AISMA Doctor Newsline

A helpful resource for the practice business

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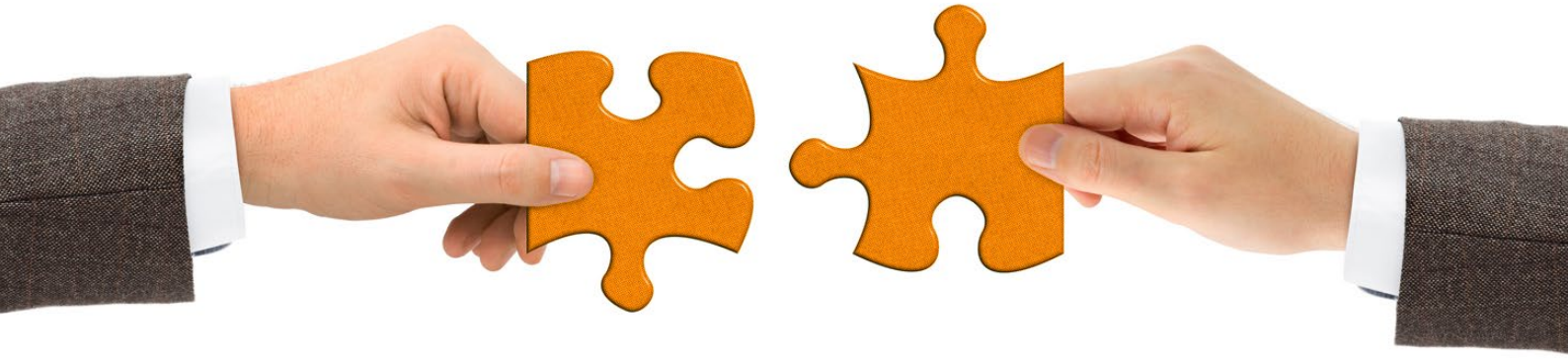
Make your merger fit for purpose

Funding changes in the NHS mean more and more practices are looking at merging with neighbouring practices as the way forward. **Andrew Pow*** advises on some areas to consider



If you want your merger to be successful then, generally, it must be for a reason rather than just to create a bigger practice.

Good reasons include:

- Moving to a new building allowing reconfiguration of services
- A fall in income streams which may force a reduction in costs through either reconfiguring clinical staff or reducing the cost of back office functions
- Difficulties in recruitment of key staff following resignation or retirement
- Allowing single handed GPs to access their NHS pensions and return to work
- Creating a larger practice which may be better placed to provide commissioned services moving from secondary care to primary care

Know your aims

The starting point for any merger is to identify the aims of the newly merged practice.

You then need to look at how the newly configured practice will meet those aims. Ask:

- Does the skill mix of the staff allow the practice to perform the services it wants to? For example is there a GP trainer that can lead on training of registrars and medical students?
- Do the premises allow a reconfiguration of services? For instance, if the practice is moving to a new building then can a common reception be easily set up?
- Do clinical systems allow ease of merger?

Winners and losers

The next step is to look at the viability of the merger from a financial perspective. Some of the areas to be considered include:

- What will be the profits of the new practice taking into account losses of income from NHS changes, such MPIG, and possible new income streams? There will be winners and losers so these need to be identified at an early stage
- What cost savings can be achieved from merging and reconfiguring staff? For example, do you need to replace a leaving GP partner like for like? If there are recruitment issues then what will you do?
- Are there any issues to do with property ownership and loan structures that need to be reconfigured?

Practicalities

Prior to any merger practical aspects need to be looked at including:

- Liaising with your local NHS authorities and, if in England, your CCG to arrange for approval of the practice merger
- Staff will need to be informed and compliance with employment legislation will need to be adhered to
- A budget will need to be available to deal with the costs of merging the practice
- New bank accounts and financial systems will need to be set up
- The newly created practice will need to be rebranded
- Setting up new PAYE schemes and NHS pension details for the staff
- Equipment and premises leases will need to be reviewed
- Suppliers will need to be informed and credit terms agreed
- Working capital will need to be provided to the new practice
- Preparation of superannuable income forecasts will need to be prepared for the GP partners so that pension contributions can be taken at the correct level
- The old practices will need to take advice on how to close down the old businesses
- The practices will need to allow for a period of consultation with the patients and should seek advice from NHS England on the consultation process.

Good advice

Having good advisors on board at an early stage can assist in avoiding some of the pitfalls of merging.

Morale is more than just a word!

Morale cannot be forced by edicts and injunctions. It grows from a sense of shared purpose and it is up to all in the practice to focus on that as the pressure grows, says **Kathie Applebee**

'Morale is low'. It is a familiar term in general practice.

GPs and practice teams are exhausted from overwork, relentless pressures, unrealistic demands, constrained resources, falling incomes…. The list grows rather than declines and the cumulative effect is a widespread sense of negativity.

Is it possible to have high (or even reasonably good) morale in such a climate?

Is low morale inevitable when the going gets hard and then harder? And what are the costs of low morale?

In a war zone, strong morale is essential to ensure that troops work together in adversity rather than breaking ranks and fleeing.

In the workplace, under the direction of business leaders rather than commanding officers, a similar sense of cohesion is needed to ensure that the or-

Points to consider

- Be aware that poor morale will cost your practice
- Never try to enforce higher morale by edicts
- Your staff may have high personal morale – but see they have it as a group
- Find out what the practice team thinks is their common purpose

ganisation is as efficient and effective as possible.

Alexander H. Leighton, a noted psychologist and sociologist, defined morale as the capacity of a group of people to pull together persistently and consistently in pursuit of a common purpose[i].

This depends both on the morale of individuals and their willingness to cooperate, which may include a degree of subordination of personal interests. Although individuals may enjoy high personal morale, this doesn't necessarily translate into group morale if personal interests predominate.

What is our common purpose? It is an interesting question to pose to the practice team.

What are the drivers that bind individuals together within a general practice and make it worth their while to subjugate their own preferences?

Financial reward is an obvious incentive but that contributes to personal motivation rather than team morale. A poorly paid team can outperform a well-paid team, as charities often demonstrate.

As with all inefficiencies, poor morale will be a cost to any practice. This can be demonstrated in multiple ways (buck passing, wasting time or other resources, unwillingness to take on new challenges), all of which are indicative of poor team morale.

Morale in this sense is the loss of group cohesion, where individuals become careless of colleagues and the consequences of their own actions on others.

Dwight D. Eisenhower is quoted as saying: 'The best morale exist (sic) when you never hear the word mentioned. When you hear a lot of talk about it, it's usually lousy.'

So don't hold meetings about morale, or rely solely on perks or pay rises.

The latter may help with individual morale but may not help the team, especially if some members benefit more than others.

Morale cannot be forced by edicts and injunctions. It grows from a sense of shared purpose and it is up to us, in each of our practices, to focus on that as the pressure grows.

The issue for individual practices is whether they can define and articulate their core purpose, and whether the leaders are willing to subjugate their individual requirements to develop sufficient morale within that group.

This then provides a lead and an example to the rest of the team. Management at its simplest.

i http://tinyurl.com/p5bazru

Kathie Applebee is director of Practice Consultancy Services; partner, Tamar Valley Health; director, Kernow Health CIC, and chair of Cornwall Health Ltd.

Can you question job applicants about their religious dress? Employment lawyer **Phil Allen** has some timely advice

Your staff are the public face of your practice, so you may wish to ask about a job-applicant's dress in interview.

But if you have questions about what the candidate is wearing and whether it will impact on interaction with patients, or health and safety, should you raise them?

Yes, you can usually talk about dress in an interview. However, what you must always bear in mind is the risk of a discrimination claim. You must not treat someone less favourably because of a protected characteristic such as race, or religion or belief.

Where the applicant's dress is worn because of their religious beliefs, this can raise difficult discrimination issues.

Dress and the risk of discrimination

You can't turn a job applicant down because of their religion or belief, that's direct discrimination.

However where you turn someone down for an apparently neutral reason, that may be indirect discrimination if it disproportionately impacts on those sharing a particular religious belief.

For example, if you don't want people with beards to work in your practice you would not be rejecting certain applicants because they were Muslims, but a greater proportion of Muslim candidates would be unable to get your job.

A rejected candidate could claim you had indirectly discriminated against him. Importantly, indirect discrimination can be defended if you can justify your approach/rule, by showing that the requirement was a proportionate means of achieving a legitimate aim.

It is worth GPs and practice managers noting a recent case.

The Employment Appeal Tribunal recently considered a claim brought by a trainee nursery assistant after she turned a job down because she was asked questions about her dress in interview (Begum v Pedagogy Auras t/a Barley Lane Montessori

day nursery).

This candidate was an observant Sunni Muslim whose religious beliefs obliged her to dress modestly. She chose to wear a jilbab (that is a garment which covers most parts of the body save the face) which was full-length and flowing, together with a hijab to cover her head.

There was discussion in her interview about the jilbab she was wearing. The manager questioned whether she could wear a shorter jilbab while working, as she was concerned that its length constituted a trip hazard for her and for other staff/children.

Following the interview, the candidate refused the job saying she had been insulted by the conversation, and subsequently pursued a claim for religious discrimination against the nursery.

The Employment Tribunal accepted that the manager who raised the issue had sufficient experience to know what constituted a potential trip hazard, and that she applied equivalent health and safety concerns to all staff.

And the Tribunal found that there was no discrimination as the practice being applied by the nursery was a requirement that members of staff dress in ways which did not endanger their health and safety, or that of their colleagues/children.

That was not detrimental to Muslim women, who could wear clothes which covered their bodies without needing to wear a garment which was a potential trip hazard.

The Employment Appeal Tribunal has confirmed that the Tribunal was able to reach that conclusion and has upheld its Judgment.

The Tribunal also considered whether the nursery would have been justified had the approach otherwise amounted to indirect discrimination.

It held that the manager's wish to protect health and safety was a legitimate aim, and a requirement to wear dress which was not a trip-hazard was a proportionate response.

Health and safety can be a justifiable reason

There can be a temptation to shy away from discussing potentially contentious issues with job applicants, particularly where they involve protected characteristics such as religion or belief.

Sometimes that is the right approach. However this case illustrates that sometimes the correct approach will be to carefully explore what impact dress may have on an individual's ability to fulfil their role.

Importantly in this case an experienced nursery manager engaged in a genuine discussion about considered health and safety problems.

You may be challenged on exactly why a question was asked and what you were trying to achieve. Whilst it is difficult to state definitively for all cases, a clearly defined health and safety concern is more likely to be justified.

So what can you ask?

- Be careful and consider what you ask in interview and ensure your questions are asked in a genuinely exploratory, even-handed, and considered way.
- Discrimination claims can arise from questions asked about dress. However if you carefully think through your reasons for asking the questions, appropriate questions can be asked.
- Ensure that those in your practice who undertake interviews are fully up to date with developments in discrimination law so that an ill-advised interview question does not expose you to a claim of discrimination.

What about communication concerns?

In a different recent case, an Employment Tribunal found that a school had acted proportionately in requiring a Muslim teaching assistant who wore the niqab to avoid covering her face in the classroom, in pursuit of the legitimate aim of facilitating effective interactions with children.

Conceivably, given the importance of fostering trusting relationships with patients, the principles in this judgment might carry over to a GP practice, but each case and role will need to be considered on its own facts.

What about a dress policy and smartness?

Many employers wish to impose a requirement to be smart, including dress-codes and uniform policies.

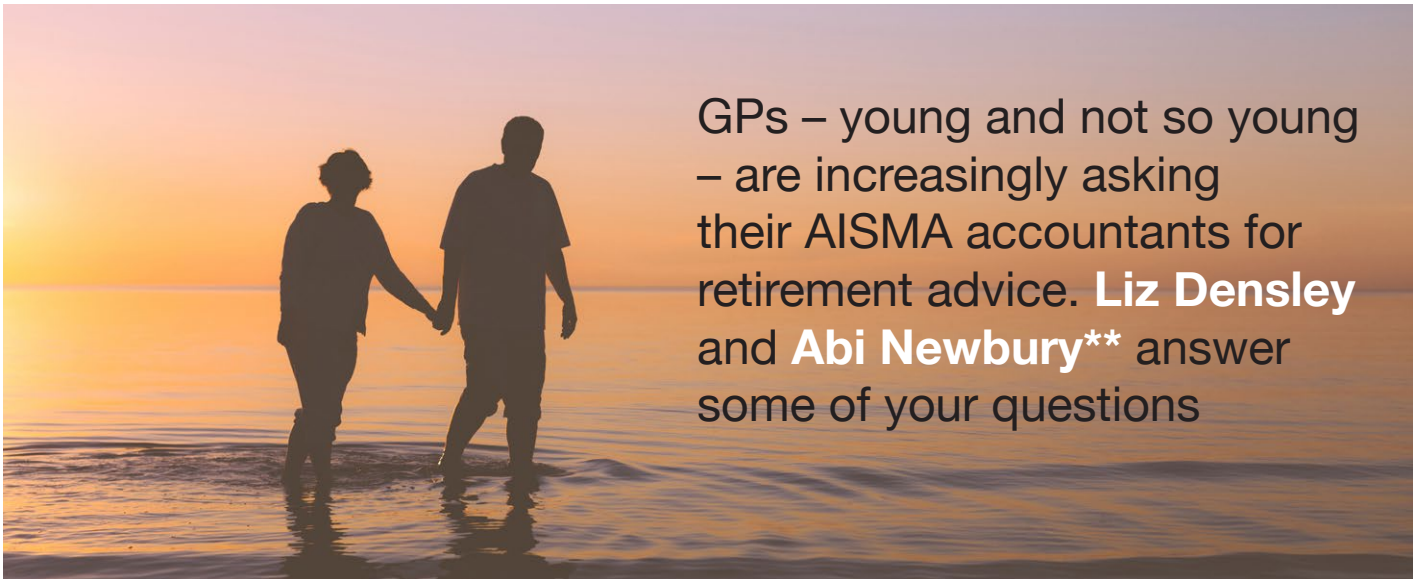
These can be imposed in many cases, but where they conflict with religious dress a challenge is less likely to be found in the employer's favour.

In a leading case, BA's no visible jewellery policy which was intended to maintain a certain corporate image, was held to fail to protect an employee's ability to manifest her religion when she wished to wear a cross.

Importantly, a different finding was made in considering an NHS Trust's no jewellery policy, where the risk of cross-infection justified a ban on a cross-necklace for a member of nursing staff.

Phil Allen is a partner and member of the employment team at Weightmans LLP

Tips to help you consider the right retirement date



GPs – young and not so young – are increasingly asking their AISMA accountants for retirement advice. **Liz Densley** and **Abi Newbury**** answer some of your questions

When is the best time to retire?

We now see very few doctors who work to normal pension age, take their pension and stop work totally. So why is this?

- Increased superannuation contributions – many feel that they would rather have the cash now, perhaps to put children through university, rather than building up a further pension.
- Annual allowance charge – where the pension fund and contributions are such that they breach the annual allowance charge limit. Do they want to pay the tax (or have the scheme pay it)?
- Lifetime allowance charge – where the fund exceeds the limit. Do they want to pay tax on it?

Your decision about this needs to be made with a suitably experienced financial adviser. This article only looks at tax aspects, but often the answer is emotional rather than arithmetic.

Many GPs are saying that when they have built up sufficient pension to live on in retirement they will come out of the NHS Pension Scheme.

Add to this the ever increasing pressures of general practice and many doctors, of any age, prefer to work fewer sessions.

What pension options are available?

- Keep working and continue in the Scheme
- Keep working and become a deferred member of the Scheme
- Keep working and opt in and out of the Scheme
- Take pension with 24 hour retirement and return to work
- Take pension and fully retire

Tax effects to consider

When contributions cease of course the tax relief on the contributions will also stop. But this can come as a shock when a large tax liability arrives a long time later, even where a warning was given in the first place.

For example: You stop paying contributions at 31/3/15. So tax for 2015-16 will be higher. It won't affect payments on account due in January and July 2016.

But your January 2017 tax will reflect the higher tax both for 2015-16 and the first payment on ac-

count for 2016-17.

So if contributions were £20k, and you are a 40% taxpayer, then in January 2017 you will have to pay £12,000 more tax than might have been expected. That is, 40% tax due on the loss of relief plus half again as a payment on account.

If you stop contributions at the same time as taking the pension then there is a risk that the combined pension and continuing income will push into the 45% tax bracket (for income net of pension contributions in excess of £150,000).

Watch what tax code is operated against the pension. If it is not your marginal rate of tax then there will be an adjustment on the self assessment tax return. This again may cause a tax shock, on top of that arising on stopping contributions.

Be careful if you stop pension contributions and don't continue working. It is useful to have some pensionable earnings after retirement to ensure you can claim tax relief on the final superannuation contributions. These are only paid after the pension certificate is completed nearly a year after the retirement date.

If you do leave the Scheme with no intention of further work then try to pay a good estimate of any balance of superannuation before the end of the tax year in which you retire.

Other considerations

As we are looking at imminent retirements, we are not discussing retirements under the 2015 scheme here and the possibilities of buying early retirement – the ERRBO (Early Retirement Reduction Buyout).

This can enable doctors whose pension date is greater than age 65 to buy out the reduction that would apply if they retired at 65 or later but before their normal retirement date.

Consider loss of benefits too – death in service in particular – if you come out of the scheme whether temporarily or permanently.

If you drop in and out of the scheme, you are likely to have to complete two pension certificates each year – one a 'seniority only' certificate and one covering the period in which you are in the scheme.

24 hour retirement

Under the 1995 and 2008 schemes a GP may retire from the NHS totally for 24 hours, and then return to the NHS for not more than 16 hours a week for the first month – then can go back to however many hours they want.

Be careful here. Retire from the practice and your partners are free not to take you back. So get agreement first.

Note that you cannot take annual leave to reduce your hours below the 16 hours a week unless it is holiday based on a less than16 hours a week contract.

Single handed practitioners have a problem. There is a real risk that they will lose their contract if they retire from the NHS for one day. It is usually necessary to bring in a partner to ensure that the practice continues.

So when should you retire?

There is no general rule of thumb here and each case needs to be looked at on its merits, particularly if the accounts are not prepared to 31 March.

Sometimes the use of overlap relief on retirement can give rise to 45% rather than 40% tax for a period and changing the retirement date may be enough to keep under that level.

Leaving the NHS Scheme will also give rise to the use of any overlap relief in respect of superannuable earnings. Depending on the circumstances this could push someone up a tier and cost additional pension contributions.

In some cases it can reduce pensionable income to the level where seniority payments are lost or restricted. Retiring early in the fiscal year in these circumstances will mean that there is less seniority payment to restrict.

Retiring from practice early in an accounting period can mean a delay on withdrawing your capital from the practice.

Most practice agreements say that capital is to be repaid x months after the accounts are approved.

So for example if you were to retire on 31 March, where accounts are made up to that date, you might get your capital out in, say, September following your retirement date.

But if you retired on 30 April, you would not get your capital agreed before the September a year later.

This timing issue is not a problem if separate accounts are drawn up to your retirement date – but this is a material extra cost that most practices do not want.

Above all, don't let tax alone control your actions.

We looked at figures for one GP where it was going to save him £5,000 if he worked two months longer than he'd planned – but when it came down to it, he decided he really didn't want to continue.

From a practical point of view, retiring at an accounting date may be tidier and easier to understand.

But where there is flexibility in retirement date then it is worth looking at options and doing the calculations before choosing a specific date.

OPINION

Making GP pay transparency clearer?

Deborah Wood, vice-chairman, AISMA

AISMA member firms are now entering their season of client meetings to discuss the 31 March 2015 accounts - and in England thoughts are turning to how that financial information will be used to satisfy the new contractual requirement for publishing earnings.

By 31 March 2016 practices have to publish the mean earnings relating to the 2014-15 financial year for all GPs in their practice.

Practices with a 31 March year end will have to use the data from their 31 March 2015 accounts.

But for all our other GP clients with a non-March year end it is the accounting information for their financial year that ended in the period 1 April 2014 to 31 March 2015 that can be used.

The reported figures are intended to indicate the average GP earnings, net of expenses, for the provision of the NHS core contract and nationally determined services.

Practices will have to set out the number of full and part-time GPs in the practice alongside the mean earnings information.

Guidance notes and examples are provided on pages 10 to 16 of the 2015-16 General Medical Services (GMS) contract guidance document published in March 2015.

In particular, tables 1 and 2 detail the income and expenditure sources that should be included and excluded.

So how easy will it be for practices to determine these figures?

Well, not all sets of practice accounts will contain the details needed and further analysis may be required which could lead to significant additional time or fees being incurred.

However, practices whose accounts are prepared by AISMA member firms will no doubt be able to access the required level of detail fairly readily.

What is an average?

The calculation of the average is taken based on the actual number of GP performers who are party to the contract for at least six months in the financial year: partners, salaried GPs and long term sessional doctors.

It is not a measure of full-time equivalent earnings, where full-time is taken to be eight sessions a week or more.

What impact will the publication of such figures have?

It is intended that readers of the information will be able to compare the average GP earnings of one practice with another, and with average NHS dental practitioners and with average NHS hospital doctors who will also have to publish similar data.

But I doubt that the GP practice data will have any positive bearing on the real issues currently facing general practice, such as the recruitment of GP partners for the future sustainability of the business and management of an efficient practice while providing timely access and high quality of care.

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. www.aisma.org.uk

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