limit of £1m.

This is described as a 'permanent' change, though experience tells us there is no such thing when it comes to tax limits. For those GP practices carrying out capital improvements over the next few years, this will offer valuable tax relief.

Top tips to maximise income from your surgery premises

Could your building earn you more in these challenging financial times? **Bryn Morgan** provides some tips to consider

It has never been more important for GP practices to maximise income generated from their surgery premises while also minimising expenditure.

There are various steps to achieve this.

NHS premises funding

The main source of premises income for most practices will be either notional rent (if owner occupied) or rent reimbursement (if leased) and so it is important to understand how this funding works and is assessed.

It is normally available to practices with a GMS or PMS contract under the Premises Costs Directions 2004 or 2013.

Usually, it will be equivalent to a market rent for the space used for the NHS services, including an element of funding towards the costs of external and structural repairs along with buildings insurance. The amount is determined by NHS England/ICB on the basis of a valuation by the district valuer.

Business rates, water and sewerage charges and clinical waste disposal costs are also reimbursable. But various costs are not, such as for internal repairs and decoration, utilities (electricity, gas, telephones and data), and facilities management like cleaning and security.

Notional rent paid to owner occupiers is reviewed on a three yearly cycle. The review dates should be diarised by the practice and reviews initiated promptly because the process can take months and sometimes years to settle.

It is wise to engage your own specialist primary care valuation surveyor to negotiate with the district valuer and, if necessary, to assist you with the appeal process.

If your premises are leased, then your lease will set the review dates and should have been approved by the commissioners in order to qualify for reimbursement. Ideally your lease's terms will say that the rent on review should not exceed the reimbursement.

If not, there is a risk that any rent increase on review may not be matched by the reimbursement - leaving a shortfall for the practice to meet from its own resources.

To avoid this, when agreeing lease terms and also during the rent reviews, it is important

"Undocumented lease arrangements are unfortunately fertile ground for disputes so are best avoided"

to use specialist primary care surveyors and solicitors to help secure the right protections.

Tips

- Understand what is and is not funded by the NHS, and budget accordingly.
- For owner occupiers
  - diarise and promptly action notional rent reviews with the help of a specialist valuer.
  - use the appeal process if you do not agree the district valuer's assessment.
- For tenants
  - make sure lease terms are approved by the commissioners and negotiated by specialist valuers and solicitors to include rent review protections.
  - on rent reviews seek advice and make sure you comply with the process.

Other income sources

If you are fortunate enough to have surplus space not required for your NHS contracted services then you may be able to lease or hire it to others, such as a pharmacy, dentist or other healthcare provider.

The terms should be well negotiated with assistance from a specialist valuation surveyor and solicitor, to ensure you obtain the best rent with appropriate rent review terms and, where possible, can pass on certain costs.

This may be via a service charge, or the tenant may be given direct responsibility for repairs and decoration.

Ideally, these terms should be formalised before the tenant goes into occupation because afterwards this can become much harder and as the landlord you may be on the backfoot. Undocumented lease arrangements are unfortunately fertile ground for disputes so are best avoided.

It is especially important to be careful not to rent out space for which you already receive NHS funding as this could amount to fraud if you are receiving double income for the same space.

This does not mean you cannot share the reimbursed space with others which may be desirable for good reasons, such as collaborating to provide integrated care. In such circumstances you should be able to legitimately charge the user of the space a proportion of the non-reimbursable costs.

If you lease your premises, you must check if the lease allows you to enter arrangements with third parties and if so on what terms. Failing to comply can in the worst cases lead to forfeiture of the lease.

When leasing space to third parties, good management of the arrangements should also help you recover the maximum rent and appropriate service charges. In most cases rent reviews are triggered by the landlord so you should diarise the review dates and engage a specialist valuation surveyor to help you achieve the best outcome on reviews.

If existing leases are ending it is important to be pro-active and not let arrangements drift or you could be leaving money on the table.

Ideally, take advice on your options at least 12 months before the lease is due to expire. If the lease has security of tenure, then the default position is that the tenant may be able to hold over at the same rent potentially indefinitely if no action is taken.

Tips

- Leasing or sharing space with others can be a good way of increasing income but first check impact on NHS funding and (if applicable) your lease terms.
- Ensure lease terms are well negotiated with the help of a specialist valuation surveyor and solicitor – avoid undocumented arrangements.
- During the terms of the lease make sure rent reviews and service charges are managed well to maximise income.
- Review and seek advice on options at least 12 months before the lease expires.

Mortgages

For owner occupiers with a mortgage it is important to keep the terms under review. Seek advice from a specialist mortgage broker to check whether you are on the best terms or whether there are opportunities to perhaps remortgage to reduce costs.

Tip

- Regularly review mortgage terms with assistance from a specialist broker

Importance of good housekeeping to minimise partnership disputes

Unfortunately, partnership disputes are rising and often centre around the premises.

In many cases I have seen, practices could have avoided, or at least minimised, significant costs (tens and sometimes hundreds of thousands of pounds). And that is not to mention the aggravation and breakdown of relationships between partners if they failed to agree clear property arrangements in their partnership agreements.

For owner occupiers this will include basic terms such as who owns a share in the premises and how this is to be valued on retirements.

Who contributes to the costs of repairs and maintenance is another important issue which is often overlooked and affects both owner occupiers and tenant practices.

Once agreements are in place it is important to follow them and review and update them when partners come and go. Good housekeeping can prevent a positive income generating and valuable asset morphing into a troublesome and costly headache.

Tips

- Agree and document premises arrangements in your partnership agreements
- Review and update them when partners come and go.

Bryn Morgan is a partner in the healthcare law firm Hempsons and specialises in advising GPs on property matters

ASK AISMA!

GPs' questions covering a variety of challenging scenarios where partners are leaving are answered here by Abi Newbury***

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

HELP! I'LL SOON BE THE ONLY PARTNER LEFT

Q **I am a partner in a three-partner practice with 6,000 patients. Both of my partners are retiring and we can't find replacement partners.**

I don't want to merge with the big practice down the road and I don't want to give up, but I can't see an answer right now. What can I do?

A It may seem daunting, but you can consider alternatives to partners. Changing the mix of the clinical team could not only help you but potentially make the practice more successful, both financially and in terms of job satisfaction.

First consider what you do, that only you or a GP partner can do, and then look at what could be delegated. You may find for example that with a combination of salaried GPs, nurse practitioners, paramedics, additional nurses and HCAs, supplemented with locums and a business manager to deal with the day-to-day running of the practice, you could not only cope, but prosper.

You would have to be prepared to give up the 'low end' of your work, so that you could concentrate on the more challenging patients. You could also, perhaps, look closely at the patients that take up the most of partner time to make sure that there is a clinical need for a GP, or whether someone else could be looking after them.

Once you have considered how staffing could work, then look at the financials.

Your accountant will be able to help you with a detailed budget and the tax implications to show the effect of different permutations of staff. Be aware that as a sole practitioner, small changes in the business will affect you personally - whether

positively or negatively.

Consider the cash flow implications and how to pay outgoing partners. They may be prepared to leave in capital and earn interest to give you time to find new partners. Or they may wish to retain ownership of the premises as a long-term investment.

Make sure you have a practice manager who can control all the financial aspects of the practice - as well as the running of it - or consider using your accountants to do some of the bookkeeping, payroll and reporting tasks in the short term.

This would then free up the practice manager to take on business running tasks done historically by partners.

Consider what you can do to make your practice appealing to salaried GPs and new partners. It is not all about the money – it is about creating the work environment where people can thrive – which may include training opportunities, flexible working and remote working.

While it is a huge challenge to run the practice as a singlehanded practitioner, there are successful practices out there who deliberately choose to run on this practice model.

WHAT IF I HAND BACK THE PRACTICE CONTRACT?

Q **I am a partner in a three-partner practice with 6,000 patients. Both of my partners are retiring and we can't find replacement partners. I can't see any alternative but to hand the contract back. What does this mean for me financially?**

A Firstly, remember that a partnership has joint and several liability for debts incurred.

If you are sure that handing the contract back is your only option, then it is best to do this by dissolving the partnership at the same time as your partners retire, so that they share in any liabilities and it is not all left to you. You should consider your partnership agreement and take legal advice.

Normally, someone will be appointed to run the practice or the patients will be absorbed into neighbouring practices who may well take on some or all of the staff. Failing that, there could be a liability for redundancy costs.

If the premises are leased you will have a liability under the terms of that lease, unless someone is prepared to take it over. That could be expensive.

If the premises are owned by the partners,

you will need to either sell them or lease them to another business.

Note that the sale value might be very much less than you expect if the premises are not going to be receiving a notional rent. In the meantime, if you have a mortgage on the premises then you will have to continue to repay it, but without the benefit of any income coming in to cover it.

Look at other contracts – you may find you have contracts for phone systems, printers and scanners, or clinical equipment that you will continue to have to pay for – or will need to pay a lump sum to get out of.

There is little value generally in the practice fixtures and fittings unless a similar business would want to take on the building.

From a tax point of view, you might have a 'tax time bomb' if your practice does not prepare accounts to 31 March – which could give you an unexpectedly large tax liability on the cessation of the practice.

Generally, just walking away from the practice should be the last resort. Ideally if you can't find replacement partners/staff then look to merge with another practice, who will keep the premises on as a branch surgery and who will continue to employ the staff.

Work with your ICB and your LMC to achieve the best result for you and your partners, your patients and your staff.

IMPLICATIONS OF MOVING FROM A SALARY TO PARTNER

Q **I'm a salaried doctor in a three-partner practice and two partners are retiring. The remaining partner wants me to become a partner now. What do I need to consider financially?**

A You will need to consider income levels and stability, the investment required and the risks that come with running a business.

Consider what share of the profits you will be

entitled to. Look at the partnership agreement to see who is entitled to what.

Some practices have lots of 'pre-shares' – income to which the person earning it is entitled. Others put everything in the 'pot' to be shared in profit sharing ratios.

Look at the practice accounts for the last three years. Ideally, ask your accountant to review these and report back to you on things you need to question, or matters that might worry you.

In particular, look for income that will cease as a result of the retiring partners – and discuss the costs of how the leaving partners will be replaced – be it with new partners, salaried doctors, locums, nurse practitioners, paramedics or others. That will give you an indication of what your profit share might be.

Consider whether you will need to buy a share of the premises and how that will be financed.

Also think about how much working capital you will need to contribute to the practice and whether that will be by way of a lump sum or by restricting your drawings for a period.

Look at what liabilities you will have to share in, including (but not limited to) lease of the premises, and contract leases for equipment like phones, copiers and scanners.

Consider if there could be a Final Pay Controls liability. This can happen where, for example, a member of staff has 1995 pension scheme service (even if before they joined the practice) and they have had a substantial pay-rise – perhaps to persuade them to stay or take on further responsibilities.

Find out how drawings are calculated and whether you are responsible for paying your own

tax or whether it is provided for in the practice before you make any drawings. If drawings are not regular, consider how that will affect your personal financial responsibilities.

Work with your accountant to look at 'take home' pay as a salaried doctor and as a partner. Remember that if you are building capital within the practice, that is value that you can take when you go, so factor that in if it seems the net take home does not change (or even drops).

Understand the longer-term plans for medical services in your area. Will you be encouraged to join with other practices, or move into a health centre? And if so, what does that mean for the planned existing investment?

And don't forget to take into consideration the non-financial matters – such as the additional responsibilities and stresses of being a business owner versus more say in running the practice and employing appropriate staff with the opportunity to develop and build your ideal practice.

aisma association of independent specialist medical accountants

At the heart of medical finance

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Ten ways to lose your locum

There are many ways it can go wrong when you take on a locum. **Fiona Dalziel** shows some of the most common ones – and suggests solutions

We've all been there. Well, as a practice manager I have. You have finally found a locum to cover a day that was starting to look worryingly thin in terms of GP cover.

You get into the practice first thing that day, only to find that one of today's nurses will be off sick. You get on the phone to your other nursing colleagues while the remaining nurse sees booked patients.

Surgeries have been running for 30 minutes by the time you realise you have forgotten that your new locum started today first thing! Well – big sigh of relief – the locum turned up and is seeing patients.

You can now get on with the rest of your day, which turns out to be uneventful, although the locum seems to consult very slowly. A couple of weeks later, you need that new locum again, but they are mysteriously reticent about returning.

What on earth went wrong? Take your pick from the following set of possibilities.

1 The locum was given the log-in details of the absent GP.

The locum realised this was a significant issue with potential medico-legal repercussions. She organised a staff member to set her up with her own log in, during which time the surgery started to run late.

SOLUTION: Set up a personalised login for your locum the day before they arrive.

2 The locum was unclear how to put a patient through to the nurse for investigations, and where to find certificates and documents.

SOLUTION: Put this information into a written Locum Pack. Make sure each consulting room has a location list for equipment clearly visible.

3 The locum still had a lot of administrative tasks to complete at the end of the surgery.

SOLUTION: Locums need admin time. Make sure this is explicitly built into their session.

4 The surgery included two referrals. The locum was unfamiliar with the local hospitals and with how the surgery handled referrals.

SOLUTION: Reduce risk to patients by providing in the Locum Pack information about referrals and local hospitals/services, including what is available in the practice, for example in-house physiotherapy.

"Define clearly, preferably in writing and before the start date, what a 'session' consists of and how any additional tasks will be paid"

5 The locum saw a female patient of 32 who presented with some worrying symptoms and who had a complex history. She knew all the other GPs were busy and was not sure from whom to seek some advice.

SOLUTION: Reduce patient risk, and the chance the patient will have to come back again, by identifying a GP mentor for the locum. The mentor will know the locum is around and the locum will know how to contact them. Also, see below at item 7 – handing over.

6 The locum's booked surgery ran very late. A partner popped her head round the door to ask the locum to do a few call-backs to patients who had been telephone triaged earlier.

This presented a logistical problem for the locum, who had other commitments later in the day.

SOLUTION: Define clearly, preferably in writing and before the start date, what a 'session' consists of and how any additional tasks will be paid.

Include what type of session it is - telephone/face-to-face/online or a combination. Will there be house calls and how is fuel covered? Clarify whether this is an ad hoc locum session or whether there is a possibility of longer-term work.

7 Once the work was completed, the locum went home. She still had some outstanding concerns but there had been no other GPs around when she had left the building. She phoned back later in the day.

SOLUTION: The mentor should take a handover from the locum. This is a golden opportunity to demonstrate that the practice provides clinical support and opportunities for feedback.

8 The locum invoiced the practice based on her agreed hourly rate for her time at the practice. The payment arrived after she had already had to pay her superannuation contribution for the income.

SOLUTION: Get bank details in advance and pay promptly.

9 The practice disputed the amount of the invoice, saying she had done a 'normal' session.

SOLUTION: As in 6 above. A handover at the end of a surgery would be a face-to-face opportunity to clarify any 'extras'. Ideally, a defined member of the admin team should have a chance to say 'goodbye' and 'thank you' to the locum and sort any anomalies.

10 The locum did agree to go back to the practice after some discussion but then cancelled with no notice and did not give a cancellation fee.

SOLUTION: Make sure you agree cancellation terms with the locum in writing when you engage them.

This article does not cover the details of the checks you must make before engaging a locum or details of handling superannuation and taxation.

You should seek further guidance on these areas from the BMA at bma.org.uk and your local health authority or board.

Fiona Dalziel runs DL Practice Management Consultancy

Trust registration: Do GP practices need to register?

There has been much talk about the Trust Registration Service (TRS) and its implications for primary care. **Nils Christiansen** sets out the rules, considers their relevance for primary care, and shows who will need to register

Spoiler alert: most trusts in primary care will be exempt from registration, but not all.

What is the TRS?

In October 2020 the UK's Fifth Anti-Money Laundering Directive came into force requiring all UK non-exempt express trusts to register with the TRS, regardless of whether or not they would be paying tax. The obligation falls on the trustees.

What trusts are found in primary care?

Trusts are common in primary care because of their use under business partnership law and PCNs. Partnerships and unincorporated networks are not legal entities so cannot contract or hold assets in their own name. The creation of a trust is often used to overcome this problem.

Examples include:

- property being held as an asset of the partnership
- the nominated payee PCN bank account held 'on trust' for the other network members, and
- shares in GP federations and incorporated PCNs held by a nominee partner on trust for the partnership.

Are trusts in primary care registrable?

Most trusts in primary care are express trusts, and as a starting point would therefore be registerable.

But Schedule 3A of The Money Laundering, Terrorist Financing and Transfer of Funds (Information on the Payer) Regulations 2017* sets out a number of exemptions from registration.

Of particular relevance to primary care are the public authority exemption and the legislative trust exemption.

The 'public authority' exemption applies to '*A trust created for the purposes of enabling or assisting a public authority, within the meaning of section 3(1) of the Freedom of Information Act 2000 (FoI Act), or a body specified in section 80(2) of that Act.*'

GMS and PMS contractors are included in the definition of public authorities, so the exemption is available to GMS and PMS practices but not to APMS contractors.

However, whether or not they can take advantage of it depends on the purpose of the Trust. The rule is that the Trust must be *created for the purposes of enabling or assisting the public authority to carry out its functions for the exemption to apply*.

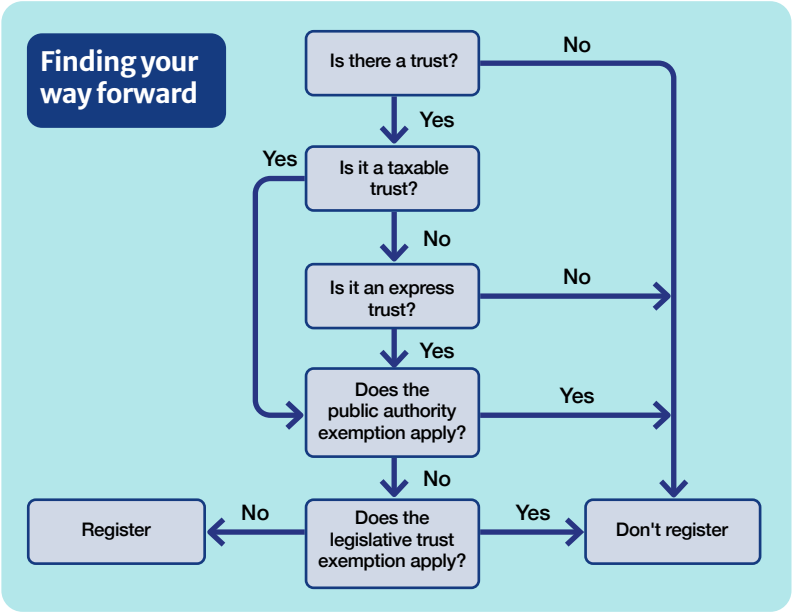
As an alternative, the legislative trust exemption would apply where a trust is 'imposed or required by an enactment'.

The most obvious example of this in primary care

is where the surgery premises are owned by five persons, but only four of them can be named as owners at the Land Registry due to the limitation placed by the Law of Property Act 1925.

So long as there are four current owners named at the Land Registry then this exemption would be available.

The process of analysis can be summarised in a decision tree (see below):



Primary care examples

While every trust should be considered on its own terms, here are some of the most common trusts arrangements in primary care:

1 Freehold and leasehold surgeries held as partnership assets

It is very common for GP surgeries to be held as partnership assets. A trust is created because, regardless of who the 'owning partners' are, the surgery is held 'on trust' for the partnership under an Act going back to 1890.

Since the surgery is almost always used exclusively for the purpose of delivering GMS or PMS services, the trust would normally benefit from the public authority exemption.

But the exemption would not apply to a surgery used by an APMS partnership. And if there are significant other parts to the building, such as residential apartments, you would have to consider if the trust's purpose was genuinely to assist in delivering GMS or PMS services.

2 Freehold and leasehold surgeries not held as partnership assets, where a subset of the owners are named at the Land Registry

If the surgery is not a partnership asset and all property owners are named on the title at the Land Registry, then there is no trust relationship.

If there are more than four owners, provided that at all times four current owners are named on the title at the Land Registry, the trust will benefit from the legislative exemption.

But if there are more than four owners and there are not four current owners named on the title, a registrable trust would exist because the legislative exemption would not apply.

3 PCN bank accounts

Most PCN bank accounts are held on trust by the nominated payee. But because PCN money derives from an enhanced service, it is by definition GMS/PMS or APMS money.

The PCN bank account therefore normally benefits from the public authority exemption unless a significant share of the monies belongs to APMS practices.

4 Nominee shares in a GP federation or incorporated PCN

Because partnerships are incapable of holding shares in their own name, nominee shareholders are normally used to hold the share on trust for the partnership as a whole.

An increasing number of PCNs have established companies for their PCN, but these shares would normally benefit from the public authority exemption since the PCN DES is an integral part of the GMS and PMS contract.

GP federation shares are somewhat different, because GP federations have often evolved to hold their own contracts and deliver their own services.

You then need to consider if the purpose of the Federation share held on trust is truly for the purpose of delivering GMS or PMS services.

Most primary care trusts are likely to benefit from the public authority exemption, and some will benefit from the legislative exemption.

But there will be a number which are not exempt, and your advisers should be alive to this possibility.

Speak with your specialist medical accountants to help identify if available exemptions apply to any trusts you have.

*Reference material

Schedule 3A of The Money Laundering, Terrorist Financing and Transfer of Funds (Information on the Payer) Regulations 2017

https://www.legislation.gov.uk/uksi/2017/692/schedule/3A

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