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AISMA Doctor Newsline

At the heart of medical finance...

Continuing continuity of care in a changed world

Fiona Dalziel discusses an increasing management dilemma for GPs and their teams - and outlines some great ideas to think about for the future

A local practice recently experienced a mass exodus of GPs, leaving patients feeling distressed and vulnerable. Their main quoted concern? Continuity of care.

The doctor who 'knows them' has suddenly disappeared and they are bereft.

While resisting a temptation to come over all 'Dr Findlay', the issue of continuity of care in practices is becoming acute.

Nothing could be further from the model of the traditional family practice than the current arrangements we have been forced into by the pandemic.

Under undeniable pressure, practices have inevitably no choice but to concentrate on consulting with patients as quickly and safely as possible.

There are undeniable benefits to the very rapid

adaptation of telemedicine but when we emerge into whatever the new normal looks like, it may be tempting simply to continue with what for many GPs and patients alike, is an extremely time-efficient consultation model.

But what is the impact on one of the treasures of British general practice, continuity of care?

The RCGP's *Continuity of Care Toolkit* defines continuity as a critical element of general practice, acknowledging the importance of both relational continuity and informational continuity. Patients see their GP and wider practice team as the 'keeper of their story'.

This can be in terms of both the trusting relationship with the GP as an individual and of the fact that a patient's record follows them round their contacts with different team members.

Informational continuity is generally not a major concern. GPs consulting remotely from home can still have access to the record and the days of patient notes languishing for ages under a seat in the GP's car are long gone.

But what of relational continuity?

Before Covid struck, this had been under building threat. The advent of Advanced Access with its emphasis on speed of being seen above all else was a starting point.

Although it is acknowledged that patients choose appointments based on a balance between 'how soon to be seen' and 'whom to see?' based on their clinical issue (Guthrie and Wyke), relational continuity is seen as central to good practice and as helpful both with diagnosis and management.

But a recent *British Journal of General Practice* (BJGP) observational study based on English GP Patient Surveys found that the trend towards bigger practices had also led to greater falls in continuity in enlarged practices than in those which had stayed the same size.

The RCGP *Continuity of Care Toolkit* identified that the proportion of patients able to see their preferred GP in England fell by 27.5% between 2012 and 2017. This probably has not improved with Covid.

Research on the impact of so much more telemedicine on continuity is almost non-existent in relation to general practice.

Looking forward into the new normal, it is important that current proportions of face-to-face versus remote consultation are not just allowed to continue without questioning the impact on continuity.

What could a practice consider in terms of balance looking forward?

First steps in looking at continuity

Decide what you are trying to achieve. For which patients do you want to improve continuity? What would that look like? Agree a clear aim as a practice.

It may be that you decide to concentrate on improving continuity for a specific group of patients. It is widely acknowledged that vulnerable patients, those with chronic conditions and psychological and emotional problems or multiple/complex problems, benefit from relational continuity.

Do not choose them all initially, otherwise you will be overwhelmed and disheartened by the sheer volume of numbers. Decide which patients in your practice might benefit most.

What to do next

Measure what continuity is like currently for your chosen cohort of patients. Consider looking at patients from the group randomly or look at frequent attenders.

Remember to look at how your systems support or negatively impact continuity. Use

"Use buddying as much as possible. Pair part-time GPs with other part-timers whose availability across the week is complementary"

methods such as process maps to look at, for example, your appointment system.

At what points in the system are there gaps or missed opportunities where an intervention could improve continuity? In theory, you may promote continuity, but patient experience may be very different.

Consult widely

For many patients, especially the elderly with multiple morbidity, face to face will remain the preferred method of consultation. But this is not the case for everybody.

What do patients actually think? What is their actual experience? Consider methods such as a survey, consulting with your PPG or establishing a focus group.

A box for suggestions about continuity will only collect sweet wrappers. Reception and admin staff are a rich source of information about the patient experience. We all know the extent to which patients ventilate to staff and keep stumm during the consultation.

Decide what you are going to change

Keep changes simple and manageable. A time-limited pilot with a review date may help.

Consider:

- For your patient group, make sure 'usual doctor' is both identified in the record and verbally confirmed at the time the consultation is arranged.
- Use buddying as much as possible. Pair part-time GPs with other part-timers whose availability across the week is complementary.
- Create small teams including nurses and admin staff. Tell the patient to which team they 'belong' then put in mechanisms to help the team communicate and share patient information.

Look again

Resist the temptation to breathe a sigh of relief. Set a review date to see if the change made a difference.

Fiona Dalziel runs DL Practice Management Consultancy

Reference material

Guthrie, B., Wyke, S. Personal continuity and access in UK general practice: a qualitative study of general practitioners' and patients' perceptions of when and how they matter. BMC Fam Pract 7, 11 (2006).

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Changes in patient experience associated with growth and collaboration in general practice: observational study using data from the UK GP Patient Survey by Lindsay JL Forbes, Hannah Forbes, Matt Sutton, Katherine Checkland and Stephen Peckham

We are here to help you bounce back

There is low short-term confidence among GPs but AISMA chairman Deborah Wood says our specialist accountants are here to help you get back on track

A Lloyds Bank Healthcare Confidence Index this winter, based on a survey of 133 GPs between September-November 2020, found that their short-term confidence suffered a dramatic 22-point drop since the start of the year.

As many as 83% said they expected financial pressures to increase in the next five years.

This reflects the uncertain economic outlook and concerns about delivering quality services to patients amidst a lack of resources.

It is, however, pleasing to see that despite the recent challenges over two thirds of GPs would recommend their vocation to their friends and family.

Following the 2020 Covid year, practices will need to start to build back their non-core income activities and to ensure patients feel safe to return to surgeries for routine care including a variety of vaccination and screening programmes.

2021 will need to focus on prevention together with building up additional services to support the frail elderly, those with long-term conditions and the expected increased issues around mental health.

Practices are therefore going to be looking for ongoing support to assist with strategic planning for their future sustainability, with over half of practices seeking replacement partners to cover GP retirements.

Nearly 75% of GPs see Primary Care Networks (PCNs) as a positive move to support sustainability and as a preference to merger.

More resources are likely to be invested in collaborative working across PCNs and in online and telephone technology to enable the continuation of remote consultations where that is the most effective for patients post Covid-19.

By becoming more efficient through digital transformation, practices will be able to focus their teams on where primary medical care is most needed and to expand the integration of health and social care across local communities.

Specialist medical accountants are ready to assist GPs, concerned about financial pressures and addressing static profitability, in preparing cashflow and tax planning forecasts.

AISMA accountants working with their banking colleagues are well placed to help practices find the optimum funding arrangements including looking at environmental impacts, better use of premises resources and managing succession across general practice.

Reference material

https://www.lloydsbank.com/assets/resource-centre/pdf/gps.pdf

Social prescribing PCN funding is good news for all

OPINION

Luke Bennett
AISMA committee member

Covid-19 vaccinations are well underway as I write but with so much constantly breaking news on the pandemic front I feel anything I say now about it risks being out of date by the time this edition of *AISMA Doctor Newsline* is circulated. So I will focus on another - different - 'good news' subject.

The good news I have in mind is a win-win for everyone – practices and their patients, health and finances.

You may have seen a recent BBC series from travel writer Simon Reeve on his time in the summer of 2020 in Cornwall. My county. A county of undeniable beauty and holiday appeal, but, as Simon reported, a county of terrible social deprivation.

But this is where my good news story starts. Duchy Health Charity is a charity which has been supporting healthcare innovation in Cornwall for the past 40 years.

Over the last year it has been working hard to promote the benefits social prescribing can bring to places which suffer the most with poverty and isolation.

Social deprivation so often leads to mental and physical ill-health, and, in the absence of anywhere else to turn, these individuals will make for the GP surgery in desperation and hope.

GPs of course want to help, but there are limits to the time and resources they have available for complicated cases where the needs are in fact more social than medical.

Pilot programmes here in Cornwall have set up social prescribing working alongside GP surgeries, run by experts in the field.

These have yielded impressive, life-changing results for the patients, and the freedom for GPs to pass the day-to-day responsibility for managing the cases, allowing them more time for the medical care which they are trained to give.

As we commence the New Year it is clear that many will be suffering the long-term effects of lockdowns, job loss, insecurity and loneliness.

The funding available to Primary Care Networks to cover the cost of employing social prescribers provides a great opportunity for these benefits to be rolled out nationwide.

Duchy Health Charity is bringing together experts from various fields and will in February premier its Social Prescribing film. I was fortunate enough to attend the preview and it is very inspiring and moving. Find out more at: **https://duchyhealthcharity.org/news/**

By encouraging the uptake of social prescribing across the country we can have a good news story to rival that of a vaccine – and one that doesn't require cold storage!

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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.
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AGONY AccoUNTant

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

In this issue she tackles queries about cutting tax payments on account, rewarding staff with cash and 'repairing' tax returns

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

CUTTING TAX PAYMENTS ON ACCOUNT

Q **Tax payments – Why can't I reduce my payments on account so I don't need to pay so much tax in January – my friend who's a GP says she's not making any payments because of Covid.**

A **There are two separate things to consider here:**

1 Have your profits reduced in 2020-21 compared to 2019-20?

The normal rules for payments on account allow you to reduce them if the expected liability for the current year is less than the previous year.

So, for locums who struggled to find work during the first lockdown, a reduction might be in order. For GP practices, our experience has been that profits have generally not gone down, although they are working harder than ever to stand still. The second half of the year may be different though.

If you reduce the payments 'recklessly' then HMRC can in theory charge penalties; in any event if actual tax comes out to be more than the reduced amount, there will be an interest charge.

2 Can you afford to make the payments due?

One of the things that has changed this year is that HMRC is being more flexible when you cannot afford to pay the tax. Some GPs chose not to pay the July tax in 2020 so, the January 2021 figure is likely to be scary!

You will need to pay interest of 2.6% if you pay your tax late.

If you are unable to pay your tax HMRC will allow you to set up a payment plan online only if:

- You owe £30,000 or less (so you might need to pay some to get it under that level)
- You do not have any other payment plans or debts with HMRC
- Your tax returns are up to date
- It is less than 60 days after the deadline.

Payments will be made by direct debit in monthly instalments, over up to 12 months.

Remember that if you obtain a payment plan, you will still need to be saving up to pay the July tax on time.

If you do not fall within the parameters above, you may still be able to set up a time to pay

arrangement, but you will need to call the self-assessment payment helpline (0300 200 3822) to discuss your ability to pay.

Note that the deadline for 2019-2020 tax returns has not been changed, at the time of writing, and remains 31 January 2021.

CAN WE GIVE OUR STAFF A CASH PREZZIE?

Q **We couldn't have a Christmas party in 2020 and it doesn't look as if we'll be able to have one anytime soon – can't I just give the cash to the staff instead?**

A HMRC allows a Christmas party – or indeed any annual event – provided it is open to all employees and costs less than £150 per head, without creating any tax liability on your staff. It has also now confirmed that staff parties can be virtual, covering the costs associated with those parties in the same way as it would for the traditional Christmas office party. This may be an option you want to consider. Alternatively, you could move your Christmas party to later in the year if you wanted to – having perhaps an Easter party instead if we are able to mix socially by then, or a summer BBQ.

However, be careful if you decide on a Summer BBQ and a Christmas party in 2021. Provided the two events total less than £150 a head you are okay. But if they exceed that figure then one of them will be taxable.

What you cannot do is give cash instead – that would be taxable. So, you might need to give more than you planned so that after tax and NIC deductions they end up with the net figure you wanted to give them.

You could buy them gifts of less than £50 each (and indeed you can do that as well as your annual party as long as it is not part of it) – but over £50 becomes taxable.

If you want to give them vouchers instead then:

*If exchangeable for cash – they are treated as cash and must be taxed through the payroll

*If not exchangeable for cash and worth less than £50 it is classed as trivial and exempt

*If not exchangeable for cash and worth more than £50 it is a taxable benefit. But you may be able to include it in a PAYE Settlement Agreement so that you pay the tax and NIC on the benefit rather than the staff member.

So, a good time can be had by all, just make sure you follow the rules here, otherwise it may be more expensive than you were expecting.

WHAT IS 'REPAIR MY RETURN' ALL ABOUT?

Q **My accountant says I need to repair my return for 2018-19. What does that mean and why the rush?**

A You 'repair' a tax return when you need to correct the original tax return – and the deadline is 12 months after the original deadline. So, the deadline for the 2018-19 return to be repaired is 31 January 2021.

Ideally you want to get your return right first time whenever you can – rather than have HMRC pick up errors and charge you penalties for being careless, or worse. However, there are several reasons why the return may need to be repaired.

With GPs the most likely need to repair a tax return is because the original return included an estimate of the annual allowance charge because the final pension figures were unavailable when the original return was dealt with.

But HMRC will recognise that if you have got an annual allowance charge you may not be able to quantify it precisely within the normal time scales. So, a reasonable estimate is quite acceptable whereas ignoring it altogether is not.

It might be something else that you had to estimate originally, such as profits when a partner has joined a practice with a year-end other than March, or something missing that was picked up while preparing the current year's return, or any error discovered in the return.

As with anything, repairs are best dealt with as soon as possible where needed. There may well be a tax effect; if you are lucky there will be a refund due. If not and the liability increases then prompt adjustment will minimise interest charges.

Whistleblowing and Covid-19: implications and key considerations for GP practices

Covid-19 has brought safety concerns and whistleblowing protections into sharp relief. Martin Cheyne explores some implications for practices to watch out for

What is whistleblowing?

This is the raising, by a worker, of some concern about a danger, a risk or wrongdoing or the potential for any of these. If a worker raises this, then if they are to be protected by the whistleblowing regime, their concern must:

1 contain sufficient information
2 be made to the appropriate person or organisation
3 be made in the public interest, and
4 be a concern about which the worker reasonably believes is wrong.

These can be very technical requirements, but the starting point for GP practices should be to treat the whistleblowing protections as very broad and relatively easy to apply.

It is generally in the public interest for whistleblowing protections to be afforded to workers and so the technical requirements are often not substantial hurdles to overcome.

What are the protections afforded to workers who blow the whistle?

If a worker suffers a detriment of any type or is dismissed because they have raised a protected concern, then they can seek:

- an Employment Tribunal to have their employment immediately reinstated whilst they bring their claim
- reinstatement or re-engagement of their employment (and all related back pay) at conclusion
- compensation for any dismissal
- compensation for any other detriment to their employment.

In all cases, the compensation that could be payable is uncapped. This can be substantial, particularly if the worker is unlikely or unable to find similarly remunerated alternative employment.

Some of the largest awards made have involved employees who have had to retire after they raised their concern, having failed to rapidly find new similar work.

As part of ensuring that workers are protected, there is no minimum period of service before workers are protected. Even a new employee, still in their probation period, would be afforded the protection of the whistleblowing legislation.

In the NHS, the 2013 Francis review examined the causes of failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. A whistleblower raised the issue with regulators and this protection was extended further to the recruitment process.

This applies to most NHS public bodies, although not necessarily directly to GP practices themselves.

"Covid and issues relating to Covid are highly likely to cover at least two or three of the whistleblowing subjects"

How do we know if it is a whistleblowing concern?

A whistleblowing concern does not need to expressly say 'this is a protected concern and I am blowing the whistle'. It could be raised with the employer openly as a whistleblowing concern, but it may wrongly state or suggest that it is merely a grievance.

If the concern being raised relates to a wider public interest or has potentially wider implications or has the possibility of impacting other workers, then it may well be a whistleblowing concern.

Often the nature of the concern can be clarified with the individual raising it, though if there is doubt whether to treat it as a whistleblowing concern, GP practices should seek professional advice.

To whom should the concern be raised?

Most whistleblowing concerns are raised with the employer and the employing practice would usually be the recommended, best and first place for a worker to raise their concern.

However, raising something with the employer is not a mandatory requirement of the whistleblowing regime and concerns can be raised with legal advisers, regulators or another relevant body.

It is not uncommon, for instance, for the Health and Safety Executive (HSE), NHS England or CQC to be the initial recipient of a concern.

Those bodies will then usually contact the practice to seek an initial view and they are likely to expect a full investigation and an outcome report provided.

What types of concern are covered?

The whistleblowing regime, introduced by the Public Interest Disclosure Act 1998, covers a wide range and overlapping variety of subjects. They are (this includes their concealment):

- Criminal offences
- Breach of any legal obligation
- Miscarriages of justice
- Danger to health and safety of any individual, and
- Damage to the environment.

What Covid examples are there?

Covid and issues relating to Covid are highly likely to cover at least two or three of the whistleblowing subjects. We are already seeing media coverage of concerns where the whistleblowing regulations could apply. Some examples:

- Failures to follow Government guidance
- Inadequacy of Government guidance
- Rapid developments or contradictions in Government guidance
- Workplaces failing to be properly risk assessed as Covid secure
- Concerns about travelling to work in shared or on public transport
- Inadequate workplace ventilation
- Inadequate washing facilities
- Inadequate distancing between workers
- Co-workers failing to undertake mandatory self-isolation
- Exposure to patients who are or are likely to be Covid positive
- Inadequate measures to protect clinically vulnerable staff

- Inadequate, insufficient or failing Personal Protective Equipment
- Patient failure to comply with good Covid secure practice
- Patient behaviour and complaints.

One of the most widely reported Covid interventions was by the HSE in September 2020, which found multiple failings by management at the Department for Work and Pensions.

It found:

- A line manager giving instruction to a group of staff, without maintaining social distancing
- Designated two-way walkways, despite being only one metre wide
- Designated walkways passing too close to desks designated as useable
- Stairwells inappropriately designated as two-way, when even passing places failed to provide two metre distances, and
- Small tables, breakout pods and benches without 'do not use' signage.

The HSE undertook its inspection having received a report of a 'workplace concern'. It is likely that a worker reported their concerns to the HSE – that worker would almost certainly be protected by the whistleblowing legislation.

Martin Cheyne is a partner with Hempsons' employment team

So what should the practice do?

Practices will likely have in place an existing whistleblowing policy. That should always be the start point for consultation and be a reference material. Other policies, such as the grievance policy, may also be relevant.

Practices should have a trained, designated officer responsible for ensuring that an appropriate investigation is undertaken.

This could be the practice manager, a partner or HR professional. If a whistleblowing concern is received, they should carefully consider what has been raised and whether they have sufficient information.

It is vital to ensure that the worker is not, at that early stage, punished in some way. This can easily be inadvertent: taking action to protect an employee can easily be construed by the worker as 'punishment'.

Practices should take care to avoid simply sending an employee home, thinking that would be in the employee's interests.

Explore with the employee what they may want and need: if a whistleblower is to be open about their concerns, they may want or need their identity kept confidential.

Communication is always key and where an employee or worker is already raising a concern with a practice, it is vital to engage with them rapidly and, where possible, look to immediately ameliorate things or provide the worker with assistance.

An investigation into the concerns will always be needed. Usually, more information will be required and so exploring this with the employee will often be an early step. Dealing with this in the Covid pandemic though may mean that inquiries are made using remote systems rather than face-to-face.

A particular issue that practices will face in winter 2020-21 will be their simple capacity to deal with an investigation.

Covid, influenza, staff absence and even vaccination programmes will all likely impact on a practice's capacity to progress.

If this is going to mean that an investigation cannot swiftly be undertaken in the normal way, then practices should be open about the likely delays. They can also consider getting external support and seeking the forbearance and agreement of those involved.

After the issue is investigated, there needs to be a form of reporting back to the individual (and possibly a regulator or other body).

At the very least, this ensures that it is appreciated that the concern is taken seriously, but it also allows any remediation to be transparent and clearly understood.

Finally, practices may need to consider data protection principles in what feedback can be provided, particularly if the concerns raised involve the actions of individuals or other staff.

For instance, it is unlikely to be appropriate to describe the extent of disciplinary action that is to be applied to co-workers.

Big issues to consider when GP practices incorporate

Latest guidance presents GPs with more areas to consider in 2021 when they are thinking about incorporating. Andy Pow focuses on what you need to know**

GP practices were historically run on a partnership model but AISMA firms have increasingly been quizzed about whether doctors should operate their core GMS or PMS contract through a limited company.

Now updated guidance from commissioners in England highlights further issues to consider when incorporating.

1 Taxation

Companies are taxed differently and owners can extract income through salaries or dividends.

Following changes in dividend tax rates a few years ago the tax savings of operating through a company compared to a self-employed partnership narrowed.

With the interaction of pension tax relief rules, operating through a company could result in more tax and national insurance being paid by the business and its owners.

Care therefore needs to be taken when structuring any new business vehicle to avoid increasing the tax burden.

2 Pensions

Any transfer of a business to a limited company needs to be done so it ensures that staff retain access to the NHS Pension Scheme.

Business owners also need to be aware that, due to the calculation methods, their personal pensionable income through a company will likely be reduced compared to the partnership route. Pension values on retirement will be lower as a result.

3 Personal risk

The downside to the partnership model is that there is unlimited liability for the partners. This means if the business assets do not cover liabilities then responsibility passes to the owners.

In reality, risk is low for a traditional small general practice that is providing the majority of its services to the NHS.

But as services grow and other providers contract with the practice, contractual risk

grows and a model protecting personal liability is useful. A limited company provides a model which gives a degree of personal protection.

4 Flexibility and compliance

The partnership model is a very flexible model allowing changes in partners and partnership shares which happen frequently in general practice. A limited company set up would require more formal transferring of shares on changes, thereby increasing compliance obligations.

5 Premises

A big consideration when transferring the business model is how this interacts with the GP premises. Owned premises may need lending restricting or formal leases between owners and the business to be put in place.

Practices who lease may need leases reworked and the landlord's approval to vary the business structure. But a limited liability company could reduce risks in taking out long term leases on premises.

6 Commissioning process

One of the biggest issues faced in transferring the business from a partnership to a limited company model has been how commissioners viewed the change and how to novate the contact.

There has been a lack of clarity nationally over procedures and different views taken at local level. But NHS England has recently introduced a national procedure for commissioners to follow which will give more consistency in approach across the country.

The new procedure has not altered the ability to change structure but has suggested requirements to be met before agreement is given to a novation of a GMS or PMS contract from a partnership to a company. However, it does allow commissioners more influence in how the business is structured and run.

The guidance suggests a commissioner could:

1 prohibit changes in company control and ownership that could otherwise pose sustainability challenges

2 prohibit the company from entering significant financial arrangements (for example, high value financial loans)

3 place conditions on the company which must be satisfied before dividends can be distributed.

Guidance also states that commissioners could set out terms which include:

1 any actions that rest with the provider upon contract termination, ie requiring personal guarantees

2 minimum working capital requirements to provide confidence that the company will always be able to cover routine business running costs and its liabilities

3 Provisions to promote greater transparency and monitoring in line with other NHS contracts.

These would include transparency in reporting the annual company business plan, financial accounts, management information, staff pay and dividend payments.

The new guidance therefore gives commissioners a far greater power in directing how the business operates with potential increased scrutiny. It also reintroduces the concept of personal risk.

So take care when looking at whether practices should move from the longstanding partnership model to a limited company model.

The clarity from commissioners, while useful in setting out a framework and process for the change to happen, introduces the risk of increased commissioner involvement in the running of the business.

It also potentially reduces one of the benefits of a company, that being less personal risk. Practices should therefore tread carefully and consider all angles.