AISMA Doctor Newsline

A helpful resource for the practice business

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Budget 2017: How it impacts on GPs

Chancellor Philip Hammond's 'backtrack' Budget 2017 contains a number of stings for GPs. **Andrew Pow*** and **Neelum Ali** report on the main tax and business measures he revealed

In his Spring Budget Chancellor Philip Hammond promised to provide a strong and stable platform ahead of Brexit negotiations and to get Britain 'back to live within its means'.

Income tax

As previously announced in the Autumn Budget, the main tax rates for 2017-18 are as follows:

- The main personal allowances will be £11,500 (increasing to £12,500 by 2020).
- The basic rate band is £33,500, which means the higher rate tax kicks in when income reaches £45,000. In Scotland there will be differential tax bands and higher rate tax will commence at £43,000.
- The additional rate band will remain at £150,000.

GPs with income exceeding £100,000 will continue to see their personal allowance tapered away, reducing to nil when income reaches £123,000.

Class 4 NIC – U-turn

The Chancellor announced a surprising political U-turn on his proposed rise in National Insurance rates for the self-employed.

The Budget had announced that from 6 April 2018 Class 4 NICs would increase to 10%, with a further increase to 11% the following year.

These changes were initially justified as a way of narrowing the gap between taxes paid by the employed and self-employed.

But this increase was met with a flurry of criticism from the self-employed, business lobby groups and MPs as the Government had previously pledged a triple lock on income tax, NICs and VAT in its manifesto.

In response to the backlash the Chancellor has now announced in a letter to Conservative MPs that *'In the light of what has emerged as a clear view among colleagues and a significant section of the public, I have decided not to proceed with the Class 4 NIC measure set out in the Budget.'*

The Chancellor also confirmed the Government will continue with the abolition of Class 2 NICs due in 2018. This will save all self-employed doctors £148.20 a year but will cost the Treasury around £400m a year.

So how will Philip Hammond plug this tax gap? A Government review of the increasing number of self-employed people is underway and we could expect further surprises in the Autumn Budget in changes to self-employed rules to claw the money back into the Treasury.

Dividend changes

There was bad news for GPs who work through their own companies and extract profits as dividends.

Currently shareholders can each take £5,000 over and above their personal allowance, in tax free dividends.

But this limit has been axed to £2,000 from April 2018.

So, this will mean GPs who take the full £5,000 dividend and are basic rate tax payers will see a tax rise of £225 whereas higher rate tax payers will now face almost a £1,000 tax rise!

Good planning in the meantime will be to use up as much of the tax free dividend allowance prior to April 2018.

Who knows if the dividend allowance will be further reduced or even withdrawn in the future?

Fundamental administration change affecting GP practices

One of the biggest changes to hit GP businesses which has yet to come into force is reporting under 'Making Tax Digital' (MTD).

The full rules though do not yet exist at the time of writing and both software developers and accountants are becoming concerned around the short timescales.

GP surgeries (including all self-employed and landlords) with turnover above the VAT registration threshold (increased by the Budget to £85,000) will be required to keep records in a digital format and make quarterly reports of income and expenditure to HMRC from as early as April 2018, using appropriate software.

MTD for business below the VAT threshold will be deferred by 12 months, but only until April 2019. But there is no time for complacency.

Smaller businesses and landlords should use this time to prepare and adapt so they are in a position to make a smooth transition to keeping digital records and updating HMRC quarterly.

For many businesses this will lead to additional pressure in dealing with administration work and practices should work with their AISMA accountants to get MTD ready.

MTD will eventually result in the death of the personal tax return with little or no chance of a rescue.

NHS crisis

Hammond said the NHS was 'central to the values of the Government and that it was vital that everyone had access when needed'.

The key health and care announcements in the Budget included:

- £2bn over three years to be allocated to social care in a bid to alleviate the pressures on the NHS.
- A Green Paper setting out the options for the future of the funding of social care.
- £325m in capital funding over three years for Sustainability and Transformation Plans that are ready to go, with a further capital funding announcement for the remaining STPs in the 2017 Autumn Budget.
- £100m for the trial of GP triage projects in A&E departments. Disappointingly there was no additional support for general practice in the community.

There are questions on how the Government will fund and recruit GPs to work on site at hospitals when there are already too few to meet the public's

needs. A system already overworked, underfunded and stretched to its limits will have to work even harder.

New IR35 rules on long term worker… employed or self-employed?

New rules have been confirmed for workers in the public sector supplying their services via their own personal service companies or other intermediaries.

From 6 April 2017, the public sector employer/ agency that engages the worker will be responsible for determining the employment status of the worker in deciding whether or not to deduct tax and national insurance - even though the worker invoices for the services via their own company.

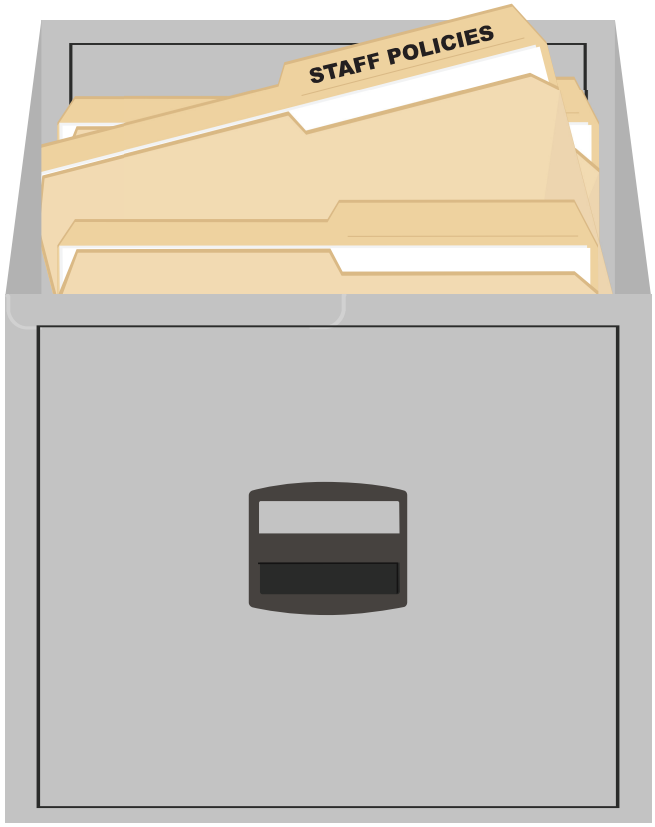
An online tool 'The Employment Status Service' is now available via HMRC's website and can help make that decision although care must be taken when answering the questions.

Pensions

Finally there was no change to the Annual Allowance or Lifetime Allowance rules. With the Budget predicting increases in inflation ahead, higher earning GPs need to prepare for increasing Annual Allowance tax payments in January 2018 - and potentially even bigger in January 2019.

Time to spring clean your staff policies

Unplanned absences can hit GP practices hard. **Fiona Dalziel** shows how up-to-date staff policies can keep costs down



When I was a very inexperienced practice manager I had a member of staff whose relatives dropped like flies.

They were all her cousins and all of them lived about 250 miles away. Attending a funeral involved several days' leave.

Of course, eventually I worked out that I was being had. But not before giving her quite a lot of time off and, as a consequence, treating unfairly the rest of the staff with fewer cousins and less brass neck.

There are more ways of looking after the practice's resources than simply practising excellent financial management.

Every time a staff member is unexpectedly not present, services are impacted and there is a good chance the absence will eventually produce a cost.

That cost may simply be in the price of covering the absence but it could also be in unexpected management time and, less immediately and tangibly in money terms, in additional pressure on

staff still at work.

Most of these costs, while unavoidable, can be minimised by some good housekeeping on a regular basis. And here's how:

● Don't ever find yourself saying 'Oh, I think we usually….'

Make sure that, for most eventualities, you are able to produce a policy.

Your practice may already have a good set of basic policies based on employment legislation, but when you are ambushed by a surprise situation your consistency and fairness may be undermined if your usual policies don't seem to fit.

● Make sure your sickness absence procedure is a useful document which helps staff back to work

Your policy should be up to date, reviewed regularly and clear. Your staff should all be aware of its content.

All sickness absence requires sensitive handling and consistency, so your policy should reflect your intention to be open and transparent and avoid discrimination.

Include in your policy how you will keep in touch with absent staff at agreed intervals. This may include meeting on neutral ground or at home.

Make clear that you may use occupational health advice and that you may refer staff to the Fit for Work Scheme to make a personalised plan for returning to work. (fitforwork.org or fitforworkscotland.scot)

● Handle compassionate leave consistently

You will need a policy to do this. Paid compassionate leave is discretionary, as unplanned absence is covered by dependent leave, but the deceased may not be a dependent.

Your policy could state different durations of paid leave depending on the closeness of the employee's relationship to the deceased.

Fit notes can be requested to cover if a longer absence is required due to a bereavement reaction.

● Manage Time Off In Lieu (TOIL) effectively

Some practices prefer to allow staff to take time off instead of paying overtime or may offer the option. The advantage is one of cost, although there are a few points to watch.

A manager should agree TOIL in advance and keep a record. Set a limit for the amount of TOIL any employee can accumulate before it is taken. Do not allow staff to 'owe' the practice time. Make sure all absences are covered by a policy.

● Understand dependent leave

The purpose of dependent leave is to cover unexpected absences and it is unpaid.

It is intended to provide 'a reasonable amount of unpaid leave to take necessary action to deal with particular situations affecting dependents'.

Dependents are defined as a spouse, civil partner, child, parent or person living in the same house but not grandparent (unless they are in the same house). This leave is normally only of one or two days' duration in order to put in place arrangements.

For more visit the ACAS website: https://tinyurl.com/kz9stta

Parental leave would be the appropriate method for handling planned absences such as covering the long school holidays and is also unpaid.

The statutory regulations for it are available on the ACAS website. The leave is taken in blocks of a week and requires 21 days' notice.

https://tinyurl.com/ojuqsy

● Think about jury service

This unexpected absence can put pressure on a small practice.

Consider introducing a policy for whether your members of staff will be given full pay or must simply claim loss of earnings from the court, which may be less than their full pay.

Staff must be given time off for jury service but in an extreme case you as the employer could ask for a delay and save on the cost of cover.

● Unplanned GP absences

Resist the temptation to reach for your locum list – keep costs down by seeing whether any GPs would like to do some extra sessions, either paid or as TOIL.

And, finally…

- Keep good records of all absences.
- Keep your policies up to date.
- Take advice if you are unsure – be fair, consistent and non-discriminatory.

Fiona Dalziel runs DL Practice Management Consultancy

OPINION

Ghost of Budget past returns to haunt locums and practices

Bob Senior, Chairman, AISMA

Most GPs breathed a sigh of relief following the Chancellor's last Budget as it was generally felt to be fairly low key from their point of view.

The proposed changes to Class 4 National Insurance from April 2018 were of course unwelcome, as no-one likes paying more to HMRC, but the increases were quite modest in comparison with some of the problems being faced by general practice.

The Chancellor's subsequent about turn on the matter following a raft of comments and complaints about whether or not he was breaking an election promise does at least provide some breathing space for a few years.

But it clearly shows that modern Chancellors commonly make announcements in a budget that will not actually come into effect until people have almost forgotten about them.

It is precisely that sort of delayed action time-bomb in the 2016 Budget that is now causing practices significant angst in relation to their payments to locums.

Following a number of high profile embarrassments in the press the then Chancellor announced in the 2016 Budget that the Government wanted to ensure anyone working for the public sector though a Personal Service Company (PSC) was paying the correct tax and National Insurance.

To achieve that HMRC would release an online status checker that all public sector organisations would have to use before making any payments to PSCs from 6 April 2017.

That status checker has now been released and the potential impact is only now being appreciated by GPs. Although the majority of locums do not operate via PSCs the number using limited companies has steadily increased.

Whether or not a payment to someone operating thorough a PSC is caught by the legislation depends on their precise working arrangements with the practice. But it is quite likely many will be caught.

If the intermediaries' legislation is deemed to apply to a particular payment then it will make the work much less attractive to the locum and more expensive for the practice.

A result of fewer locums and increased cost to general practice seems to be an unintended consequence of a decision taken by the Chancellor a year ago.

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GP contract: 10 important areas GPs and managers should be aware of

All change! English contract changes for 2017-18 are assessed here in an accountant's viewpoint from **Luke Bennett****

By the time you read this, you will no doubt have seen the details of the changes to the GMS contract introduced on 1 April 2017.

The changes also apply for practices with PMS contracts, but as is the nature with PMS contracts, there may be some variation as to how the changes are applied locally.

Points of particular interest from a financial perspective are these:

1 Global sum

The global sum per patient is being increased £4.76 per patient a year from £80.59 to £85.35, a rise of 5.9%.

But the reason for the apparent generosity of this increase is that it includes the £2.87 per patient previously paid via the separate Avoiding Unplanned Admissions DES, which has been withdrawn.

The vast majority of practices don't provide out-of-hours cover themselves, and the global sum payment, net of the out-of-hours deduction, has increased by £4.71 per patient from £76.44 to £81.15, so in reality the rise is 6.2%.

The important point to note here is that the global sum is paid on the list size as weighted by the Carr-Hill factor, so when assessing the impact for your practice ensure you are basing your figures on the weighted list size, and not your actual list size.

2 Avoiding Unplanned Admissions DES

As noted above this was discontinued on 31 March 2017. There will be a contractual requirement for practices to focus on the management of patients with severe frailty but with a much reduced bureaucratic burden.

3 QOF

The value of each QOF point for the average sized practice has increased by 3.6% from £165.18

to £171.20.

However this increase merely reflects the fact that the list size for the average practice has also risen by 3.6% from 7,460 to 7,732.

Therefore if your list size and disease prevalence are unchanged, you will receive the same amount per point in 2017-18 as in 2016-17.

4 CQC fees

The hated CQC fees are to be reimbursed in full in 2017-18. This is to be greatly welcomed as the fees are proposed to increase by 76% in 2017-18 so that, for example, the fee for a practice operating from one site with between 5,000 and 10,000 patients is proposed to be £4,526 in 2017-18.

Practices will need to claim a specific reimbursement for this cost, which may be detrimental to cash flow if Local Area Teams are slow in making payment, but it does provide transparency that this cost is not being borne by the practice.

As there is to be a full reimbursement of the whole cost and not just the increase, practices will be better off than they were in 2016-17.

5 MPIG

Not a contract change as such, but a reminder that 2017-18 will be the fourth of seven years over which the MPIG is being withdrawn. Practices will see a reduction of 25% in their MPIG compared with 2016-17.

6 Seniority

Again not a newly announced change, but a reminder of the existing policy to phase out seniority payments completely by 31 March 2020.

At the time of writing the seniority scales for 2017-18 were not published, but are likely to be between 10%-15% lower than those paid in 2016-17 although partners will of course have moved one year up the scale.

7 Employer pension contribution rate

It is recognised that more resource is required to adequately administer the NHS Pension Scheme, and following a consultation period it has been decided that the fairest way of raising the funds is to charge a levy on all employers.

This is being implemented by raising the employer pension contribution rate from 14.30% to 14.38%. This will increase employment costs for practices, so that for example, the employer contribution for a salaried GP on a gross salary of £75,000 will rise by £60 from £10,725 to £10,785.

It will also mean that the employer pension contribution that partners pay on their own behalf will increase slightly.

8 Indemnity costs

A payment will be made to practices to cover the rise in professional indemnity costs. Unlike the global sum increase, the payment is to be based on the actual number, not the weighted number, of patients on the practice list.

A payment of 51.6p per patient at 1 December 2016 is being made in March or April 2017, with a further payment a year later.

This rise is to cover not only the increased indemnity costs being suffered by partners but also salaried GPs and locums.

Practices who pay their salaried GPs' indemnity directly will not need to take any specific action. But where salaried GPs pay their own indemnity costs, practices will want to see evidence of the increase the GP has incurred to ascertain how much their pay should be increased.

Locums are likely to want to increase their rates but this will be subject to market forces in each area.

9 Sickness cover reimbursement for GPs

One very important change is that practices will be entitled to sickness cover reimbursement, and that this will no longer be a discretionary payment. In particular the qualifying criteria based on list size has been removed.

The payment which can be claimed after a GP has been absent for two weeks will be a maximum of £1,734.18 a week.

While this will not cover the full cost of engaging a locum it will make a significant contribution. Practices and GPs will want to review the level of their locum insurance cover in the light of this new policy, as they may find they can reduce the cover required.

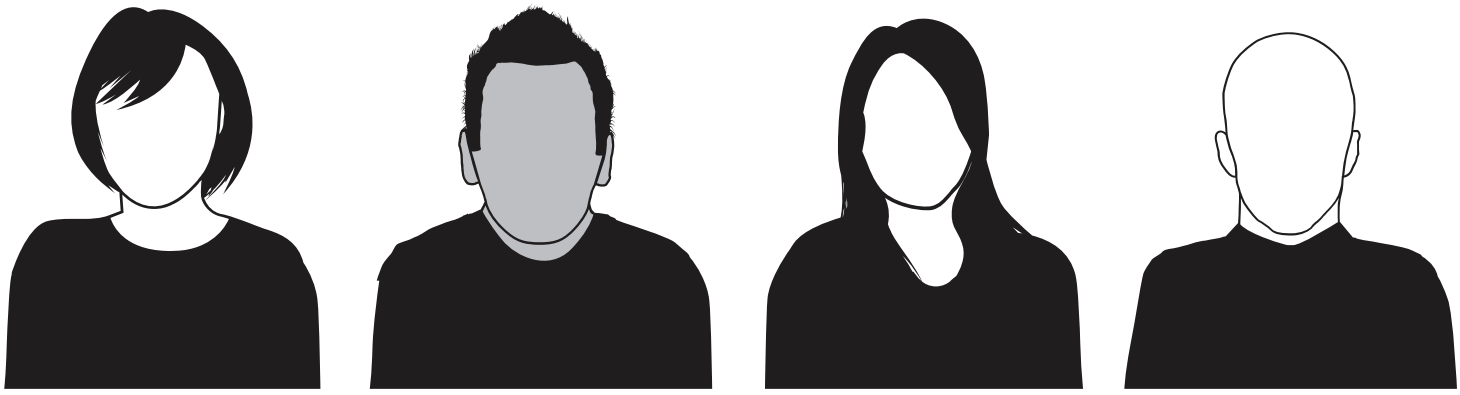
£8m has been added to the national budget for this increase in locum reimbursements. Given the high levels of sickness absence among GPs because of stress and other issues, one wonders if this is sufficient and sustainable given the pressure on NHS finances.

10 Learning disabilities DES

The amount being paid per health check is being increased from £116 to £140.

GP employers have new laws to keep in their sights

Stay up to date on the latest employment law affecting GP practices. **Stuart Craig** highlights those likely to have an impact



Headline changes to employment legislation have been rare in recent years but this has not halted the slow creep of further subtle regulation.

The problem for GPs is that some of the developments set out in this article are not immediately obvious as being relevant to their practices.

But each could have a direct impact because of the nature of GPs' work and the organisations practices are commissioned by.

Language requirements

On 22 December 2016 new legislation came into force requiring all public sector employers to meet the new 'fluency duty'.

Under section 77 of the Immigration Act 2016, a public authority is required to ensure public sector workers in customer-facing roles speak fluent English (or in Wales, Welsh). Customer facing roles are those where speaking to the public is a planned, regular and intrinsic part of the role. This contact could be in person or by telephone.

A code of practice has been issued as guidance to help understand the Act's requirements. It contains a checklist which employers should use to assess each role.

'Fluent' means the staff member has a command of spoken English (or Welsh) which is sufficient to enable the effective performance of their role. The code of practice also contains a list of factors to be considered when determining the standard required for each job.

The impact this could have on GP practices is that the term 'public sector employers' is likely to have a wide definition. So public sector organisations commissioning or subcontracting work to GP practices or federations are likely to insist in contractual arrangements that the organisation delivering the commissioned or subcontracted service engages individuals who meet the new law's requirements.

As the public sector organisation is obliged to meet these new requirements it is anticipated they will look to push down this responsibility in the contracts they award. Therefore GP practices are highly likely in coming years to be subject to these new arrangements.

If this occurs, then it is up to each GP practice to satisfy itself that its customer-facing staff are fluent in English. This could be by a formal test or through conversation in the interview process. This is likely to increase the administration required for

recruitment.

For current staff, and if practices become subject to this legislation through contract, GP practices should provide training to employees who are struggling to meet the requirement.

This should be allowed during their normal working hours, at the employer's cost. This could be via formal language classes, online resources, or one-to-one conversation with a native speaker, ideally someone who understands the role's context.

So this could potentially lead to higher training costs and potentially performance management issues if an individual is not meeting minimum requirements.

Keep a close eye on the detail of any new contracts awarded by CCGs or NHS Trusts in order to identify if these obligations are being imposed on your practice.

NHS conflict of interest

From 1 June 2017, senior NHS staff must:

- declare any gift over £50
- refuse any hospitality more expensive than £75
- seek permission to engage in outside employment, and
- notify their employer of any shares they hold in companies that do business with their organisation.

Staff can accept any hospitality up to £25 but will have to declare if it is between £25 and £75.

These new obligations are part of guidance on tackling conflicts of interest and are a result of a public consultation group led by Sir Malcom Grant, whose aim was to 'protect the taxpayers and the use of the NHS pound.'

To crack down on perceived conflicts of interest, in particular the frequently reported issues within CCGs, Sir Malcom's team's guidance is that staff must declare any shareholdings and interests in the ownership of any company which might do business with their own organisation.

NHS England has been particularly concerned about recent figures that seemed to suggest CCGs in England may have awarded just under 500 contracts worth close to £2.5bn to service providers which one or more of their board members had a financial interest in.

The guidance will affect NHS bodies such as CCGs, trusts and foundation trusts. However, other organisations (such as GP practices, social enterprises and community pharmacies) have been invited to adopt the guidance as good practice.

It could be again a situation where a commissioning organisation or NHS Trust that subcontracts work to a GP practice or federation will expect them to adopt this guidance as part of its contractual relationship.

One way of practically incorporating the guidance into a GP practice's culture would be to include specific reference and obligations in individual contracts of employment - for example practice managers, in particular those in a business development role - or in the partnership agreement. Both documents could list the potential consequences of a breach of the guidance.

GPs are already under a duty to maintain a register of gifts given to partners or staff of the practice by patients, relatives of patients or potential suppliers where the value of the gift is over £100. However, this new guidance potentially imposes more onerous duties on GPs.

National Living Wage and National Minimum Wage increases

In April 2017 the National Living Wage (NLW) and the National Minimum wage (NMW) increase. The NLW rises from £7.20 to £7.50 per hour. That will mean over £1,400 a year more for a full-time worker previously on the National Minimum wage (or £500 from last year's NLW).

The NMW categories increase:

- 21-24 year olds – from £6.95 per hour to £7.05.
- 18-20 year olds – from £5.55 per hour to £5.60.
- 16-17 year olds – from £4.00 per hour to £4.05.
- apprentices – from £3.40 per hour to £3.50.

Considering GP practices' wage budgets are already stretched, these increases will only serve to intensify the proverbial headache, which GP practices may struggle to relieve.

But the increases are not optional. Fail to pay the NLW or NMW and the taxman can send a notice for the arrears and issue a fine against the employer. Still refuse to pay and HMRC can bring a claim on behalf of the employee.

GP practices should therefore review their pay structures to ensure they are in line with the latest NLW and NMW thresholds.

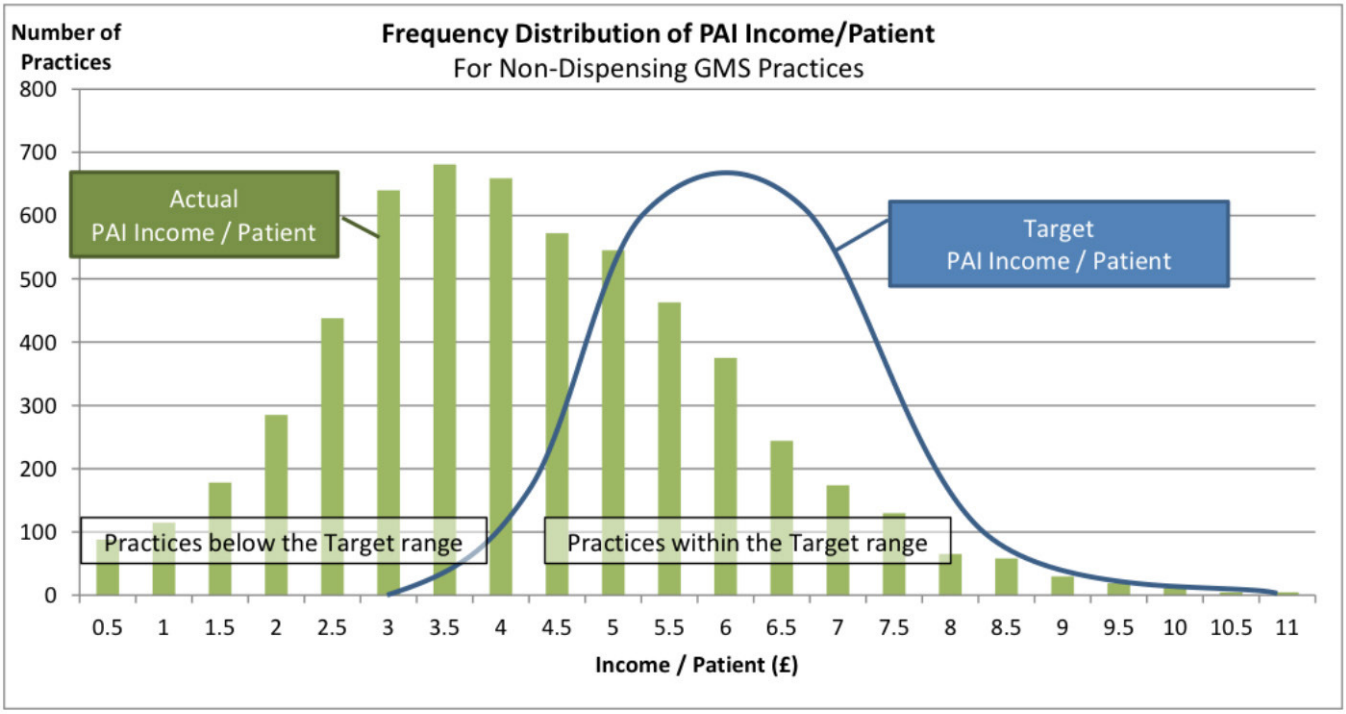
Any individual who is not paid in accordance with NLW or NMW can enforce their individual rights in an employment tribunal and seek recovery of the owed wages.

Stuart Craig is employment partner at law firm Ward Hadaway

Are you getting enough for your Personally Administered Items?

Most practices are not claiming for all of their Personally Administered Items (PAIs). **Tracy Hole** explains how you can

PAI income = NHS Refund Price – Discount + VAT + Prescribing Fee



Personally Administered Items (PAIs) are the drugs and devices used within the practice for which income is claimed from Prescription Services.

We analysed the 2015-16 PAI income of 5,800 non-dispensing practices and calculated the Actual PAI Income/Patient they received.

The green graph (see above) shows the number of practices occurring at each band of PAI income. The average is £4.04, with most falling in the range of £3.00-£5.00 per patient a year.

We know from research and individual practice reviews that most practices do not have the systems and processes in place to ensure they receive all the PAI income they are due. And as can be seen on the graph, most are below the target range.

We have found the typical shortfall between Actual and Target income is £0.50p-£2.00 per patient a year.

For the surgeries we have worked with we have increased the income per patient to the target levels indicated by the blue line in the graph.

Where do you fall on the graph?

Your PAI income for 2015-16 will have been reported in your accounts. Divide the figure by your patient list size to calculate the PAI income per patient and then see where you are on the blue curve.

Things affecting your income per patient

Any number of factors will affect your PAI income per patient, and therefore where you should be on the blue curve.

These include:

PMS or GMS

Some PMS practices negotiated for the prescribing fee element of PAI to be part of their baseline payment and so when the individual PAI payment is calculated, no prescribing fee is included.

Since April 2016 this has changed and all practices now receive prescribing fees of up to £2.40 per PAI as part of their drugs payment. These practices have been excluded from the graph above.

Cancer drugs (ie Decapetyl, Prostap, Zoladex)

Some practices prescribe these drugs while others buy them in. Our data shows that practices typically have one-two patients per thousand on these drugs which, if the drugs are bought, will equate to a PAI income of £1-£2/patient for their whole patient list.

The number of flus vaccinations administered

'Flus' result in an income of around £10 per vaccination. The percentage of patients who have flu vaccinations is typically 14%-25%, although some practices are over 35%. Therefore this has a significant impact on the resulting PAI income figure.

Our recommendations

Practice managers and their accountants should calculate their PAI income/patient and compare the figure with those on the graph. If they are at the lower end of the Target range, they should take action.

To increase the PAI income and profit:

- Know what is claimable.
- Claim for everything, even the very low value items. For example, a 12 pack of sutures costs less than £2, but along with the dispensing fee, can generate an income of £43 per pack
- Buy in drugs that would otherwise be sent to the pharmacy for patients to collect. For example, purchasing Zoladex costs £1,000 per patient a year, but results in an income of £1,200 a year. Not all drugs are profitable, so check carefully.
- Run effective flu vaccination campaigns. 'Flus' account for around 40% of your annual PAI income, and 70% of your PAI profits.

Over the last two years, community pharmacies have ramped up their marketing of flu vaccinations. This is helping reach more people, but is also directly impacting practice income. Get ready for the next vaccination season, and ensure you reach as many patients as possible.

Implement an end to end process with checks and balances, from ordering to payment, to ensure nothing is missed.

And don't forget, while this will increase income, to maximise profit you also need to ensure you are not paying too much for the items you buy.

Over the past 18 months suppliers have increased the price of reimbursable items above the NHS Refund Price. There is little you can do about this so you must ensure you are buying at the lowest available price.

Following these steps will result in an immediate and lasting increase in practice income and profits.

Tracy Hole, a former GP practice manager, runs Ash Lane Consulting, a company helping practices increase profits and improve efficiency