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AISMA Doctor Newsline

At the heart of medical finance...

Plan to survive!

Avoid making decisions in crisis mode. **Fiona Dalziel** lays out a new year's blueprint to help you take a step back and come through the crisis by making good decisions

I have heard this phrase a lot during the last 18 months or so: 'May you live in interesting times.' Whatever the disputed origin of this phrase, it is alleged to have been a curse.

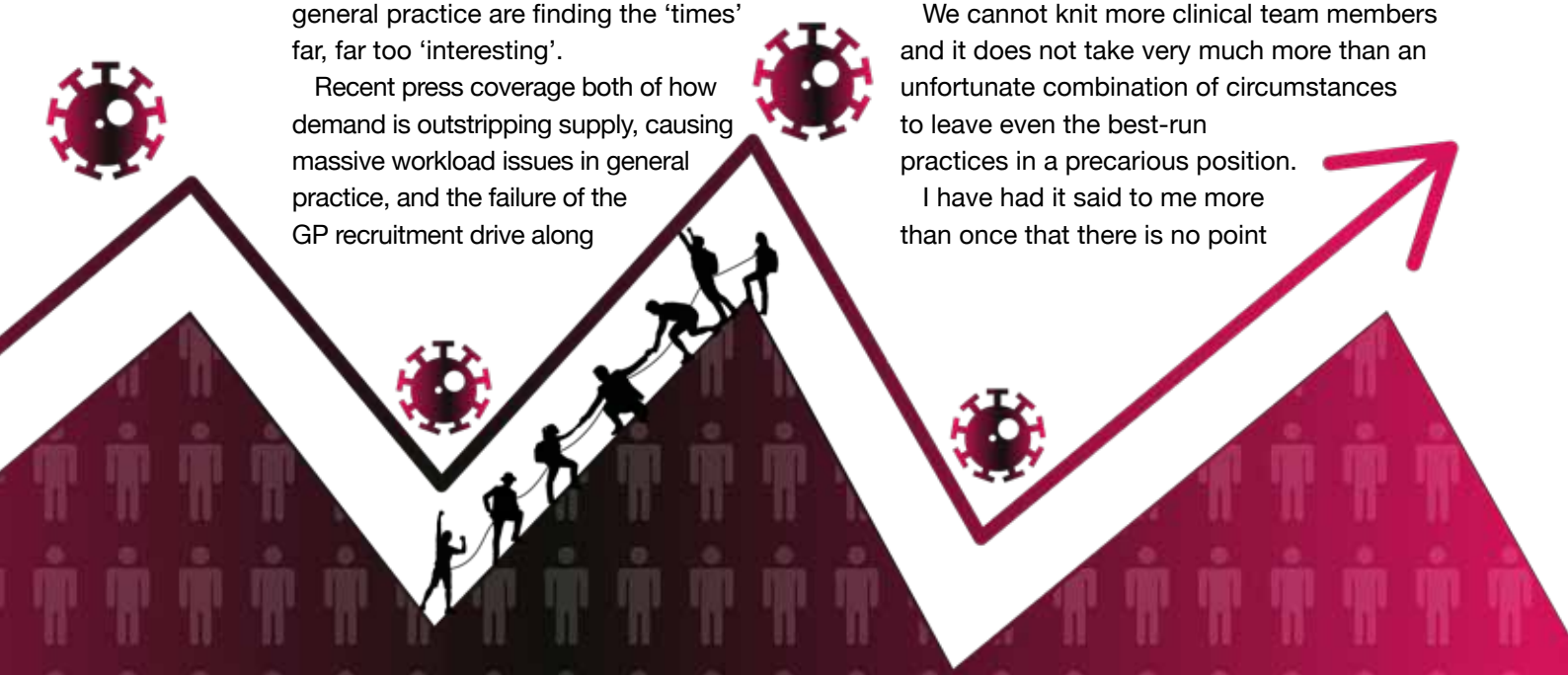
It is certainly indisputable that we do, indeed, live in interesting times. And those working in general practice are finding the 'times' far, far too 'interesting'.

Recent press coverage both of how demand is outstripping supply, causing massive workload issues in general practice, and the failure of the GP recruitment drive along with what can only be called GP bashing does not help young doctors to choose to join us.

In addition, qualified Advanced Nurse Practitioners (ANPs) are in short supply, able as they are to transfer seamlessly between GP practices and the hospital.

We cannot knit more clinical team members and it does not take very much more than an unfortunate combination of circumstances to leave even the best-run practices in a precarious position.

I have had it said to me more than once that there is no point



in planning, because the future is so unknown.

But nobody makes good decisions in crisis mode and the more we can look at what might happen, assess its possible impact, and decide with clear heads what action we might take in the circumstances, the more likely we are to make good decisions. Plan to survive!

1 Get together as a team

Possibly the hardest part of this whole exercise! Agree that, whatever comes your way, you are going to get through it together. Consider this as a way of looking after yourselves and regaining at least an impression of control.

2 Identify potential risk areas (see below for examples)

The potential risk areas will vary from practice to practice, depending on circumstances.

3 Assess how likely they are to happen

This is simply a process of looking at the risk area and deciding whether the possibility is vanishingly small or is appreciable enough to cause a bit of concern.

You can rank the likelihood using a simple scale. This means that you consider possible risk areas but only use valuable time working on the ones which have a significant chance of coming about.

4 Agree what action to take

Think about both (1) what you could do now to mitigate the risk and (2) what you could put into place if it actually comes about. Including as many team members as possible in discussions can reap benefits here.

I know a practice who discovered at such a meeting that a receptionist was extremely interested in becoming a healthcare assistant. She was trained into her new role without a hitch and provides much needed help to the practice nurse team. A new receptionist was quickly established in post.

Common risk areas

Broadly, there are common areas which could impact seriously on a practice, but each practice's circumstances are different and so, therefore, will be the associated risk areas.

Consider the following:

- **Loss of a partner (illness, resignation, retirement) and an inability to recruit a replacement:**

Salaried GPs make a massive contribution to workload but are not in a position to shoulder the extra responsibilities of partnership and this can leave a big gap.

You may already suspect a partner is planning to retire but avoid being caught out – put this on an agenda at regular intervals and review everyone's individual intentions.

- **Loss of a salaried GP or long-term locum:**

These team members soak up lots of appointments and are sorely missed if they move on. Again, make sure you are meeting regularly and looking forward in order that you can avoid surprises.

Salaried GPs and locums are much in demand; what else can you be doing to make sure your current team members feel valued? Do you offer them regular one-to-ones or protected learning time?

- **Loss of other key clinical team member(s):**

What if you have come to rely significantly on a couple of ANPs who decide to move on? Make sure that all team members are working to the top of their licence to ensure value for money and as much flexibility as possible.

- **Further workload increases:**

At the time of writing, Omicron is impacting our workforce simultaneously with GPs being part of the drive to quickly maximise vaccine rates. Some practices have been unable to provide services short term.

If something similar was to occur, what will you have learned from this (latest) crisis, and what might your strategy be? Under severe pressure, many practices will concentrate on the delivery of normal services and additional, income-generating activities will not be possible.

However, in normal circumstances the cost-effectiveness of the additional activity is important to consider, including:

- the costs associated with providing the service (staffing, premises etc)
- who needs to be involved in the decision?
- who will be willing to help?
- what might the impact be on routine patient care?

And finally - time together at coffee time and lunchtime (remember these?) is one of the first things to go when workload cranks up.

However, when considering some of the risk factors above, we have identified that working as a team and feeling valued are extremely important. Only abandon protected time with your colleagues if you have identified the potential risks as well as benefits.

Fiona Dalziel runs DL Practice Management Consultancy

What a drag – and it's going to get worse

OPINION

Luke Bennett*
AISMA committee member

'The art of taxation consists in so plucking the goose as to obtain the largest possible amount of feathers with the smallest possible amount of hissing.'

This memorable quote is attributed to Jean-Baptiste Colbert, Louis XIV's finance minister, and is just as applicable now as it was then. Being able to raise large amounts of tax without anyone noticing or complaining is a boon to any Chancellor.

One tried and tested method is known as 'fiscal drag'. This is the outcome arising when tax allowances or bands are left unchanged but, due to inflation and earnings growth, more taxpayers get pushed into higher tax brackets.

No budget announcements have to be made that get scrutinised or make headlines the next day. Just by doing nothing and remaining silent, additional tax can be raised.

For example, it was Alistair Darling in the April 2009 Budget who introduced the reduction of personal allowance for individuals with income exceeding £100,000. That limit has never been increased whereas if it had kept pace with inflation it should only apply now to individuals with income over £132,000.

There are other examples of allowances or reliefs that have not increased. The pensions lifetime allowance is being frozen between 2021 to 2026, and the annual allowance of £40,000 has been left unchanged since 2014.

One of the oldest unchanged reliefs I can recall is the inheritance tax annual gift exemption. This was increased from £1,000 to £3,000 in 1984 but has remained at £3,000 ever since!

While inflation is low the fiscal drag is less noticeable, although as illustrated above, over a longer period the effect is still significant. However, as we are now entering a period of higher inflation, the impact of fiscal drag is going to increase.

This begs the question, what can GPs and practice managers do to mitigate the effects of higher inflation?

- Review at least annually the charges you make for private medical reports, rents charged for use of premises and any other contracts where the price is set by the practice.
- Take professional advice to ensure any personal investments are reviewed to achieve a balance between growth and risk.

Finally, be thankful if you are member of the NHS Pension Scheme. One of the huge benefits of the Scheme which can be overlooked is that benefits are automatically indexed linked, so are not eroded by inflation.

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All change for NHS pension contributions

After more than six years of having no change to tiered rates, James Gransby warns we may be only months away from a big shake-up which will see many GP surgery staff paying extra in NHS pension contributions from April 2022**

Why is a change being proposed?

The consultation refers to the McCloud pensions remedy and explains that the NHS Pension Scheme has moved from being final salary linked to a career average revalued earnings (CARE) model.

All members will build up CARE benefits from 1 April 2022.

It explains that these proposed changes ensure the costs and benefits of the scheme are more evenly shared.

What are the proposals?

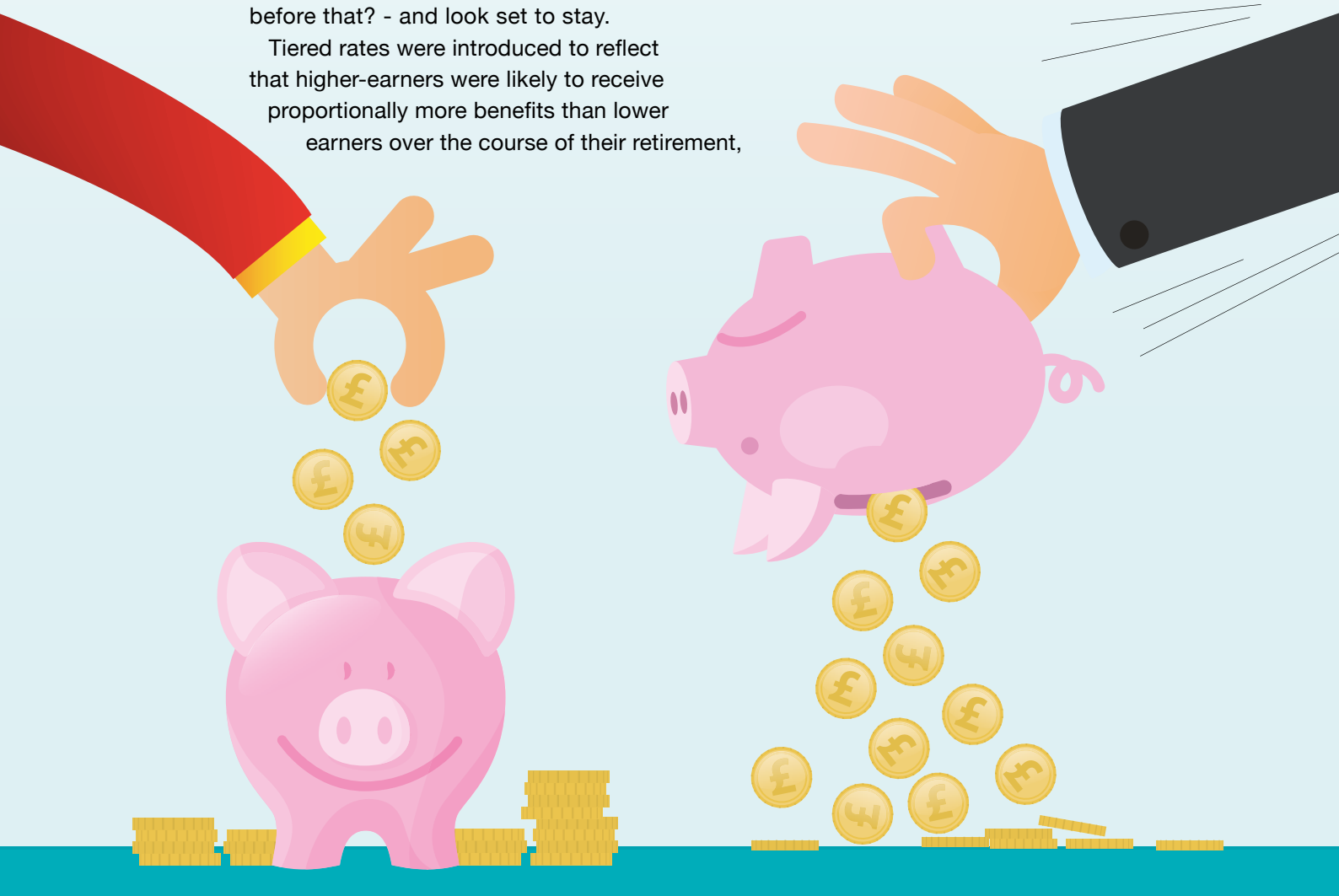
Tiered rates have been around since 2008 - do you remember the good old 6% flat rate before that? - and look set to stay.

Tiered rates were introduced to reflect that higher-earners were likely to receive proportionally more benefits than lower earners over the course of their retirement, due in part to their final salary link.

To ensure the cost of the NHS Pension Scheme was fairly distributed and affordable for all members, these tiered contribution rates asked higher earners to pay proportionally more than lower earners.

This principle remains while trying to maintain an overall yield of 9.8%. The table on the following page shows the proposed changes to the bandings and rates.

You will notice that the proposal is to make the changes over a two-year period. The approach is designed to minimise the impact on take-home pay while giving members time to adjust to the changes.



Current tiers	Pensionable earnings (rounded down to nearest pound)	Current rate	Rate from 1 April 2022	Rate from 1 April 2023	Proposed tiers
-	-	(WTE pay)	(Actual pay)	(Actual pay)	-
Tier 1	Up to £13,231	5.0%	5.1%	5.2%	Tier 1
Tier 1	£13,232 to £15,431	5.0%	5.7%	6.5%	Tier 2
Tier 2	£15,432 to £21,478	5.6%	6.1%	6.5%	Tier 2
Tier 3	£21,479 to £22,548	7.1%	6.8%	6.5%	Tier 2
Tier 3	£22,549 to £26,823	7.1%	7.7%	8.3%	Tier 3
Tier 4	£26,824 to £27,779	9.3%	8.8%	8.3%	Tier 3
Tier 4	£27,780 to £42,120	9.3%	9.8%	9.8%	Tier 4
Tier 4	£42,121 to £47,845	9.3%	10.0%	10.7%	Tier 5
Tier 5	£47,846 to £54,763	12.5%	11.6%	10.7%	Tier 5
Tier 5	£54,764 to £70,630	12.5%	12.5%	12.5%	Tier 6
Tier 6	£70,631 to £111,376	13.5%	13.5%	12.5%	Tier 6
Tier 7	£111,377 and above	14.5%	13.5%	12.5%	Tier 6
-	Expected yield	9.8%	9.8%	9.8%	-

This appears to hit those earning below £47,845 with reductions for higher earners. Is that fair?

The consultation document explains that higher earners do not benefit as much from the 2015 Scheme as they used to from the 1995 scheme. This is because it is a CARE scheme (although GPs have always accrued benefits on a career averaged basis and so this statement is more aimed at hospital doctors).

The examples point out that with a required yield of 9.8%, those earning in the first three tiers are protected against this rate by being subsidised by higher earners.

True but it may not come as solace for those who will see their net pay reduce from 1 April 2022 as a result of these changes - particularly as that date also coincides with the first time they will be required to pay the 1.25% Social Care levy increasing their National Insurance bill too.

In relation to the possibility of a flat 9.8% rate for all, the consultation says: 'In a CARE scheme, members accrue the same proportional benefit and there is an argument that everyone should pay the same rate - that is the 9.8% yield.

'However, the department proposes to retain a tiered contribution approach recognising the mutual intention of the scheme and the continuing desirability of facilitating participation across the whole NHS workforce having regard to potential affordability concerns for lower earners.'

Is it just the rates and bandings that are changing or is there anything else?

As well as the rates changing, the contribution rate applicable will be based on actual annual pensionable pay rather than Whole Time Equivalent earnings. This will be fairer for those working part time.

Those with multiple part time roles with different employers are more complex and cannot be aggregated. But it is hoped that those with multiple part time roles with the same employer may benefit.

The bands will also be linked to movements in Agenda for Change pay awards each year.

What does linking the band to Agenda for Change pay awards mean in practice?

For starters it means that the bands will change every year compared to the last six years where these have also remained static.

It will hopefully help members avoid the 'cliff edge' situation where a small pay rise or bonus could lead to a reduction in net pay.

Did you know that currently, someone earning £47,845 would see a reduction in their net income of £1,531 from getting a £1 pay rise?

Role	Full /Part time	Salary	Monthly cost vs now (after tax)	Cost per month vs 9.8% flat rate
HCA	Full	£19,918	£15 extra	£46 less
HCA	Part (60%)	£19,918 WTE	£2 less	£48 less
Nurse	Full	£31,534	£19 extra	Same
Nurse	Part (60%)	£31,534 WTE	£32 less	£43 less
GP	Full	£114,000	£85 less	£160 more
GP	Part (60%)	£114,000 WTE	£51 less	£96 more

What effect does this have on take home pay?

The consultation sets out some examples of this compared to the current rates, summarised in the table above.

People will tend to compare with what they pay now, rather than the 9.8% yield, but it is an interesting comparator.

When will we find out whether these changes are going to take place?

The result of the consultation would need to be announced soon after it closes on 7 January 2022 so that payroll processing departments can make the changes ready for the April 2022 payroll run.

Are employer rates changing too, or when might they change?

This consultation deals solely with member (employee) contributions. The next review of employer contributions would be from April 2024, after the results of the next round of pension scheme valuations takes place based on 2020 values.

The previous increase to employer rates from 14.3% to 20.6% has been paid centrally for GP employers in England since its introduction, so if rates were to change then this may or may not happen next time. The last uplift to employer rates for GP partners was the addition of a 0.8% levy which brings the total employer cost, before central funding, to 14.38%.

Might employee rates increase again in future?

It cannot be ruled out, and over a long enough time horizon then they will no doubt change again.

Readers may remember that the yield rose from 6.6% to the present 9.8%, with the increase phased in over the three years 2012 to 2013 and 2014 to 2015.

The McCloud remedy will cost the whole of the Public Sector £17bn to fix and they have already frozen something called the cost cap (which was set to improve benefits for those in the 2015 scheme from 1/54th to nearer 1/48th build-up in pension annually).

The BMA has filed legal action in relation to this recently, but it shows the willingness to pass on the cost of McCloud to members and not just taxpayers.

" It could be a good idea to make your employees aware of this potential change at an early stage "

What actions should I take for my practice?

It could be a good idea to make your employees aware of this potential change at an early stage. As mentioned above, when coupled with the first payment of the 1.25% Social Care Levy, many employees will see a drop in net pay in their April 2022 pay packet, despite gross earnings being the same.

Forewarned is forearmed, as they say.

ASK AISMA!

Partnership fairness issues dominate the topical questions from GPs answered here by Abi Newbury***

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

SICK PARTNER WANTS FULL SHARE

Q **One of my new partners has been off work sick for some months and is insisting that because they have not signed the partnership agreement, they are entitled to a full share of profits whether they come to work or not. That's not what we agreed.**

A This is a legal question rather than an accountant's question, but it does highlight the need for a partnership agreement to be signed as soon as a new partner joins the practice.

It is no good leaving it until the end of their 'probationary period' and saying they are only a real partner from then on if they are being held out to be a full partner in every other way.

One would hope that, morally, a new partner would abide by the terms of the old partnership agreement if they have not yet signed the new one – particularly if everyone has been operating on the basis of a verbal agreement, but it is by no means clear cut.

If it is found that there is no agreement, then there is a risk that the Partnership Act 1890 will apply, and profits will be split equally, regardless of how many sessions or additional work individual partners have carried out.

So, if you find yourself in this situation seek immediate legal advice from specialist solicitors who understand general practice.

If there is a risk you could get caught like this, contact a solicitor immediately to get a new partnership agreement drawn up.

For the future, do not take a partner on without them signing up to a partnership agreement that sets out exactly how profits are shared, and just as importantly, when profits are not shared (i.e. agree what happens if there are absences from the practice).

If you cannot get this agreed before the new partner's planned start date, consider taking them on as a salaried doctor initially, until it can be sorted.

WHY SHOULD MY TAX REFUND GO TO THE PRACTICE?

Q **My accountant has completed my tax return and it shows a refund being due to me, but he says it has to go to the practice. That can't be fair.**

A Some practices save for partners' tax within the practice, paying out drawings after withholding these tax savings, which are later paid on to HMRC on behalf of the partners.

This is reflected in the individual partner's 'current accounts' within the practice financial accounts. The accountant will estimate the tax due on the individual's profit share with a balance due/due to be repaid shown in practice creditors/debtors, so that the partner's current account shows the tax liability due for the year and reflects the real investment in the practice.

So, if the actual payments made by the practice are more than the amount estimated as due, the practice accounts will show that amount as being due back to the practice (and when the refund is received it will 're-balance' the 'current account').

The individual partner will not get the tax refund directly as well – otherwise it would effectively be received twice.

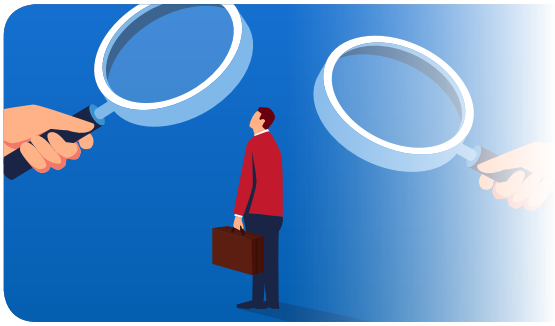
Where tax is not provided for in the practice – then the partner would have to pay this personal tax liability directly – and would therefore also be entitled to any refund.

WHAT TO LOOK FOR IN OUR NEW PARTNERS

Q **I'm the newest partner in a four-partner practice where the three others are all close to retirement. We're in the fortunate position of having prospective partners wanting to join us. What should I be looking for? And what should I say 'no' to?**

A You are indeed in a fortunate position in having a choice of potential partners. With clinical abilities being a given, what other qualities do you want?

1 Consider your own non-clinical skills, determine where the gaps are, and choose someone who can help fill that.
2 Consider where their attitude falls on a line of 'patients come first/money is a by-product' and 'money comes first/patients a necessary evil'. Neither end of the scale is the perfect place to be but you are likely to be able to work together better if you are at a similar place on the scale and have the same attitude.
3 Consider their history. If they have moved from another partnership find out why. It may be as innocuous as having to move geographically to follow a partner's job, or to be nearer parents for childcare support – or it may be someone who



didn't work out in a previous practice.

Dig deeper to find out why - remembering you are only hearing one side of the story. Our experience shows that often the trickiest partners are those who have been in previous partnerships and not stayed!
4 Make sure to choose someone that you can get on with, that your staff will get on with, and that your patients will get on with. The wrong person can make life difficult for everyone, even if they are a brilliant doctor.

After all, you spend a huge amount of time with your partners and you need to be able to work comfortably with them and fully trust them in all matters relating to your business.
5 Don't rush into a decision – ideally, have the preferred candidate work with you either as a locum or a salaried doctor for a period so that both you and they can make sure that they are a good fit.
6 And in today's litigious world make sure that your choice is documented and fair, and that no-one can claim discrimination of any sort.
7 Having chosen, make sure you have a watertight partnership agreement signed on day one.

Facing a claim

What you need to know about The NHS Resolution Clinical Negligence Indemnity Scheme for General Practice. Nearly two years on from GPs' new state indemnity scheme, Emma Summerfield and Vicky Rowlands give an overview of experience with the claims process and explain the support you will get if you are named as defendant

Overview of the schemes

Indemnity for clinical negligence claims was historically provided by defence organisations such as the MDU, MDDUS and MPS. But from 1 April 2019 NHS Resolution began operating a state indemnity scheme - the Clinical Negligence Scheme for General Practice (CNSGP).

Claims were covered by NHS Resolution from that date and the MDDUS and MPS have also transferred all their historical GP claims to NHS Resolution. These are dealt with under an Existing Liabilities Scheme for General Practice (ELSGP). The MDU continues to deal with any claims for this period itself.

GPs should note that both schemes only apply to any liability in tort (civil wrongdoing) arising as a breach of duty, so it is imperative for MDO cover to be maintained for any issues falling outside of the schemes.

Overview of a claim

To succeed with a clinical negligence claim, a claimant must satisfy a three-part test:

1 Establish a duty of care was owed
2 Show there has been a breach of that duty, and
3 Show an avoidable injury has been suffered (known as causation).

The first part of this test is clearly established in a patient/doctor relationship. To establish a breach of that duty, the claimant must show the care provided fell below that which would be provided by a responsible clinician practising in that field of medicine. This is often referred to as the Bolam test.

When to report a claim

You should contact NHS Resolution to report a claim or potential claim:

1 Upon receipt of a request for disclosure of medical records from a solicitor

2 Upon receipt of a Letter of Claim – this is important as the letter should be acknowledged within 14 days

3 Upon service of Court proceedings – again this is important as certain documents need to be filed at the Court within 14 days

4 If a complaint has been investigated and the proposed response makes admissions which would amount to an admission of breach of duty and/or causation

5 When there is a notifiable patient safety incident which has or may have resulted in severe harm

6 If there is a demand for compensation

7 If any communication is received from the Parliamentary Health Service Ombudsman

8 If there is any intended offer of compensation or other redress

9 In the case of group action – any adverse issue which has the potential to involve a number of patients.

A claimant must show that but for the breach of duty they would not have suffered from the injury complained of. There are some variations to this test in certain circumstances.

For the parties to investigate a claim, expert reports are obtained from clinicians who practise in the relevant fields of medicine but who are independent from those in the case. Check the box above to see when you should report a claim.

The NHS Resolution helpline is available 24 hours on 0800 030 6798. It will be able to advise if the matter needs to be formally reported in at that stage or advise you when to get back in touch.

You will be told what needs to be done to enable the claim to be reported. Alternatively, you can e-mail **ELSGPnotifications@resolution.nhs.uk** if your inquiry relates to a claim before 1 April 2019 and you were an MDDUS or MPS member at the time of the incident.

For post 1 April 2019 it is **cnsgpnotification@resolution.nhs.uk**

The role of the panel firm

A panel firm of solicitors is often appointed to investigate after a claim is reported to NHS Resolution. The instructed solicitor is now acting on your behalf, and possibly on behalf of some of your colleagues if the claim is pursued against more than one person.

It is important to remember that, as well as investigating the claim, they are there to support you.

Panel firms are usually initially instructed to obtain expert reports to comment on breach of duty and causation. These will determine whether admissions should be made or whether the claim can be denied.

NHS Resolution will advise you when a panel firm is being instructed and, following instructions, the panel firm will often seek your comments or arrange a convenient time to speak to you. Be open about what you can recall and ask any questions you have about the claims process.

Input required from a defendant GP

The first time you are likely to be asked for input is during the investigations which follow the Letter of Claim. This is usually the first formal step in the claim process and will set out a chronology of the facts and the allegations being pursued. You may be asked for your comments on both the chronology and the allegations themselves.

Without input from the people who treated the claimant, the instructed experts will only have the content of the records to base their opinion on.

Understanding a clinician's usual practice and ensuring a correct interpretation of the records is vital to ensuring the experts have taken all relevant information into account.

Once the expert reports have been received and the Letter of Response has been drafted, if it contains any admissions it will need to be approved. If you have been named as a defendant then you are usually asked to approve the admissions.

If the allegations relate to something more systemic and the practice has been named as the defendant then an agreed nominated individual will need to approve the admissions.

This might be the practice manager or a practice partner. It is important to let the panel firm and/or NHS Resolution know who has the authority to approve any admissions.

If admissions have been approved in the Letter of Response, the panel firm or NHS Resolution will investigate the value of the claim. No further input will be required in this process but you will be kept up to date.

If liability is denied but the claimant proceeds with the claim, the next step is for court

proceedings to be issued and served on the defendant.

One of the documents, called the Particulars of Claim, sets out a chronology of the facts and the allegations. This may be similar to the Letter of Claim, or the allegations may have changed.

In response, a defence is served. This will need to be approved and signed by someone with appropriate authority, maybe a GP partner or the practice manager, even if liability is denied.

The solicitor will work with you to ensure all relevant documentation and material is identified. As well as patient records this will include any complaints correspondence or practice investigations.

The next step is to exchange witness statements with the claimant's solicitor. The comments you have previously provided will be put into a statement for you to review in detail before signing and a further conversation may be needed with you to ensure all points are covered.

If a case proceeds all the way through the court process then the final step is a trial. If you have given a witness statement, you will be called as a witness to give your evidence and to be asked further questions by barristers representing each side.

You will be advised what to expect and what will be involved. If you have not given a witness statement, but you have been the nominated point of contact, you may be asked to attend the trial to observe and answer any last-minute questions.

"...please be assured that both NHS Resolution and panel firms ... will guide you through every step of the process..."

We fully appreciate that being named as a defendant in a claim can be an unpleasant experience. It may have been many years since you assessed the patient and going over the details can be distressing.

But please be assured that both NHS Resolution and panel firms deal with these claims daily. They will guide you through every step of the process and provide the level of support that suits you.

Emma Summerfield and Vicky Rowlands are associate solicitors with Hempsons