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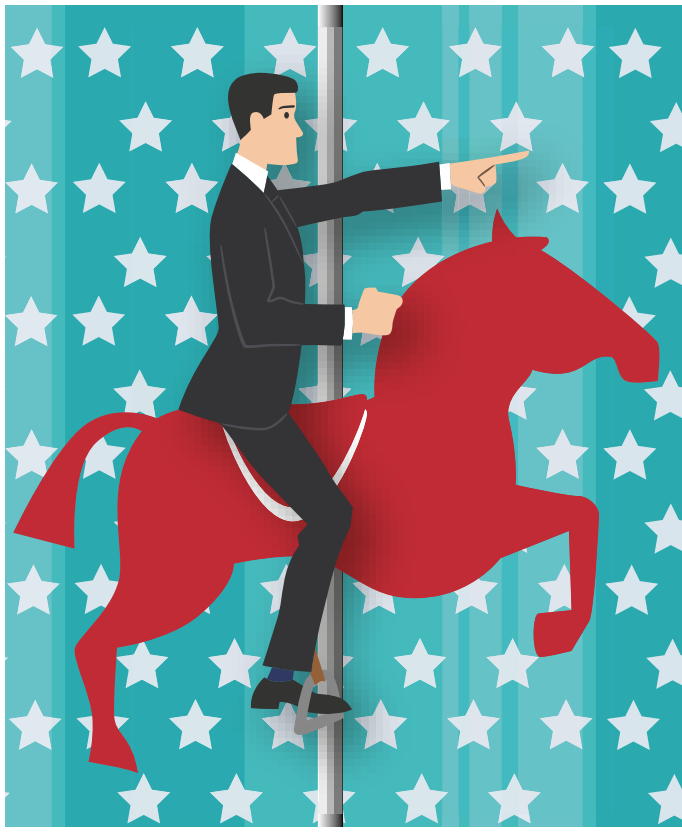
AISMA Doctor Newsline

At the heart of medical finance...

Top tips for when you have a partnership change

As soon as there is any change in partnership property or partnership membership speak to your accountant to check the financial and non-financial factors to consider. **Nick Holmes*** advises on what to watch



1 Existing partners: with a change in profit sharing ratios is there to be a change in property ownership as well?

2 Ensure you use up your annual exemptions for Capital Gains Tax and that the transaction qualifies for entrepreneur's relief.

I recently took on a new client where they made a property change mid-year but there was no profit-sharing change. Therefore some partners did not qualify for entrepreneur's relief as they had not reduced their commitment to the partnership within the time frame.

3 Changing from property ownership to leasehold: ensure you understand if there are VAT implications for this and whether all the VAT cost on the rent will be reimbursed by the NHS or not.

Also, existing property owners selling may not be the continuing partners who are signing the lease – understand the implications for future changes and the 'last person standing' situation.

4 Partnership agreement: is it up to date and does it reflect the current partners' wishes and understanding of how to deal with changes? For example, the compulsory purchase or 'option' to buy out a partner on retirement/departure or death.

5 Accession/joining deed: rarely does a new partner sign a partnership agreement before or on day one of joining. So, is the offer letter detailed enough to refer to issues like earnings, property, subscriptions, seniority, and holiday with reference to the partnership agreement?

6 Departure deed: this is not always needed if your partnership agreement is sufficient but it is advisable.

Is there a clause covering the partnership and outgoing partner for after-departure superannuation and seniority adjustments? After-date seniority clawbacks do occur and can be considerable.

"The most important advice I can give is to communicate more and keep on good terms with all partners in the event of any change. Look at all changes as a situation to be discussed with your AISMA accountant."

7 Superannuation payments and dealing with Primary Care Support England (PCSE): for new joining partners the payments may not start for the first year of a GP being a partner. Understand the tax implications of delays in payment.

8 New partners joining: should profit sharing be at 100% parity, at reduced parity for a period or should it even be a fixed core amount with an allowance for the employer's superannuation?

Also, estimate and confirm the drawings for new partners both before and after they have joined so that there are no surprises.

Ensure that any subscription costs are considered correctly. Some pay through the partnership bank account and some personally.

9 Partnership debt: ensure that the partners' names on the title deeds and any declaration of trusts/bank documents are reviewed and amended at every point when a partner joins or leaves.

A single change every few years may be supported by the bank but multiple changes in a short period of time that should have been made years ago could lead to the debt being called in and redemption penalties being imposed.

10 Saving for tax within the practice or personally: partners joining who used to be employed could go 21 months without paying any tax and then have a sizeable tax bill due.

Ensure you are planning for it in line with the profits earned and drawings being paid.

For partners leaving there could be a 'tax time bomb'. It is important that predictions are made before a partner ceases the partnership and an agreement reached as to who will be paying the tax bills to prevent overdrawing in the partnership or overspending personally.

11 Partners drawing an NHS Pension due to taking 24-hour retirement while working or at retirement from the partnership: check your tax code and ensure that it falls in line with the tax reserves being made either in your partnership for you or by you personally.

Far too many times I have seen pension incomes undertaxed and then an unwelcome tax bill coming at the same time as a reduction to pension income - a double blow.

12 Valuing the partnership premises: on average partnership changes used to happen every few years. But now there can be multiple changes in the same year.

Consider an agreement to only value the premises, say, every two or three years at most. If there is a partnership change in the following one to two years after the last valuation then that last valuation will be used to reduce requests for multiple valuations and therefore multiple valuer's fees.

13 Rights to future income: I have seen a few occasions in the past year where some retiring partners have claimed a right to the future solar panel income.

This needs to be documented in the partnership agreement to prevent unnecessary disputes and legal costs after a partner retires.

14 Calculating profits in the final year or period when a partner leaves: watch out for premises costs incurred in the final period where the cost is perceived to benefit future partners more than the partner who is leaving.

Also, be careful to apportion income received or costs incurred to continuing partners after a partner leaves if the departure happens mid-year and full accounts are not prepared to that date. A departure deed can assist here.

The most important advice I can give is to communicate more and keep on good terms with all partners in the event of any change. Look at all changes as a situation to be discussed with your AISMA accountant.

Be ready, your next January tax bill could be worse than the last

OPINION

Sue Beaton, AISMA committee member

In our Opinion piece last summer we warned of the possible jump in tax bills following the introduction of the tapered annual allowance for pension growth in 2016-17, where taxable income exceeded a certain level.

Many GPs indeed felt the pain on 31 January 2018 when the first real impact of the tapered annual allowance hit.

But although the sharp tax rise may have seemed painful for some, it could well be worse in January 2019. It is important to be aware of this and plan ahead to meet any additional tax due.

So why should this year be worse than last?

Tapering of the annual allowance for pension growth (on all pensions, not just NHS) commenced on 1 April 2016 and reduces the standard allowance from £40,000 by £1 for every £2 'earned' over £150,000.

The tapering continues reducing the allowance down to a minimum of £10,000, which occurs when taxable income, including pension growth, reaches £210,000 or more.

As these measures were only introduced from the 2016-17 tax year onwards, with the affected balancing payments arising in January 2018, many GPs were still able to make use of the last remaining unused annual allowances from the previous three (pre-tapering) tax years, thereby reducing the impact of the full force of the tapered allowance.

It is highly likely that many GPs will now have used up previous years' allowances and if so, the taxable growth will not be able to be reduced by these going forward, making the tax hit greater.

But another factor increases the potential tax charge too. Pension growth is also calculated with reference to the movement in the Consumer Price Index (CPI). This has increased considerably (by 2%) over the last year, so accelerating the growth rate between 2016-17 and 2017-18.

When this is combined with a tapered annual allowance for 2017-18 and the lack of further unused past allowances, it is evident that tax bills in January 2019 could be much higher than they were in 2018.

This could even be the case if profits have fallen, given the above factors, making meeting the tax bills even more difficult.

It is therefore essential to be aware of the current and on-going position at the earliest possible stage. Higher tax bills could potentially occur annually, especially in years where the CPI is high.

To be as prepared as possible, it is important to obtain an annual pension saving statement from your NHS pensions agency.

These must be requested directly from the pensions agency. A point to be aware of is that the statements do not calculate tapered annual allowances and instead, sometimes misleadingly, assume the standard £40,000 applies.

Once received, you should pass the statements to your AISMA accountant or IFA who will discuss with you further.

It will be important to assess your options regarding payment of the tax relating to the pension growth. The 'scheme pays' route may be an option but only on the growth over the standard £40,000 allowance.

Other future considerations might include whether to continue paying into the NHS Pension Scheme, the number of sessions worked, and the amount earned or the type of work undertaken. As ever, discussing options with your advisers is recommended.

Cash in on other carrots to motivate your staff

So, you want to motivate your staff more but have not got the money? Well, it is not all about cash. Fiona Dalziel sets out some important techniques

As we look ahead to the joy that autumn will bring – the flu season and the impossibility of recruiting GPs – it is easy to think that managing the practice will continue to offer more obstacles than opportunities.

Take, for instance, the recent Agenda for Change pay award versus the GP pay award.

The main impact of these awards is to increase the differential between what independent contractors can afford to pay staff and what staff, for example nurses, could earn if they were to work in hospital instead of a GP practice.

This comes at a time when all practices are looking for ways to increase the range of team members able to share both the clinical and non-clinical workload. It is easy to feel defeated.

In parallel with this, a recent study published in the RCGP's *British Journal of General Practice* highlights the importance of valuing receptionists.

The study looks in detail at the receptionist's role in delivering alternative models of care, specifically researching practices who had introduced telephone consultations, e-consultations or internet video consultations.

In England, the *GP Forward View (GPFV)* has offered other possible solutions to ease the GP workload. Many practices, some supported by their Clinical Commissioning Groups (CCGs), have introduced *Active Signposting and Clinical Correspondence Management* (*for details see references on the next page*).

These suggested developments all mainly rely on expanding the roles of non-clinical team members, including receptionists.

The actual change being introduced, whether a *GPFV* initiative or an e-consultation, does not really matter. What does matter is the study's conclusion.

It said that practices generally underestimated the importance of the contribution of reception staff to the planning and successful

implementation of such changes. And it concluded that a lack of receptionist involvement could contribute to low uptake of these initiatives.

Why does this matter and how does it link to the pay award issue?

We often believe that better pay will motivate people to work harder or better or both. However, American business management guru and psychologist Frederick Herzberg said that money is not a sustainable motivator.

In other words, it may cause a short-term improvement but the effect is not long-term. What does motivate people is job stimulus, involvement, opportunities for advancement and feeling valued. Read more about this in Charles Handy's book *Understanding Organisations* (*see references on the next page*).

How can we use this to create an opportunity?

GPs and managers understand that staff are their greatest, and most expensive, asset. All practices value their clinical teams, but many fail to capitalise on the asset which is their non-clinical team.

The result is that new initiatives stumble due to a lack of involvement from the whole team in their development.

What can we do to motivate staff without money?

Involve them

I look back with a cringe at the number of times I wrote a new office procedure myself, only to be told, quite rightly, that I had missed out details and that parts of it would not work.

Involve your office staff right at the start of your planning process. Many have years of in-depth skills and knowledge into which you can tap to make your new initiative really take flight.

The net result? Your staff feel that their opinion counts and potential obstacles will be recognised and dealt with at an early stage.

Avoid the temptation to think 'that will all take time – I'll be quicker doing it myself!'. You will save time in the end and your staff will be keen to contribute in the future.

Let them know how they are doing

Many managers ask staff to undertake (usually tedious) data collection for setting a baseline before a change or measuring its effectiveness after implementation.

This is perfectly reasonable, but it is much more motivating to give them the data to look at once it has been analysed and ask them for their reaction.

Giving feedback on a job well done costs nothing, takes almost no time, and should not be saved up for the annual appraisal. Make sure you take time to have a few minutes with a member of staff who is shining. Equally, have a chat with the staff member who is struggling, and figure out a solution together.

Delegate effectively

Effective delegation does take some time to set up and implement. It is a valuable skill which will help you make the most of your team's talents. Check out some simple steps (*see box below*).

To delegate effectively:

1. **Think carefully about what you need done, the expected outcome, and the timescale before you meet the team member.**
2. **Describe the task in clear and specific terms. Ask the team member to repeat back to you what they think you expect them to do to check understanding.**
3. **Clarify what decisions they can make independently and which you want to discuss with them.**
4. **Agree at what points you will review progress and stick to them. This does not preclude you from informally checking how things are going. Review more frequently early on in the project.**
5. **Give the necessary training and resources, which may include time.**
6. **Agree how you'll reflect on how it all went**

And, lastly – why not share the *BJGP* article with your staff as a starting-point?

Fiona Dalziel *runs DL Practice Management Consultancy*

Further reading

General Practice Forward View, NHS England, April 2016

- https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

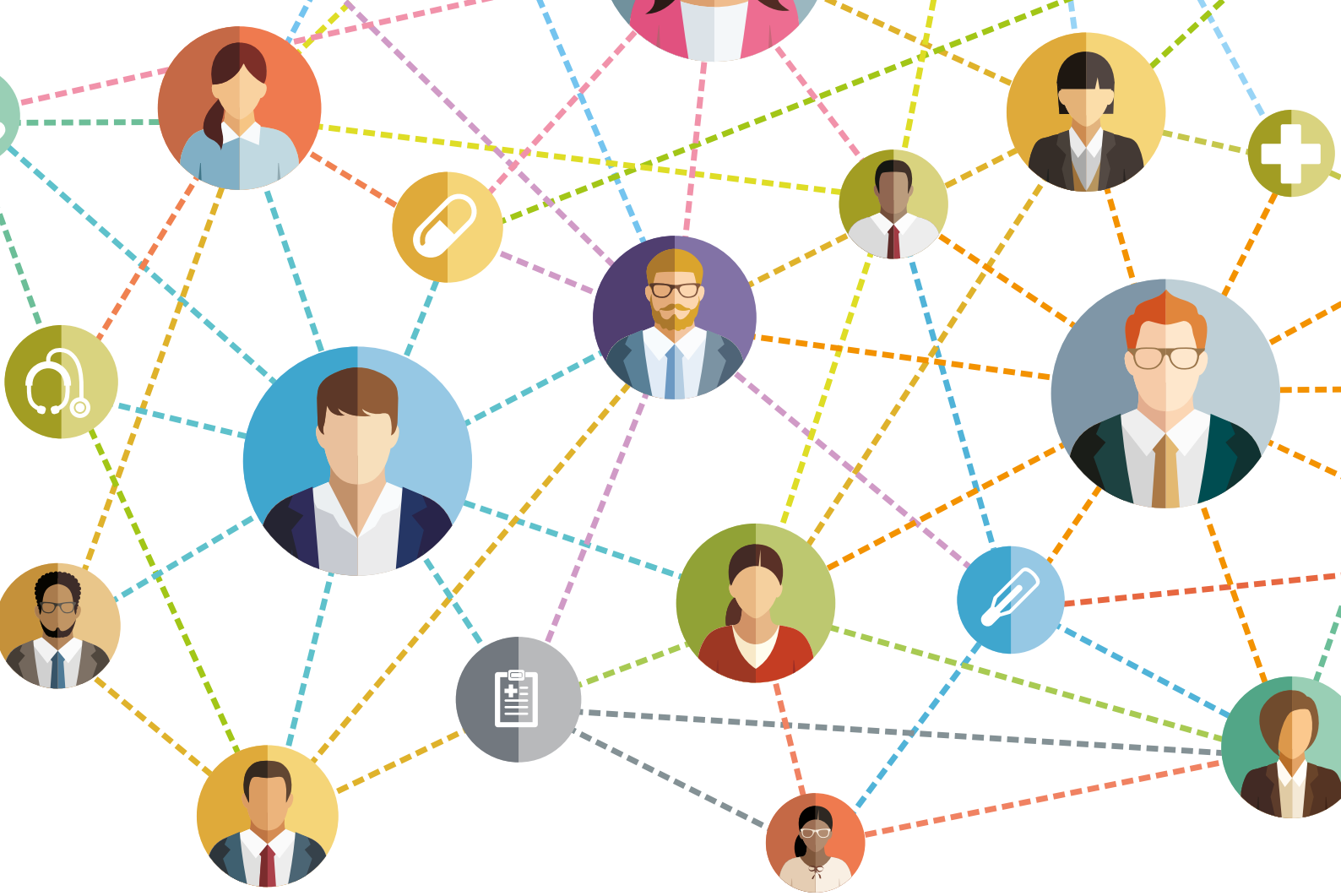
High Impact Actions in detail

- https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/documents/the-10-high-impact-actions-overview-slides

Receptionists' role in new approaches to consultations in primary care: a focused ethnographic study - Heather Dawn Brant, Helen Atherton, Annemieke Bikker, Tania Porqueddu, Chris Salisbury, Brian McKinstry, John Campbell, Andy Gibson and Sue Ziebland. Br J Gen Pract 2018; 68 (672): e478-e486. DOI:

- https://doi.org/10.3399/bjgp18X697505 or https://bjgp.org/content/68/672/e478

Understanding Organisations, Charles Handy, 4th edition. Penguin Books



Tune into a new network

Three years ago, Alison Oliver wrote in *AISMA Doctor Newsline* about the new models of care proposed in the *NHS Five Year Forward View*. Now she explores another model that is set to be the next big thing – the primary care network

NHS England's document *Next Steps on the NHS Five Year Forward View* (March 2017) talks about 'encouraging' practices to join primary care networks. Practices cannot currently be forced to join a network.

However, many practices will feel that joining one will offer benefits. Practices considering joining or forming a network should consider:

- **Organisational structure**

Practices might decide that the best way of working together is by merging into a single organisation, or they might decide that a looser association is more beneficial.

Advice should be sought on the most appropriate model for your objectives, considering both financial and legal considerations.

- **Interface between services**

Careful consideration needs to be given to how different members of the network will work together and the interdependency between services. Roles and responsibilities will need to be clearly defined.

- **Governance**

It is essential to have robust governance systems for the network. You will need to consider how the network will be led and how the different parties will contribute to decision making and leadership.

- **Workforce**

You will need to consider how the staff of the different parties in the network will work together and what training, changes to terms and

"As well as achieving better integration of services and better access to services for patients, these networks are one way of responding to the strain on practices caused by funding cuts and problems with GP recruitment and retention."

conditions and so on might be needed to enable the network to function effectively.

- **Premises**

Think about what the premises requirements are and whether any services need to be relocated. Will new premises be required, or existing premises disposed of?

- **Patient consultation**

Ensure that patients and other stakeholders are consulted about any changes in the way in which services are provided.

- **Sharing information and technology**

Consider what information needs to be shared between the network members and how to achieve this in a way that is compliant with NHS policy and the General Data Protection Regulation.

Think about whether there are particular IT requirements in order to achieve an appropriate degree of integration.

- **Regulatory matters**

Ensure all network members have appropriate procedures, licences and permits to comply with regulatory requirements.

It is important that there are appropriate legal agreements between the network members dealing with all these matters.

The future

As part of the long-term NHS plan, it is expected that there could be substantial changes to the GP contract.

The NHS England Board Paper: *Developing the NHS long term plan: primary care reform* (4 July 2018) states that the commitment to supporting the nationwide development of 1,000-1,500 primary care networks is one of five drivers for contract reform.

So, while joining a primary care network is currently optional for practices, it remains to be seen whether this might change under the 2019 contract.

The background

What is a primary care network?

According to Rebecca Thomas, writing in the *Health Service Journal* (*The Commissioner: Primary care networks – the new show in town needs a second act*, 4 May 2018), 'the idea of a primary care network in one form or another has been rehashed and reshaped over several decades.'

The latest iteration of the primary care network can be found at the heart of NHS England's *Next Steps on the NHS Five Year Forward View*, which states that practices will be encouraged to work together in primary care hubs or networks with a combined patient population of at least 30,000-50,000.

These networks will share community nursing, mental health and clinical pharmacy teams, diagnostic facilities and responsibility for urgent care and extended access.

As well as achieving better integration of services and better access to services for patients, these networks are one way of responding to the strain on practices caused by funding cuts and problems with GP recruitment and retention.

The report goes on to say that the primary care network model does not require practice mergers or closures and does not necessarily depend on the physical co-location of services. There are various contractual and structural vehicles by which practices can work together in this way.

How have primary care networks evolved?

In February 2014, the King's Fund published a report, *Commissioning and funding general practice: Making the case for family care networks*, which advocated a new approach bringing together funding for general practice with funding for a range of other services with a population-based capitated contract.

The report argued that these networks would enable GPs to strengthen their role as providers and co-ordinators of care in collaboration with other staff working in the community.

The *NHS Five Year Forward View*, published by NHS England in October 2014, proposed a number of new models of care aimed at breaking down the boundaries between primary care, community services and hospitals to achieve better integration of health services, social care and mental health services.

One of those models – the Multispecialty Community Provider (or MCP) model – placed primary care providers at the heart of delivering a more integrated service for their populations, envisaging 'extended group practices' offering a wider range of care to registered patients.

The MCP model was not constrained to a particular organisational type, and the *Forward View* suggested that MCPs might take the form of federations, networks or single organisations.

Then in October 2015, NHS England chief executive Simon Stevens launched the Primary Care Home Programme. This is an approach developed by the National Association of Primary Care which brings together health and social care professionals from GP practices, community and secondary care providers, social care providers and the voluntary sector to provide personalised care for their local community.

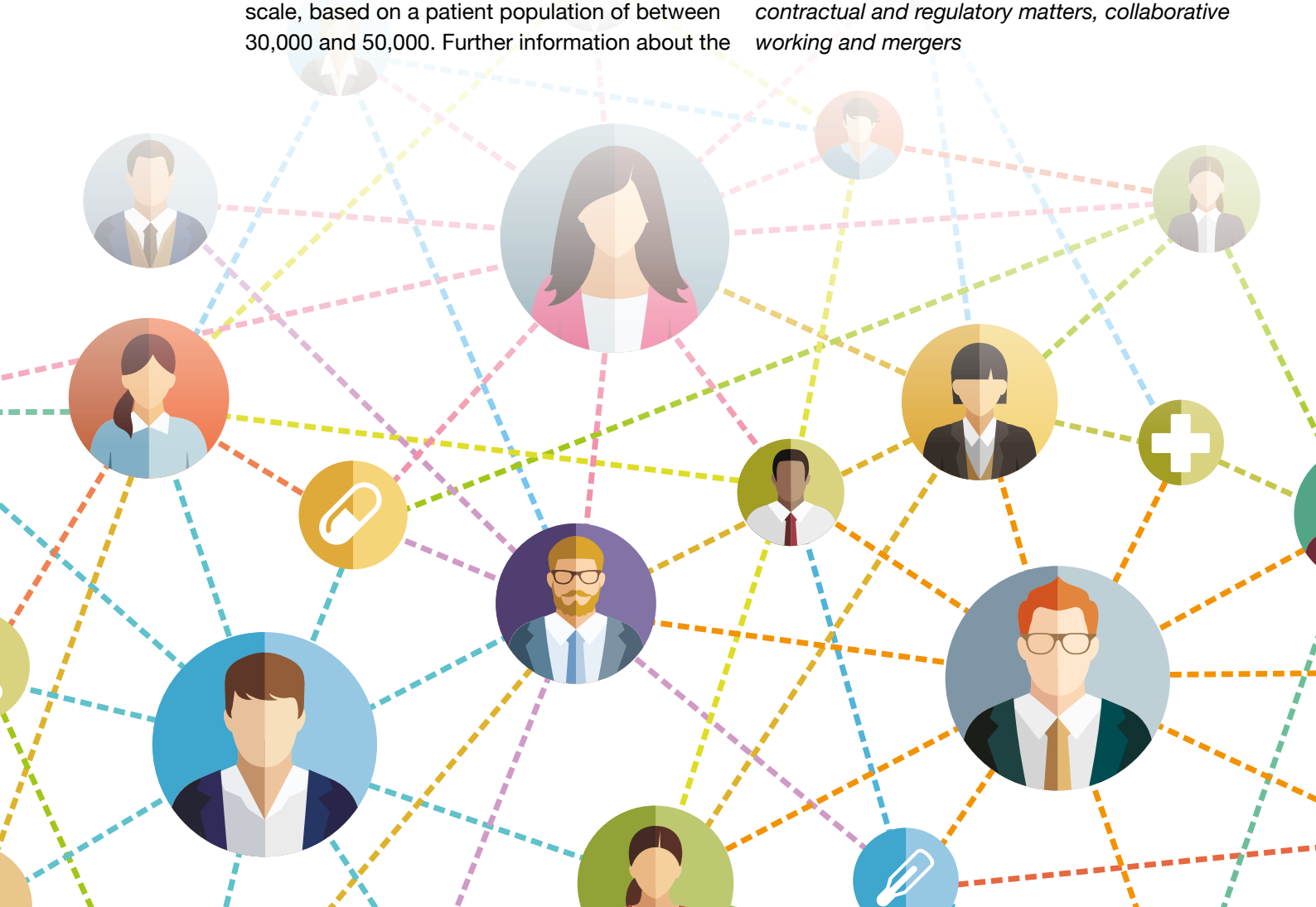
The Primary Care Home can be said to be a variation of the MCP model, but on a smaller scale, based on a patient population of between 30,000 and 50,000. Further information about the Primary Care Home, including a few interesting case studies, can be found on the NAPC website: http://napc.co.uk/primary-care-home/.

The latest primary care network model seems to draw strongly from the Primary Care Home model: both envisage clusters of GP practices working with other health and social care professionals to deliver coordinated care and both are based around a theory that the optimum patient list size is 30,000-50,000 patients.

Four years on from the publication of the *NHS Five Year Forward View*, integration is still at the heart of NHS policy.

According to an article in the Health Service Journal on 29 June 2018 (*Long-term plan to spread 'new care model vanguards'* by Dave West), 'the current focus of NHS England's integration work is primarily on 'integrated care systems' and 'primary care networks', which it has said will cover England by April 2019', with less focus on MCPs and primary and acute care systems.

Alison Oliver *is an associate solicitor with top 100 law firm Ward Hadaway. She advises GP practices on a range of legal issues, including partnership agreements and disputes, contractual and regulatory matters, collaborative working and mergers*



AGONY AccoUNTant

Our agony accountant 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 our accountant deals with GPs' pension problems

Q **Do I have to change to the 2015 pension scheme if I choose not to?**

A A The 2015 pension scheme came into force on 1 April 2015. With the 2008 scheme there was a pension choice exercise allowing NHS staff to choose which scheme they were in.

But this time round there is no choice. NHS staff fall into three categories for those in the 1995 scheme with a normal pension age of 60.

If you were born before 1 April 1962 then you do not have to move into the new scheme and can continue building up benefits in the scheme you were in.

If you were born after 1 September 1965 then you had no choice and automatically you will have joined the 2015 scheme on 1 April 2015.

Those born between those two dates are transitional members and depending on age they will transfer into the 2015 scheme at some point between 1 June 2015 and 1 February 2022.

Those having to move have no choice and will join the 2015 scheme at the relevant date for their age.

Q **Primary Care Support England (PCSE) has still not processed our practice's GP pension forms for 2016-17. What are the implications of this?**

A Practices were required to submit the 2016-17 Type 1 pension forms for GP partners to PCSE by 28 February 2018. If this timescale was met, then assuming there were no issues, PCSE indicated that adjustments would be taken out of the March

2018 GMS/PMS payments.

But AISMA accountants are reporting numerous issues where forms have not been processed. There were issues with submitting as this year PCSE required the documents to be uploaded via its website. This proved problematic due to file size and browser issues.

If adjustments have not gone through, then practices need to raise this with PCSE. If it does not process these then this raises several issues.

Firstly, from a cashflow perspective there will still be an over or underpayment. Your accountant can advise what to expect.

Secondly your NHS Pension record will not be updated. NHS Pensions rely on PCSE to update the annual earnings.

This means that the GP's Total Rewards Statement will be out of date. If the GP has applied for their pension, then NHS Pensions will generally chase the outstanding form but everyone else must wait.

This has implications for having up to date information for pension planning. It also delays NHS Pensions issuing Pension Savings Statements needed for the accurate finalisation of tax returns.

All in all, a pain for you and a pain for us – an accountant without information is truly an accountant in agony!

Finally, we have the issue of tax relief. HMRC rules only allow GPs to claim tax relief in the year of payment. Where there is an underpayment then tax relief will therefore be delayed if PCSE does not process any adjustments before the tax year-end on 5 April.

Keeping on top of this and making sure your accountant is aware of when adjustments are processed is important for many reasons.

Q **The NHS Pension Scheme poses a dilemma for me. Should I stay or should I go? What do I need to think about?**

A This is clearly a question from a GP who likes The Clash! Many GPs are looking closely at whether they should stay in the pension scheme or pull out and invest elsewhere.

There are many issues to this. In most cases this type of question is driven by the increasing taxation charges for those with net earnings above £110,000.

AISMA accountants have been warning about this for a few years now – and many are reporting in 2017-18 that a lot more GPs are being caught with significant tax bills.

Pulling out of the scheme has implications – your pension will no longer grow through contributions and there are changes to life and ill health benefits. Understanding the impact on these benefits is important.

AISMA accountants can advise on the tax issues – but will not be able to advise on whether a GP should stay in or pull out of the scheme.

That will need to be looked at by an Independent Financial Advisor. Generally, I would recommend that a three-way conversation is held between the client around their needs, the accountant around the tax costs and the financial advisor around the investment growth.

It is not an easy decision and must be taken carefully.

If you want to ask a question, please message us via Twitter @aismanewsline

For now, though AISMA advisors should be the first point of contact for an understanding of the NHS Pension scheme.

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