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# AISMA Doctor Newsline

At the heart of medical finance...



## Don't slip back!

Achieving good quality status with the CQC is one thing. Keeping it is another. **Fiona Dalziel** gives her tips for staying on top


First, the good news: a recent CQC report for 2018-19 reported that 74 practices in England rated 'requires improvement' had successfully been uprated to 'good'.

And now for the bad news: 17% of practices rated 'good' the previous year had slipped to either 'requires improvement' or 'inadequate'. This is an increase on the slippage rate from the previous year.

Several years ago, in one of the forerunners of CQC, the Royal College of GPs offered two voluntary quality awards: the Quality Practice Award and Practice Accreditation. Many practices successfully completed these and went on to achieve excellent results from the CQC, but only some re-applied.

Even well-developed practices who assumed an award would be straightforward to achieve found that a significant amount of work was needed to meet the required standard throughout the practice first time around.

The situation in Scotland is different in another way – without QOF to provide structure and motivation it is a challenge to maintain quality momentum over a range of clinical areas (and they don't have the CQC).

So, before every practice manager in England decides to move to Scotland, let us consider what is going on.

## Why is it hard to maintain quality?

- The energy generated the first time around, either through enthusiasm or sheer panic, is hard to maintain or re-generate
- Other urgent priorities immediately fill the space once the evidence is submitted and the process has completed
- Key personnel may move on
- It is such a tough experience that the prospect of going through it all again tempts everyone to put off re-starting
- The practice may have done well and then had a lull in assessments; all that energy has been diverted into new projects and challenges.

Most practices will experience some of the above at some stage in the process. So, what are the top five things to work on to ensure your practice achieves the standard you aspire to on an ongoing basis?

## Top tips for keeping up with quality

### 1 It's a planning priority

When planning the practice's priorities for the next year, make sure that space has been allowed for this significant area of activity.

Although the theory is that, as with retired QOF indicators, the work 'becomes routine practice', the reality of working in general practice today means that this volume of work cannot just be absorbed as day-to-day if the practice aims to do well or improve.

### 2 Leadership

Very little, or nothing, will happen without effective leadership. An experience of no, or ineffective, leadership is an element common to all struggling practices.

The maintenance or improvement of your practice's CQC status is reliant on a minimum of a GP and practice manager leading the process.

Of course, the whole team has a responsibility to contribute but setting an example, generating energy, motivating and monitoring are all leadership responsibilities which make the crucial difference.

GPs should not simply assume that the practice manager will cope marvellously on his or her own next time around.

### 3 Procrastination

A practice manager's coffee mug said: 'Don't rush me – I'm waiting for the last minute!' She


kept that mug for a long time but when she took it home on her retirement day she realised that it had lost its meaning.

She had broken her habit of procrastination and the difference in her effectiveness had been evident in how the practice was run. It is far too easy to let today's crisis take over what you had planned.

This is not effective management practice and when it happens frequently it can become simply an avoidance tactic. By the way – that mug was mine.

## 4 Scheduling and prioritisation

Decide on the most difficult and complex tasks and make them top priority for action now. Work out a programme for everything else. You won't stick to it, and it will alter along the way, but you will have done the work of recognising the priorities.

You will still have a bit of a last-minute rush, but it won't be a last-minute rush to complete a difficult and complex task.

## 5 Delegation

This is a whole-practice activity, not a solo by the practice manager or a duet between the practice manager and lead GP.

For something like the CQC or any other large project, the leader's job is to delegate and monitor progress of the delegated tasks, not to do all the work alone.

Ensure delegated tasks explicitly name the responsible individual(s) in plans and progress reports. Offer guidance and resources.

If you are unsure how to delegate, do a small amount of research to check you are following all the steps by searching online for 'how to delegate successfully'.

Many practices today face significant challenges, especially with recruitment. It is easy to be constantly firefighting and many practice managers tend to shoulder a lot of the burden along with the GPs.

Achieving consistency or improvement with the CQC will only happen if the practice is able to keep an eye on quality as an ongoing priority amongst the emergencies.

### Reference material

***Care Quality Commission Annual Report and Accounts 2018-19***

https://www.cqc.org.uk/sites/default/files/20190812_annualreport201819.pdf

**Fiona Dalziel runs DL Practice Management Consultancy**

# The bitter pension tax pill will taste no sweeter any time soon

OPINION

**Sue Beaton** AISMA committee member

A relatively small number of doctors faced a large tax hit when the annual allowance for pension growth was lowered to £40,000 in 2014-15.

But this changed drastically from 1 April 2016 when tapering of the annual allowance for pension growth was introduced. It cut the standard £40,000 allowance by £1 for every £2 where total adjusted taxable income exceeds £150,000.

Although unused allowances - should there be any - from the previous three years could be utilised, these have long since been used up for a large and increasing number of taxpayers.

As you are only likely to be 'safe' from tapering of the annual allowance if all your taxable income is less than £110,000, many GPs and NHS consultants are now hit very hard with penal tax charges on the growth in their pensions. Some have got into serious financial difficulties as a result.

Over the last year or so, there have been numerous news stories in the press highlighting how tax charges are crippling doctors financially. Many chose to cut their hours, leave the NHS Pension Scheme or retire early - all at a time when the NHS is under mounting pressure and there is a doctor recruitment and retention crisis.

Professional groups such as the BMA and AISMA have fought to bring this issue to the attention of the Government, calling for a review of the tax treatment of doctors' pensions with a view to revising the 'all or nothing' pension decision they are currently faced with.

So it was therefore welcome news indeed when the Government announced earlier this year that it was consulting on proposals to make the NHS Pension Scheme more flexible to allow clinicians to take on extra work caring for patients without the fear of higher tax bills.

The initial '50:50' proposal - giving the option of halving pension contributions in exchange for halving the rate of pension growth - was quickly withdrawn as being neither flexible enough nor resolving the severity of the impact of tapering of the annual allowance.

The replacement proposal, whose consultation period ends on 1 November 2019, is to allow senior clinicians to set the level of pension accrual at the start of the year, for example 30% contributions for a 30% accrual rate or any other percentage in 10% increments.

This proposed flexibility is further improved by giving individuals a chance to review their pension growth towards the end of the scheme year once a more accurate idea of their earnings is available and amend the contribution rate if they wish.

Contribution arrears from choosing a higher accrual level would be payable before the end of the scheme year. For employed clinicians, if a lower accrual rate is chosen the employer will also pay lower contributions and will have discretion to pay to the member unused employer contributions.

The aim of these flexibilities is to allow extra working without the fear of a significant tax hit although it is argued that review of the tapered annual allowance is also needed.

On this point the Government has stated 'The Chancellor has announced that the Treasury will review how the tapered annual allowance operates in order to support the delivery of public services.'

If changes to the tax system are introduced the department may revisit the need for flexibility within the NHS Pension Scheme. It remains to be seen if any changes will be made here.

So where does this now leave AISMA clients?

Any new pension rules are unlikely to start until 1 April 2020 at the earliest. The current cycle of tax returns is for 2018-19, with balancing payments due by 31 January 2020, and there is also the matter of the current tax year, 2019-20, for which final tax settlement will not be until 31 January 2021.

It will be some time yet, therefore, before the impact of any new flexibilities will be felt.

Meanwhile it is essential you remain fully aware of the present pension growth tax rules and make plans accordingly.

Whereas a potential sweetener is on the horizon, pension savings tax charges will remain a bitter pill to swallow for quite some time to come.

# Have you got adequate protection?

GP practices are currently targets for fraudsters from both outside and inside the practice. AISMA recommends...

1 Don't let any one person be the sole signatory on the bank account for amounts over a set level – for most practices a sensible figure would be between £500 and £1,000.

2 The person approving the invoices should not be the person making the payments.

3 Invoices should always be reviewed by the person approving the amounts to be paid. Be careful not to approve both the invoice and the statement to create a double payment.

4 The partner responsible for staff should review salary payments before they are made to check for unknown names or unusual payments. Particularly check for unexpected pay increases or overtime.

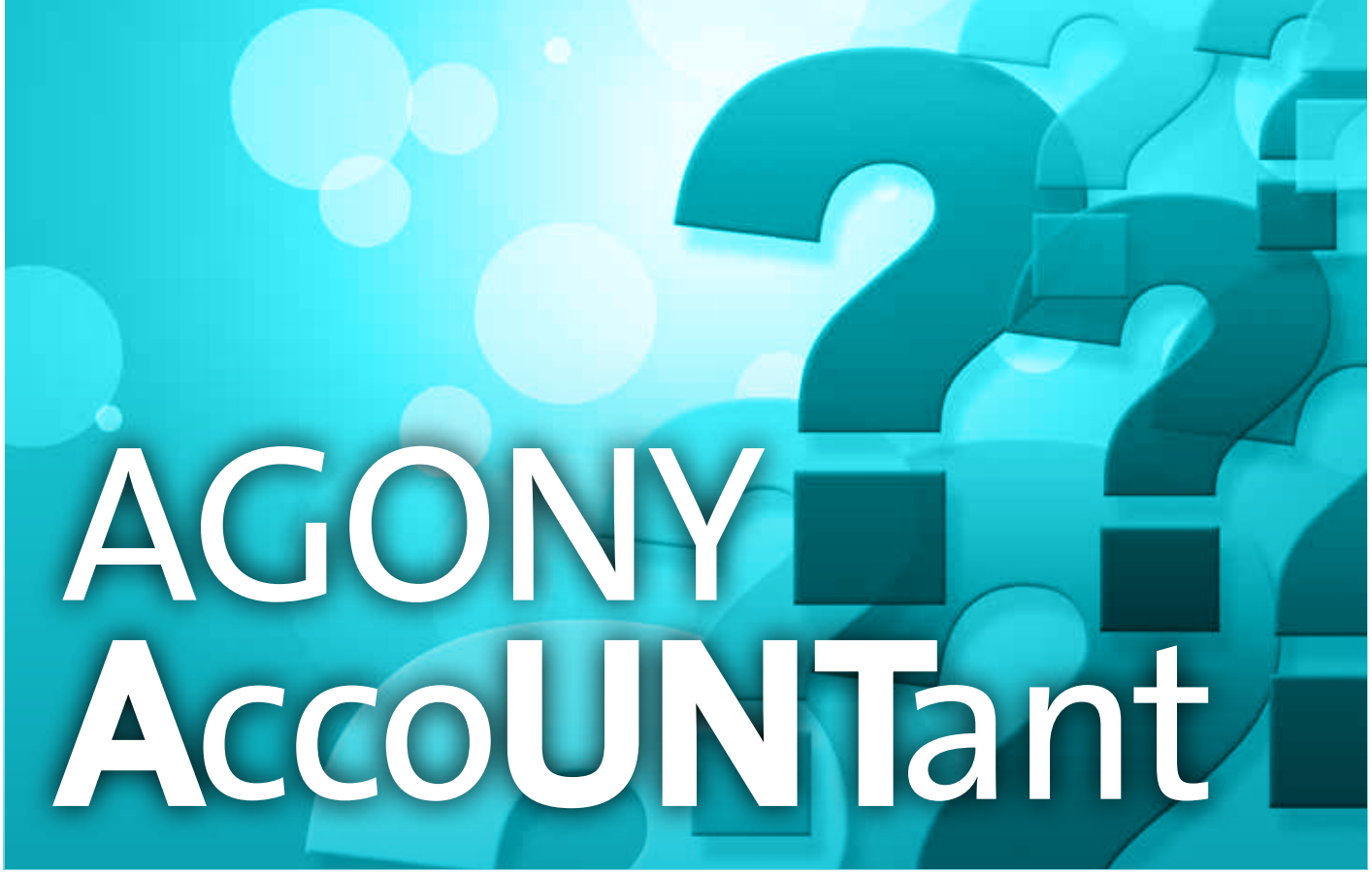
5 Review your locum payments regularly and investigate unrecognised names. Insist on accounting records disclosing who the locum is covering for and why.

6 Have a detailed budget and compare with actual figures monthly, or at least quarterly, to pick up anything unusual. For example, use key ratios to check that drugs costs v reimbursements are on track. Drugs, medical consumables and staff wages/locum costs are usually the easiest places to hide fraudulent payments.

7 Use a specialist medical accountant who will break down income and expenses in suitable detail and question movements that seem unusual. If you don't understand your accounts because there is not enough detail, potential fraud is harder to identify.

And finally, accountants are not engaged to spot fraud and may only pick it up when preparing the year-end accounts – by which time it is too late.

So make sure you keep on top of the practice finances throughout the year, not just once a year when you are preparing the information to send to your accountant.



# AGONY AccoUNTant

Our Agony Accountant Abi Newbury* answers more of your questions about general practice financial issues

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

In this issue she tackles some partnership concerns

**Q** **Our senior partner has told us he is going to retire in six months and expects a huge pay-out - and we don't even own the practice premises. Why do we need to pay him? How are we supposed to come up with all this money? It all seems so unfair when we've not had a pay-rise for years!**

**A** It can certainly feel unfair to be looking at a large capital pay-out to a retiring senior partner, especially if your own drawings have been static.

So, what is this money he is due? The page in the practice accounts that shows partners' current account balances is the best place to start to understand this.

The balance for each partner here represents either money invested directly into the practice, or profits that have been earned over the years (and been taxed), but not taken out. At retirement or leaving the practice these funds are payable to that partner, as they would be to you if you left.

In an ideal world, at the end of each accounting year, you should be looking at the business need for capital and then draw the excess out, leaving the balances in profit sharing ratios. This evens out risk and reduces the issue of having to find excessive sums when someone goes.

*"Senior partners often restrict their own drawings to leave enough overall funds in the practice for it to run"*

This is not always possible practically. Senior partners often restrict their own drawings to leave enough overall funds in the practice for it to run – rather than ask their other younger partners, who might have mortgages, pay superannuation and perhaps school fees, to cut theirs or forgo much needed bonuses. Repeat this scenario over a long period of time and we have a problem.

If the business needs to keep working capital of say £112,000 (to make the arithmetic easy),

**Here is an exaggerated example:**

| | Dr Senior | Dr A | Dr B | Dr C | Total |
|---|---|---|---|---|---|
| Balance at beginning | £100,500 | £7,500 | £5,000 | (£1,000) | £112,000 |
| Profit for the year | £125,000 | £100,000 | £50,000 | £100,000 | £375,000 |
| Monthly drawings | £96,000 | £96,000 | £48,000 | £96,000 | £336,000 |
| Extra bonuses | £0 | £10,000 | £5,000 | £20,000 | £35,000 |
| Balance at end | £129,500 | £1,500 | £2,000 | (£17,000) | £116,000 |

and profits are shared by sessions of 8:8:4:8 then balances should be 8/28 shares for a full timer – so £32,000 - and £16,000 for a half timer.

In many practices, the partners who have overdrawn would have had to find money to pay back in immediately, so if you were Dr C you would have had to find £32,000 plus £17,000 – a total of £49,000 to be responsible for your fair share.

Unfortunately, because the senior partner has taken it upon himself to protect the others from financial hardship, it is all going to catch up when he leaves, because he will want, and be entitled to, his investment out at that stage.

You will probably be able to arrange a bank loan to pay Dr Senior out – or he may be prepared to grant a loan over a fixed period, but you must be realistic and understand that you can only withdraw your real profit share each year otherwise you will end up out of kilter again.

*"be realistic and understand that you can only withdraw your real profit share each year otherwise you will end up out of kilter"*

Be proactive, look annually at a sensible budget and see what you can each afford to draw – or better still, work backwards – start with what you need to draw and then look at what you must do to achieve that.

By better understanding how these current account balances work you can determine the levels needed for the practice, draw sensibly to minimise the chances of over-drawing or the effect of under-drawing, and plan for pay-outs in advance, avoiding nasty financial shocks when partners leave.

**Q** **Our new partner is joining us in six months' time. We had to borrow money to 'buy in' when we joined years ago, but he says that doesn't happen now. That doesn't seem fair. What can we do?**

**A** New partners are very hard to find these days and often the thought of having to find a huge amount of capital to invest, on top of the risk they are taking of becoming a business owner, will put the strongest off taking up a partnership offer.

This means that GP partnerships looking for new partners now generally shy away from asking for a lump sum on day one.

There used to be a big increase in income on becoming a partner, but salaries and particularly locum earnings are so high now that an incoming partner does not see that big leap in their disposable income.

If they must take out a loan as well, which might restrict the amount of mortgage they can get, that might be the decisive factor as to whether to retain the flexibility and financial freedom of being a locum or salaried doctor.

But that does not mean the need for new GP partners to invest in the practice has gone away.

If you have been lucky enough to find a new partner who wants to join you then you need to make the transition as smooth as possible for them. Sit down with them and go through the accounts so they understand how it works and why they need to invest money in the business. Getting your AISMA accountants involved works well. They are used to explaining accounts to new doctors.

Once new partners understand why they need to contribute working capital, agree a plan on how they can do this.

Most practices now allow their new partners to restrict their drawings for the first three years or so, to build up their working capital share at a more manageable rate.

Some may prefer to borrow money to do that - the interest would be tax deductible - and be able to receive full drawings.

As a practice you can control your need for working capital to some extent. Make sure all claims are made promptly and followed up if payment is not received when it should be.

Ask for payment up front for sundry fees for which you can charge. This will stop bad debts and save staff time chasing up debts.

Use the time to improve other systems, such as to ensure claims for drugs reimbursements are maximised, that coding is working properly, and new staff are properly trained, – which will then maximise your income.

It will all come out fairly in the end, it may just take some patience in terms of the speed at which they contribute, but that is a small price to pay for the right partner.

**Q We've asked our salaried doctor to be a partner but he is asking to see a partnership agreement. Why does he need this? We've always just trusted each other and got along fine, does this mean he's going to be difficult?**

**A** There's always much to worry about when taking on a new partner. This is someone that you hope to be working with for a long time, and the wrong person (like the wrong marriage partner) can cause a lot of pain.

You do all need to trust each other and you should not consider taking on a partner who you feel you don't trust. But it is safest for not only the individual partners, but the practice business, to have a comprehensive and up to date agreement.

Making one makes you think about how you want to work. What sources of income do you not want to share? What expenses should you meet personally? What happens if someone is sick, not pulling their weight or even suspended? And what can be done if you just cannot get on with each other? The list of things that need to be covered is huge.

You need a specialist solicitor who understands general practice to pull together an agreement that includes all you need. But this is only as good as the information you provide – take time to answer any questions the solicitor asks and involve your accountant if you need assistance on the financial side of things.

If you have no up to date partnership agreement you have a partnership at will which is governed by the Partnership Act 1890. Amongst other things, this would split all profits equally and enable anyone to dissolve the partnership at any time – not a position you want to be in!

So, your potential new partner is not planning to be difficult, he is being thorough. He just wants to know that all of you (and probably you all more than him) are protected just in case anything goes wrong.

It will also give him clarity about profit shares and personal expenses, leave and absence provisions, what liabilities he is signing up for and much more – which is all very important to understand when you are moving from a safe salaried position into the unknown of being in business.

Of course, if you have other reasons why you feel your new partner may be difficult then you should tread with care and not rush to make him a partner.

When you do, a well written partnership agreement will protect you and enable you to remove a difficult partner – not having a partnership agreement would make that much harder.

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**AISMA Doctor Newsline** is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK.
**www.aisma.org.uk**

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* Abi Newbury is a director of Honey Barrett Ltd

# Keep a close eye on your 'shares'

**There are some big challenges to overcome if you share staff across Primary Care Networks (PCNs). Julia Gray explains**

PCN DES payments include staffing costs for employees who will work across the network to fulfil the contract.

The Mandatory Network Agreement published by NHS England and the BMA refers to staff sharing but does not include any detail of how that will be achieved.

It states in clause 27: 'We will each have individual responsibility for our own staff.' There is then reference to Schedule 5, in which each network can set out its own arrangements, which is left blank for networks to draft for themselves.

Getting the content of this section right is essential and could avoid a great deal of trouble and expense later.

## Identity of employer

Anyone who has run a practice will know there are plenty of traps for the unwary in employment law. These are accentuated when sharing staff with others.

The first question to address is which organisation will employ the newly recruited network staff. Will the employer be one of the practices, all the practices jointly, a company or partnership formed for the network, a GP federation, an NHS Trust or something else?

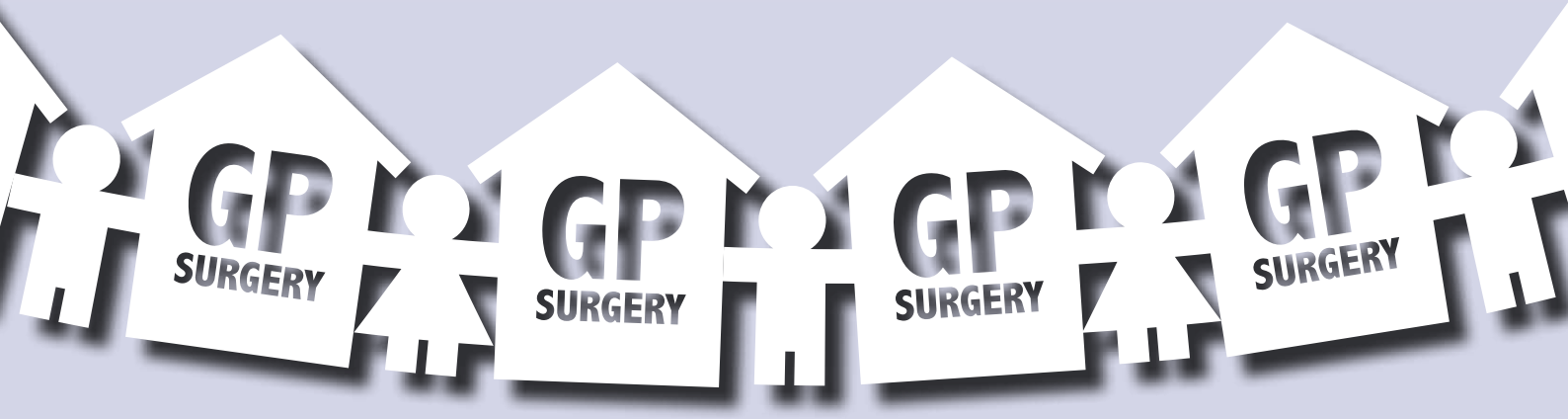
One certainty is that the PCN cannot itself directly employ staff because it is not a legal entity. The employing organisation does not necessarily have to be the employee's paymaster. For example, payroll might be delegated to the network's nominated payee which receives the DES funding.

Some of the models listed above might involve network staff being seconded out to other practices. The supply of staff to a network through a secondment agreement is likely to be a vatable supply, whether or not the staff are clinical. Secondment models may also give rise to additional obligations under the Agency Regulations 2010.

If the employer is not a practice, consideration needs to be given to whether the employer is an 'employing authority' under the NHS Pension Scheme such that its staff can access an NHS pension and to securing adequate professional negligence insurance arrangements for the employees.

## Employment terms and policies

When you have decided who will employ network staff, it will need to be determined what their terms and conditions should be and what policies should apply to them.



The two most obvious options are to employ them on the employment terms normally used by the employing organisation, or to employ them on a contract and suite of policies created specifically for network staff, and which could then be used by other employers of network employees in future.

We usually recommend the second option, although it requires more advanced planning and possible up-front cost.

Funding for network staff under the DES contract is based on NHS Agenda for Change pay scales, but that does not mean their contract needs to refer to NHS pay.

You should consider making an express connection in the employment contract between the employment (particularly any pay reviews) and the DES funding. This could make it easier to justify a future dismissal based on redundancy should funding diminish or be withdrawn.

A common source of unrest in organisations where staff work closely together but have different employers is perceived unfairness in terms and conditions.

Within a single network, staff may be expected to work alongside colleagues doing very similar jobs but employed on different terms and conditions and under different policies.

Inconsistencies in working hours, rest breaks and holidays are all common causes of discord and a source of risk. This is just one reason why practices are well advised to promote good employee relations by consulting with all staff, not just newly appointed network staff, about employment arrangements.

## Management responsibility

Having agreed who will employ network staff and on what terms, the next issue to consider is who will make the big decisions relating to employing network staff, such as who to recruit and when to dismiss them?

Practices may initially express a desire to have a say in these decisions. But when it comes to it, they may not have the inclination or capacity to engage properly with the processes involved.

To limit the risk of employment issues arising you will need to document who will deal with management and HR issues. Your network governance arrangements should cover how decisions are reached and the procedures that will be adopted to do so.

**The HR procedures that will need to be covered in the agreement include:**

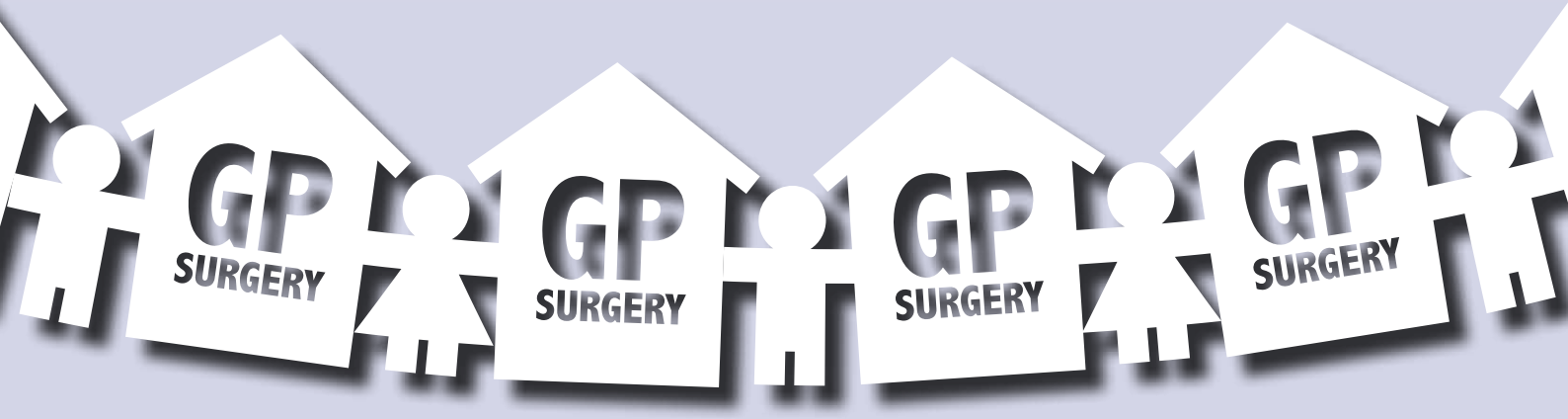
- Performance reviews
- Disciplinary procedures
- Grievances
- Leave arrangements, including annual leave and family-friendly leave
- Varying terms of employment (including whether this requires the consent of other members)
- Dealing with redundancies and meeting any payments
- Responding to claims
- Data sharing.

Do not forget that aside from data sharing issues relating to patients, as soon as organisations share staff, they will need to begin sharing data about those staff.

There will need to be contractual provision between the organisations governing this and employing organisations will need to create (or update) staff privacy notices to reflect the arrangements.

## Liabilities

As well as allocating practical responsibilities, an important aspect of the network agreement will be to formalise how legal liabilities will be shared between network members.



A common source of dispute between partner organisations who share staff is where the liable party is not the one obviously at fault, or where one of the parties is more at fault than another.

**Through a series of indemnities in the schedule to the network agreement, it will apportion:**

- Inevitable and foreseeable costs such as staff salaries
- Unexpected but potentially unavoidable liabilities such as redundancy payments, and
- Potentially avoidable liabilities, such as for awards for successful legal challenges, legal costs, and associated management costs of defending such claims.

Those indemnities will require careful drafting. Thought should be given at an early stage to whether practices will share all such liabilities equally, whether apportionment will be weighted (for example based on list size) or whether the agreement should take account of the circumstances surrounding the liability (such as who was at fault).

The agreement should contain provisions for dispute resolution which can be invoked if there is a disagreement as to liability to avoid having to make a claim in court.

The example (see box right) highlights the scope for complex employment challenges and the importance of properly drafted indemnities.

Practical and legal challenges of sharing staff are not straightforward. But they are surmountable. Networks will require specialist bespoke advice and will need to devote time to working through the options.

A well-drafted network agreement will be key to establishing relationships and liabilities from the outset and avoiding disputes later.

**Julia Gray is an employment law specialist at Hempsons**

## The scope for complex employment challenges and the importance of properly drafted indemnities

Network employee Joe is employed by practice A. He accuses his colleague (employed by practice B) of harassment. His grievance is heard by a manager employed by practice C, who decides it is unfounded.

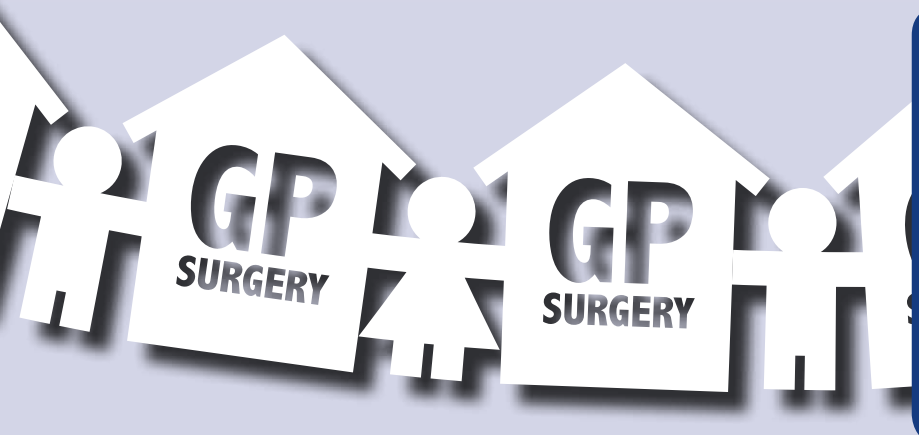
Joe brings a discrimination claim in the employment tribunal against his employer, practice A. Practice A might have had minimal involvement in the case but will nevertheless retain legal liability for claims.

An award made by an employment tribunal will almost always be solely against the employer. The indemnity agreement should provide for the apportionment of that liability after it is made, refunding practice A.

The agreement should also apportion liability for legal costs in defending the case and for potentially settling the case. Lawyers instructed to defend the claim will act for practice A, but practices B and C will have a vested interest in the outcome of the case and the way in which it is run (for example whether it should be settled and for how much).

But unless provided for in the network agreement, they will not necessarily have a say.

The stakes in some types of employment claim are high: in discrimination cases, aside from awards for injury to feelings, tribunals will award compensation for whatever it deems the claimant would have earned, had it not been for the discrimination. In extreme cases this can extend to career-long losses.




## Coming to you soon!

**Watch out for an AISMA Doctor Newsline special edition: *The AISMA Really Useful Quick Guide To Primary Care Networks*.**

Prepared by our vice chair Deborah Wood, it is a mine of information packed with smart advice and tips to help everyone in your practice understand not only what's going on but how to make the most of it!