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# AISMA Doctor Newsline

At the heart of medical finance...



## Get set for these 2021-22 GMS contract changes

As the 2021-22 financial year gets underway, practices must be fully aware of contract changes and the impact these could have on funding and workload. **Deborah Wood*** gives an expert round-up and commentary

Doctors' representatives of the BMA's GPC have worked with NHSE/I to publish contract arrangements to support general practice in 2021-22.

Their letter of 21 January 2021 updates the existing five-year GP contract, *Investment and Evolution*, which is in place through to 2023-24 and considers the exceptional circumstances of the Covid pandemic.

The main financial aspects of the agreement, with specific reference to changes implemented for 2021-22, are:


## Practice level funding

Practices will receive an uplift to the contract of £253m, which is intended to cover pay rises (2.1%), expenses increases (2.1%), population growth, additional funding for vaccinations and immunisations, and additional QOF funding.

The new global sum per weighted patient is set to rise by £3.82 from the 2020-21 figure of £93.46 to £97.28.

The out-of-hours deduction will change from 4.77% to 4.72%, equivalent to £4.59 per weighted patient.

The network participation payment continues at £1.76. *(See Table 1)*

## Additional Roles Reimbursement Scheme (ARRS)

The available funding will increase by £316m to £746m. Originally the rise was intended to support new PCN services from April 2021, but the additional four services are not now being introduced at the start of the new financial year. Priorities are being directed to pandemic matters instead.

This scheme will continue to expand and be more flexible with paramedics, advanced practitioners and mental health practitioners included from April 2021.

NHS London will also get an inner and outer London weighting on top of the maximum ARRS funding.

Any clinical pharmacists remaining on the Clinical Pharmacist in General Practice Scheme will be able to transfer to the PCN ARRS in the period 1 April 2021 to 30 September 2021.

Overall, the guaranteed investment in the scheme is shown in *Table 2.*

Every PCN will have access to a full-time equivalent (FTE) mental health practitioner allocated to be deployed wholly to the PCN but employed by the local provider of community mental health (CMH) services.

50% funding is provided by the CMH provider and 50% via the PCN ARRS funding. This will increase to two FTEs in 2022-23 and three in 2023-24, and if the PCN has more than 100,000 patients these numbers double.

## Increasing the number of doctors in general practice

Additional multi-year funding is confirmed for a programme of GP recruitment and retention.

The New to Partnership scheme continues, which enables new partners to receive a £3,000 training allowance and £20,000 plus £4,000 towards on-costs per full time equivalent GP. It is available to GPs, nurses and pharmacists who have not been a general practice partner in England previously.

**TABLE 1**

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ |
| **Practice level funding** | **8,116m** | **8,323m** | **8,576m** | **8,792m** | **9,029m** |
| **Annual increase** | **109m** | **207m** | **253m** | **216m** | **237m** |
| **Percentage increase** | **1.4%** | **2.6%** | **3.0%** | **2.5%** | **2.7%** |

**TABLE 2**

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ |
| **Additional role original funding** | **110m** | **257m** | **415m** | **634m** | **891m** |
| **Further funding** | | **173m** | **331m** | **393m** | **521m** |
| **Total available** | **110m** | **430m** | **746m** | **1027m** | **1412m** |

*"The value of a QOF point will rise from £194.83 to £201.16, with the number of points increasing from 567 to 635"*

## Pandemic response

In the last five months of 2020-21 NHSE committed an additional £30m per month for capacity expansion. Similarly additional funding was made available to cover clinical directors at 100% for the final quarter in 2020-1 where PCNs are involved in the vaccination programme.

The above funding is under review and the potential for it to continue into early 2021-22 is being considered, as I write.

## Quality and Outcomes Framework (QOF)

There will be limited changes to the indicator set for 2021-22. A new vaccination and immunisation domain is set up with £60m transferred from the childhood and immunisations DES.

No new quality improvement modules will be introduced in the coming year. The modules on learning disabilities and early cancer diagnosis are repeated from the current year with some slight modifications.

£24m is added to QOF to support the serious mental illness physical health check indicator set. There are minor changes to the cancer care domain, and to specific indicators for asthma and heart failure.


The value of a QOF point will be adjusted in 2021-22 to reflect population growth and relative changes in practice list size using data on 1 January 2021.

The value of a QOF point will rise from £194.83 to £201.16, with the number of points increasing from 567 to 635.

## Investment and Impact Fund (IIF)

This is a reward for PCNs meeting the NHS Long Term Plan objectives and GP contract requirements. Money derived from the IIF must be used for workforce expansion and primary care services. At least £30m of the £150m funding in 2021-22 will incentivise ways to improve access for patients.

There will be a phased approach to introducing any new IIF indicators. The indicators for seasonal flu vaccination, annual learning disability health checks and health action plans, and social prescribing referrals will continue.

Potential further indicators could include:

- Supporting Covid response and tackling health inequalities
- Vaccination uptake
- PCN services: Supporting delivery of the PCN service requirements.
- Access: Supporting improved access to, and experience of, general practice, and
- Sustainability: Reducing carbon emissions, to support the NHS Net Zero commitment.

## Delivering PCN specifications

There are minor updates to the structured medication review and early cancer diagnosis services within the PCN Network Contract DES.

Core funding will remain at £1.50 per patient.

The care home premium will remain at £120 per bed.

## Vaccinations and immunisations

The childhood immunisations DES ceased on 31 March 2021.

Practices will receive a monthly aspiration payment based on previous achievement with a year-end reconciliation via the transfer into the QOF indicator system

All childhood immunisations will attract an item of service fee of £10.06 for all practices achieving over 80%, but practices achieving less than 80% of their target population will not receive payment for the first 50%, only receiving payment for each immunisation beyond 50%.

## Other 2021-22 changes

It is intended to introduce an obesity and weight management enhanced service as early as circumstances allow. It will be supported by additional funding.

The transfer of funding to PCNs for CCG commissioned extended access services will be deferred until April 2022.

There will be work in the coming year to collect

data relating to terms and conditions for practice staff.

The cervical screening additional service becomes an essential service.

The definition for the core digital offer for patients has been confirmed as follows:

- Practices offering online consultations that can be used by patients, carers and by practice staff on a patient's behalf, to gather submitted structured information and to support triage, enabling the practice to allocate patients to the right service for their needs.
- The ability to hold a video consultation between patients, carers and clinicians.
- Two-way secure written communication between patients, carers and practices
- An up-to-date accessible online presence, such as a website, that, amongst other key information, links to online consultation system and other online services prominently
- Signposting to a validated symptom checker and self-care health information (for example. nhs.uk) via the practice's online presence and other communications
- Shared record access, including patients being able to add to their record
- Request and management of prescriptions online
- Online appointment booking.

## Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS)

Any changes announced to the core GMS contract are expected to be mirrored via PMS and APMS.

**Please note:** all the above information relates to contracts in England only.

## Northern Ireland/Scotland/Wales

Information can be obtained from your local AISMA accountant.

## Conclusion

As ever practices must be fully aware of these changes and their impact on practice funding and workload.

It follows that practices need to take a careful look at future strategy and work on finding the best and most profitable way of using time and resources.

Collaboration across networks will continue to be fundamental and advice should be taken at an early stage regarding how best to make the network arrangements work for your practice.

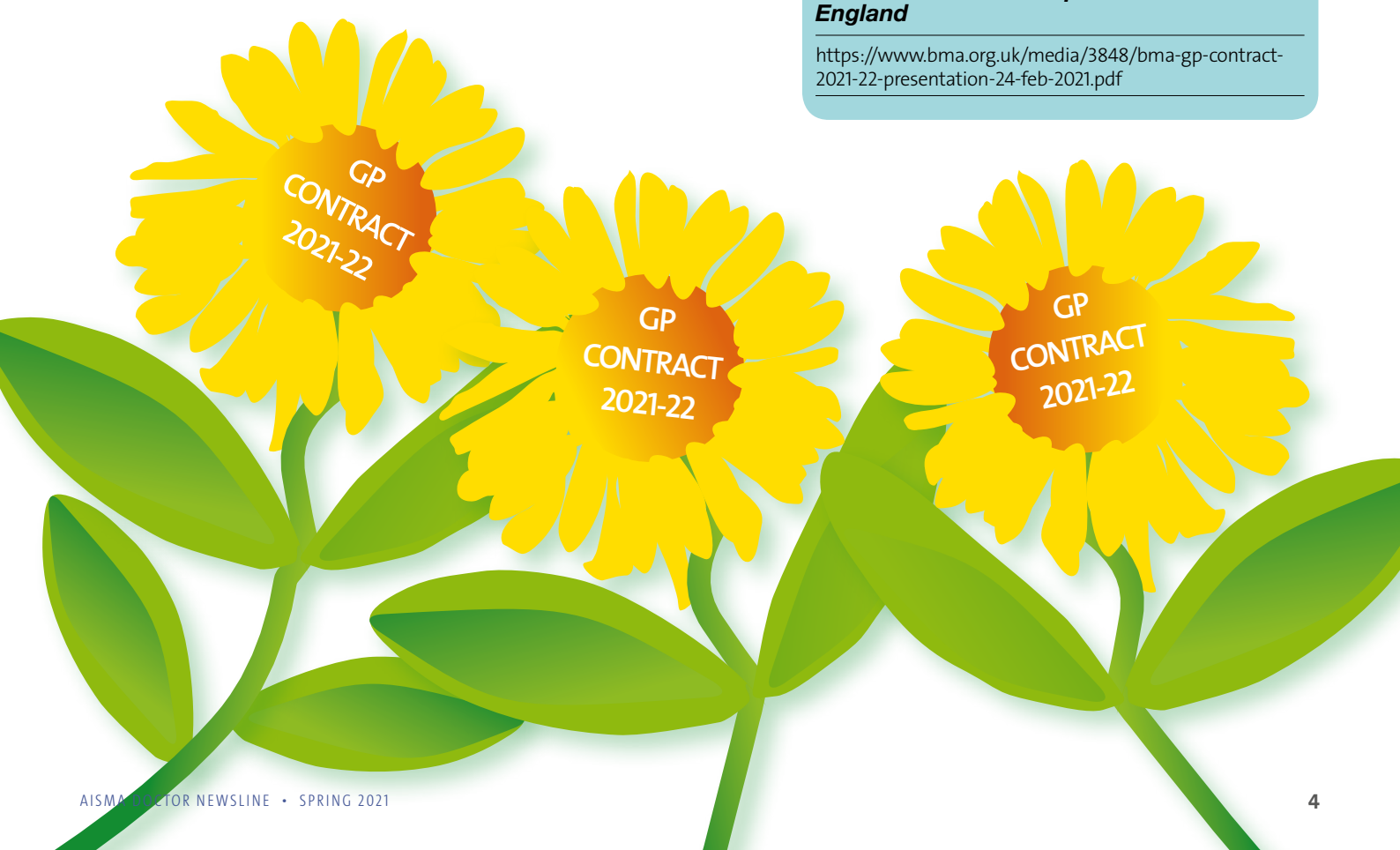
### Reference material

***Supporting General Practice in 2021-22***

https://www.england.nhs.uk/wp-content/uploads/2021/01/C1054-supporting-general-practice-in-21-22.pdf

***GP contract 2021-22 update: BMA GPC England***

https://www.bma.org.uk/media/3848/bma-gp-contract-2021-22-presentation-24-feb-2021.pdf



# AISMA's accounting is only the half of it!

OPINION

**Deborah Wood**
AISMA chairman

As we approach the end of another financial year it is a good time to stop and reflect on the past 12 months before gearing up to plan for the next one.

The impact of lockdowns, remote working and sadly a loss of very many individuals to the virus has impacted on how we all work on a day-to-day basis.

Online video meetings and telephone consultations have become the norm for accountants, advisers and our clients.

The full financial effects will not be known for some time but we will start to see the results coming through across general practice as we begin our regular cycle of preparing accounts for the 2020-21 year ends.

The BMA, NHSE and its equivalents have worked well together during this unprecedented period to regularly review contract expectations, protect or increase available funding, and support PCNs as they have set up vaccination hubs.

A new contract year starts this month (April) and this time round practices will not have to get to grips with too many changes because the funding bodies have recognised the ongoing impact of coping with the pandemic *(see the details in my article starting on page 1)*.

The ongoing cycle of GPs retiring or reducing commitments, and practices having to try to recruit new doctors, continues. But it is now helped somewhat by the new to partnership premium payments and the sharing of increased clinical staff resources via PCNs.

AISMA members continue to be on hand to support our clients through the maze of accounting issues coming from working collaboratively across networks.

This often leads to questions about VAT, employment liabilities, pension scheme access and the tax arising on surpluses held now which will be reinvested in patient services over the coming year.

As usual at this time of year, AISMA accountants will be helping practices check that PCSE and its equivalents have correctly processed the information submitted in annual pension certificates to ensure shortfalls are collected and refunds made.

All practitioners need to check their pension records are in order now while there is time to deal with updating annual allowance tax calculations to establish scheme pays elections in the window to 31 July 2021, to support any compensation claims due for 2019-20.

Those in our teams dealing with pension tax matters, and our specialist independent financial advisor colleagues, will all be gearing up to support practitioners over the coming months to understand how the outcome of the McCloud case impacts on retirement decisions, as explained in David Walker's article *(see page 9)*.

AISMA continues to work with many organisations such as PCSE, NHS Pensions, NHSE/I, NHS Scotland, the BMA and HMRC to try to ensure GPs and practices receive relevant and up to date information to assist them in managing their affairs on a timely and efficient basis.

Our member firms are also looking ahead to refreshing knowledge and sharing best practice at a virtual conference in May where we will consider a variety of tax, accounting, contract and pension matters affecting our primary care clients.

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# Help to ease the pain of partnership disputes

**Partnership disputes are time-consuming, costly, stressful and de-stabilising for a practice and the individuals involved. But unfortunately, they are also more prevalent when partners are under pressure, as during the Covid-19 pandemic. Alison Oliver and Ross Clark explore common causes of partnership disputes, how to prevent them happening and what to do if one arises in your practice**

We frequently see disputes due to:

## Partner absence

If a partner is absent for a long period due to illness or injury, or for repeated shorter periods, it can put pressure on the other partners even in an otherwise amicable partnership. Over time this results in the other partners feeling they must act to address the issue.

These disputes can be extremely sensitive to manage as there may be a tension between providing support for a partner who is ill and the needs of the practice.

## Conduct issues

Disputes often arise because an individual partner's conduct falls short of what is expected of them. This could take many forms, ranging from harassment of staff or flagrant disregard of agreed partnership procedures, through to a partner just not pulling their weight.

Sometimes conduct issues, which are generally wilful or within the control of the partner concerned, can be confused with capability or performance issues. This might indicate an underlying problem such as stress or other type of illness that might merit a more sympathetic response.

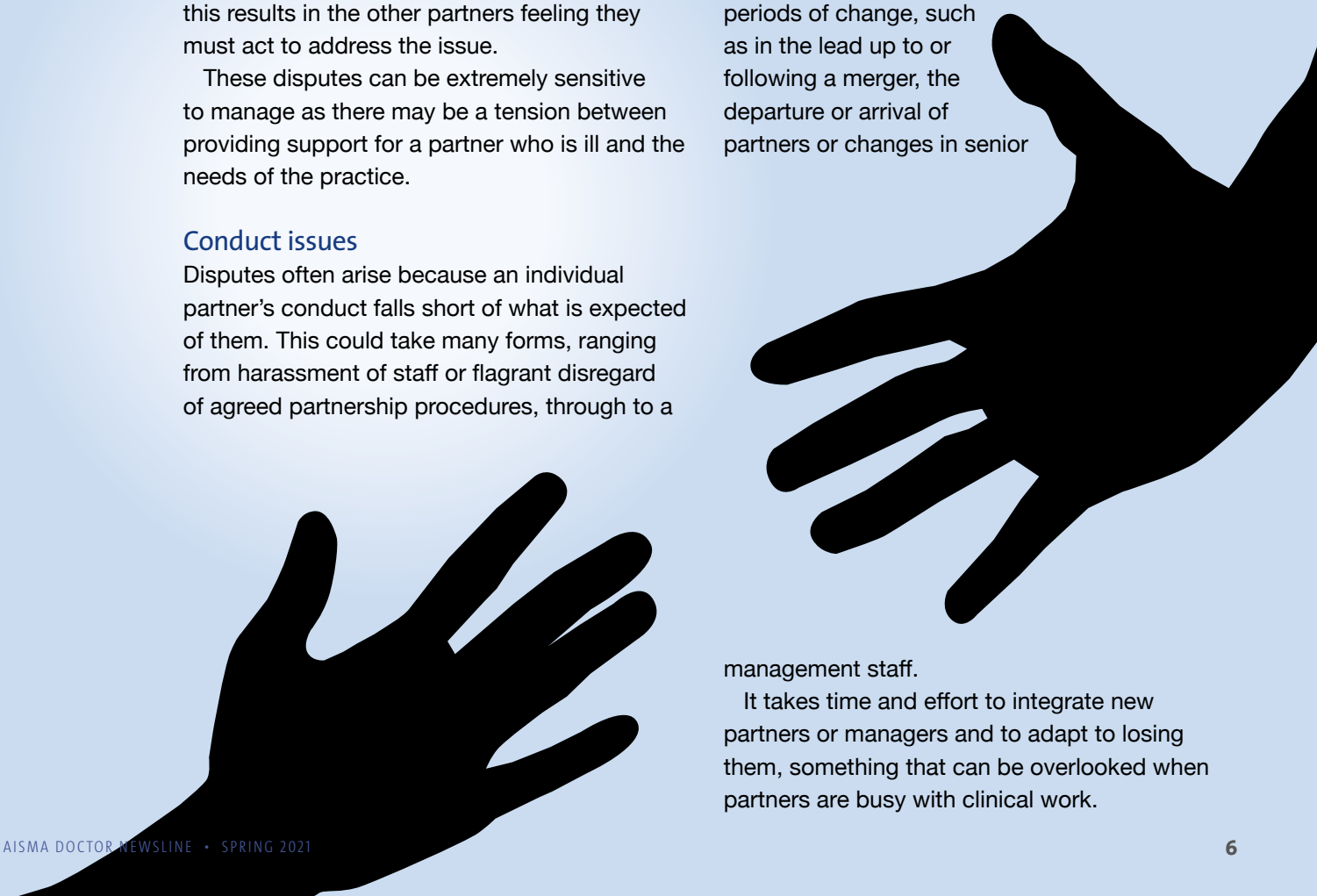
## Different objectives

Sometimes partners just do not share a common vision for the practice. We frequently see disputes where some ambitious partners want to modernise and grow the practice while others are content to 'tick along', particularly where costs are attached to modernisation or expansion plans.

## Partnership changes

A partnership can be particularly vulnerable to disputes during or following periods of change, such as in the lead up to or following a merger, the departure or arrival of partners or changes in senior management staff.

It takes time and effort to integrate new partners or managers and to adapt to losing them, something that can be overlooked when partners are busy with clinical work.



*"Try to resolve disagreements amicably at an early stage if possible. Keep minutes and notes of any discussions or meetings"*

## Personality clashes

Sometimes disputes are simply a matter of different personalities clashing. These can be difficult to address as it might not be a matter of any individual partner doing anything clearly and objectively wrong. But it may have a serious impact on the practice if one partner does not get on with the others or with a key member of staff.

## Covid-19

The pandemic has brought additional pressures on practices and we have unfortunately seen several disputes directly attributed to these.

On top of inevitable strain caused by virus-related absences and self-isolation, a particular challenge is where one or more partners are clinically vulnerable. This may impact on their ability or willingness to perform certain duties, particularly face-to-face consultations.

## What to do if a dispute arises

How you react when disagreements first arise can have a huge impact on how matters progress. Most importantly, try not to let emotions take centre stage. That may be easier said than done but emotional responses are likely to fuel the fire. If in doubt, do not send that email late at night when you are angry!

Try to resolve disagreements amicably at an early stage if possible. Keep minutes and notes of any discussions or meetings and, if possible, get the other partners to sign to confirm them as an accurate record.

Where partners are faced with different options for resolving the matter, or if there is no consensus about how to move forward, discussions should be on a 'without prejudice' basis so it is clear the discussions are not binding and are subject to partners taking advice, if they wish, before agreeing to any actions in writing.

If you have a valid partnership agreement, check to see if it deals with the issue(s) in dispute and follow its procedures. You should comply with your agreement to avoid a later claim or counterclaim for breach of your duties by any partner in dispute with you.

Without a partnership agreement, or if new partners joined since it was signed and dated without signing a deed of adherence or otherwise confirming in writing they agree to be bound by it, you are likely to be a partnership 'at will'.

This can be precarious, not least because it means there is no ability to expel a partner. In the absence of a negotiated outcome, the only option here is to dissolve the partnership. This will result in termination of the practice's NHS contract unless agreement can be reached for the contract to continue with the other partners.

Consider legal advice if your partnership agreement does not provide a clear solution or if you are thinking of taking enforcement action against a partner.

If the dispute is handled incorrectly from the start it can be difficult to recover and may limit your options. Your solicitor will advise on the options available to you and help formulate a dispute management strategy.

An ill-thought-out strategy could backfire and result in the practice having to defend a claim or counterclaim. For example, if you are dealing with a partner that has a protected characteristic under the Equality Act 2010 - such as a disability - there is a risk that the partner might claim you have either directly or indirectly discriminated against them.

It is also quite easy to take a wrong step - such as failing to comply with the notice provisions when serving a notice - which gives a partner a procedural basis for challenging the action you take against them, even if you have a well-founded basis for it.

You might want to consider mediation as a method of resolving a dispute. You are still likely to need legal advice and representation to ensure you are confident of your legal position and options if the mediation fails.

But mediation can effectively settle disputes and help prevent escalation. It uses impartial third parties to get objectively to the bottom of the dispute and helps reach an acceptable outcome.

*"Avoid falling into the trap of thinking that disputes won't arise because you all get along"*

## How to prevent disputes arising

Disputes are naturally less likely to arise when the partners get along with each other and have common objectives.

Take care when admitting new partners. Carry out due diligence before they become a partner. For example, do you know their working history and whether they have they had previous partnership disputes?

You may be considering admitting someone who has already been working at the practice, maybe a frequent locum or salaried partner, who you know well. But consider if this individual will be good in a partner's role.

They may be able to do the job they currently do but partnership brings extra responsibilities, such as managing finances and general management duties. Not everyone is cut out for these.

Although it is helpful to work with people you like, this is not necessarily a requirement, nor is it the most important consideration. What is key to a partnership is that you trust and respect the others.

Avoid falling into the trap of thinking that disputes won't arise because you all get along. Even the friendliest of partners can fall out in difficult circumstances. And those can often be the most difficult disputes to manage.

Having a good partnership agreement is critical. It can provide the objectivity needed to help prevent disputes arising, as well as a mechanism for dealing with troubles when they arise.

If the agreement clearly sets out terms such as partners' duties, meeting procedures, voting and holiday entitlements, you are more likely to be able to nip disputes in the bud.

It is easier to agree on the provisions that should apply in different situations when all the partners are on a level playing field and the issues are not personal.

For example, it is better to discuss and agree maternity provisions before you have a pregnant partner. Negotiations will then be much more personal and sensitive.

To draft a suitable partnership agreement for a GP practice, you should seek legal assistance from solicitors who specialise in primary care advice. Most generalists do not understand the intricacies of modern GP practice and the agreement might be inadequate for the issues it commonly faces.

Consider including a clause in your agreement which enables the partnership to compulsorily retire a partner if relations with them break down, often called a 'green socks' clause, even if there are no other grounds.

Exercised with care, this can help preserve a partnership's stability where there is one partner whose personality or conduct is destructive to the practice's success.

Remember, it is always better to try to prevent a dispute occurring than try to solve it once it has already happened - be prepared!

- Always have an up-to-date partnership agreement, drafted by solicitors specialising in medical partnerships;
- seek legal advice as soon as possible whenever you anticipate a dispute arising; and
- try to remain objective in the face of a dispute and do not let emotions take control of the situation.

**Alison Oliver and Ross Clark are partners in the primary care team at Hempsons, advising GP practices, provider companies and PCNs**

*Disclaimer: this article is for information purposes only and should not be relied on as legal advice. Neither the authors nor Hempsons will be liable for losses arising from reliance on the information in this article. The article is based on the law of England and Wales and there might be variations in other jurisdictions*

# Be prepared for important GP pension changes on the way

**NHS Pensions: David Walker[**] sets out what the McCloud judgment means for you**


## The story so far

Back in 2010 the Government determined that the cost of public sector pension provision was unsustainable.

It set up a commission, chaired by former Labour minister Lord John Hutton, to 'make recommendations on provision that is sustainable, affordable and fair in the long term.'

An interim report in September 2010 and a final one in March 2011 set out the commission's findings. The outcome in the NHS was the introduction in 2015 of the new pension scheme.

This linked normal retirement age to your state pension age, meaning most people would have to work longer to get a full, unreduced pension. The normal retirement ages in the existing schemes were 60 in the 1995 scheme and 65 in the 2008 scheme.

Across most schemes a system of protection was put in place to safeguard the benefits of older members nearer to retirement.

In the NHS scheme, those within 10 years of retirement remained wholly in their legacy scheme. Younger members moved immediately into the 2015 scheme, and then some in between transitioned over on a sliding scale dependent upon age between 2015 and 2022.

The McCloud judgement and another case, Sargeant, were heard simultaneously. These cases accused the government of discriminating against younger pension scheme members by not affording them the same protection as older ones. They won. This meant some form of restitution was required so that all are treated the same.

The upshot is that the government has now decided that scheme members will have the choice of having all their benefits in the years 2015 to 2022, now called the 'remedy period', either wholly in their old scheme or wholly in the new scheme.

There will be no ability to have a bit of some and a bit of the other. In April 2022 all members, regardless of age, will begin to accrue benefits in the new scheme.

As a choice is to be given, then a decision needs to be made. That decision is to be exercised at the point you take your benefits, when all relevant factors of earnings, service, and career path are known and a meaningful comparison of benefits can be produced.

But let's just go back to Lord Hutton. At section 7.34 on page 155 of his final report, he lays his position out clearly about protection. Older members would already have most of their benefits accrued in their legacy scheme, so movement to a new one would have limited impact, particularly if final salary linking remained (it does).

Protection should not, therefore, be necessary. He went on to say that 'age discrimination legislation also means that it is not possible in


*"The government has given schemes up to October 2023 to put systems and procedures in place to enable them to carry out this exercise"*

practice to provide protection from change for members who are already above a certain age.'

So, there you go. The architect in chief of all the new public sector schemes warned the Government in 2011 that protection would be unlawful. It didn't listen.

## Mechanism

In April 2022 two things will happen. Firstly, as mentioned above, everyone will start accruing benefits in the 2015 scheme.

Secondly, there will be a default position where everybody will have their benefits in the remedy period of 2015 to 2022 converted to their old scheme if they moved into the 2015 scheme. This has several knock-on effects.

## Annual Allowance pension tax charges

The 2015 scheme accrues benefits at a faster rate than the 1995 and 2008 legacy schemes. It just means that you must work longer to obtain those benefits unreduced.

What it means for Annual Allowance (AA) tax is that the higher accrual creates a greater exposure to the charge. By reverting to your original scheme, anybody with AA tax paid for the remedy period, either personally or by the available scheme-pays election method, will need their exposure recalculating on their original terms. This will mostly mean a reduction in tax.

A reduced AA exposure also means, for those affected by the tapered AA, retention of more of the standard allowance, so the impact may be reasonably rewarding.

This creates a significant problem for the NHS Business Services Authority (NHSBSA), which administers the scheme. It will have to re-examine calculations for thousands of members for seven years and, where necessary, amend a large amount of scheme pays elections.

The government has given schemes up to October 2023 to put systems and procedures in place to enable them to carry out this exercise and also put in place computer systems that enable benefits in the remedy period to be calculated in each scheme side by side so that, at retirement, you have comparative information that enables an informed decision to be made. That will be no mean feat!

Having had your benefits in the remedy period reverted to your original scheme, what happens if you end up working to 67 and it turned out you would have been better off having benefits for those years in the 2015 scheme? That can still happen.

It could, however, have a large AA implication at the time of retirement as the government is saying that all of the extra accrual for the earlier years will fall into the year of retirement when the decision is made.

But crucially it has also said it would not look to recover AA tax over and above what would have been incurred had that decision not been made. Quite what that rather general statement means in practice when we reach that point is not clear yet.

## Tax

Two things can happen to the tax position; either you will have paid too much, or you will have paid too little. If you have paid too little, the Government has said it will not look to recover tax beyond the normal statutory limits.

This means the current tax year or any of the previous four full tax years. Consequently, when we reach April 2022 and your remedy period benefits revert to your old scheme, you may face a higher AA charge for, say, 2016-17.

By April 2022 is beyond the statutory limit so any tax paid or scheme pays election made will remain unchanged.

Where, however, tax is due back to members then all tax will be repaid regardless of time limits. This is very welcome news. But it will mean much extra work, and cost, in reaching agreement with NHSBSA's AA calculations, changing scheme pays elections, and getting refunds from HMRC.

## Other issues and contingent decisions

There are several other issues. What happens to members who have drawn their pension? What happens for families who have been paid out death benefits for one scheme when the other may have been beneficial?

What about ill-health pensions paid? All these


areas are to be dealt with as a priority as the same choice has to be given.

Other side issues would include overpayment of pension contributions. The 2015 scheme annualises income to produce the tier rate at which you pay. The 1995 scheme did not. If you paid on an annualised rate, then reversion to 1995 may mean you have overpaid contributions and are due a refund.

You will get that refund, but subject to a deduction for the tax relief you received on it. This will include for years prior to the statutory recovery limit described above and is a turn around by the government from their original consultation document.

There may also have been contingent decisions taken. People may have opted not to join the 2015 scheme to avoid loss of, say, enhanced protection. AISMA argued strongly that this should be reinstated, and members given the right to re-join the 1995-2008 scheme for the remainder of the remedy period.

The government has said each such case will be looked at individually, which will mean a measure of subjective judgment from our friends at the NHSBSA.

## The figures

I have taken a reasonably typical GP client of ours and calculated pensions and AA liabilities under the current arrangements and again if remedy period benefits revert to the 1995 scheme.

| | 1995 pension at 5/4/2020 | 2015 pension at 5/4/2020 | Total AA tax due 4 years to 5/4/2020 |
|---|---|---|---|
| **Without change** | **£47,851** | **£13,237** | **£54,299** |
| **Revert to 1995** | **£57,586** | **Nil** | **£41,659** |

The GP is 52, from a well earning practice, although not extreme, and has an added years contract. From 2016-17 to 2019-20 a tapering of the AA happened in three of the four years and there was AA tax due at one level or another in each year. Below is the outcome.

The pension benefits quoted are the full unreduced benefits before any actuarial reduction if taken early. (*See Table above*)

The total pension currently is just over £61,000 with over £50,000 of AA tax. Let us say the GP was actually 60. The £47,851 could be taken without reduction and attracts a lump sum of three times that.

The £13,237 could be taken at 60, but that is seven years early and would suffer a reduction of around 30%, down to £9,266, and no corresponding lump sum. So the total pension would be £57,117 and the lump sum £143,553.

If we assume the scheme paid the tax in each case, the pension would be reduced by around £2,500 and the lump sum by a similar figure.

With the McCloud reversion, the full unreduced 1995 pension is £57,586 and a lump sum of £172,758, reduced to £55,586 and £166,758 respectively after scheme pays recovery.

In fairness, I should say that, if this GP were aged 67, the pension of £61,000 would be received in full, less the same scheme pays recoveries. The lump sum would be £143,553 from the 1995 benefits.

## What else?

Much remains unknown. Will NHSBSA continue to issue a pension savings statement for 2020-21 and 2021-22 based on 2015 membership, which will clearly be irrelevant after 2022?

After 2022 the AA position will be retrospectively reconfigured with legacy scheme results. The AA position based on 2015 benefits will therefore be superseded.

It would seem a waste of resources to produce statements that have no bearing. Will we have to resubmit GP certificates of pensionable pay to PCSE for the remedy period years showing previous scheme membership?

What is the appeals process for contingent decisions? Will revised pension benefit and pension savings statements be issued automatically? We must wait and see.

## What do I need to do?

Your decision should be made in conjunction with a suitably qualified and experienced specialist healthcare independent financial adviser. It is not just about the pension – there is life cover to consider, spouse and family benefits, and differing ill-health benefits.

Until you retire, there is no decision to be made, but specific actions need to be taken. As soon as possible after April 2022, it would be preferable to have possession of all the revised statements and AA information you require to work with your specialist accountant to ensure your tax, AA, scheme pays, contributions and tax relief are all correct for legacy scheme benefits in the remedy period.

I do not normally like making predictions, but for some of you I can see this will not all run smoothly!

# Beware the 'boiling frog' - and other tips for spring

**It is time to review energy levels and wellbeing. Fiona Dalziel suggests you start with your practice manager**

Imagine my surprise, after over 30 years in practice management, at hearing the words 'practice manager' spoken at least twice at Downing Street level in the last couple of weeks.

GP Dr Nikki Kanani, medical director of Primary Care for NHS England, announced that practice managers had been 'part of a historic moment' – and so they have. What a year.

It is undeniably gratifying and well-deserved to be recognised at this level. And not before time. It is vitally important for the quality of delivery of care in general practice that professional practice management is valued nationally.


*"It is undeniably gratifying and well-deserved to be recognised at this level"*

Massive amounts of time and energy have been spent on establishing professional recognition for practice managers in the last 30 years.

Some initiatives have had lasting impact and some have lost momentum. Some have had much-valued support from national GP bodies - thank you! - but as well as national recognition, practice managers vitally need support in the practice.

The two go hand in hand. So, thinking about closer to home, what are you doing to support your practice manager?

A year ago, practices underwent a massive transformation in how care was delivered, turning traditional models on their heads.

During the first wave of the pandemic, massive anxiety and high levels of absence, GPs and practice managers got on with redesigning services within a short space of time while continuing to function.

More recently, everything has geared up to accommodate the vaccine rollout and practice managers have once again been right there with their GPs and teams at the heart of the programme.

A year ago, change was driven by considerable amounts of adrenalin, providing energy and nimble thinking.

Now, as we hopefully emerge blinking into spring, it is time to review energy levels and wellbeing. And I suggest you start with your practice manager.

## 1 Check in regularly, informally

This is a much undervalued and under-estimated activity and is easy to de-prioritise in a day full of patients and clinical admin. But its benefits far outweigh the input required.

Try putting your head round your practice manager's door and inquiring how they are. Pastoral care for your staff is everyone's job.

## 2 Have an established pathway for issues

If your timely question raised something needing attention, where would you go with that?

Your practice's usual pathway for handling something, like discovering that all is not as well as presumed with a member of staff, may be to involve the practice manager. But what if it is the practice manager, him - or herself - who is struggling?

## 3 Check out mentoring opportunities

All managers benefit from mentoring support, by which I specifically mean someone external to the practice itself, possibly with specific skills and/or qualifications. This is doubly important in a time of rapid change and challenge.

Mentoring should ideally be provided by someone with understanding of practice management. But this is not vital.

New managers, especially those who have been promoted from within the practice, have particular support needs which mentoring can help meet. Geography is not necessarily an issue because good quality mentoring can now happen remotely.

*"Valuable ways of working may have been abandoned a year ago but you may be ready to think about reinstating them"*

## 4 Check out availability of peer support

It is important for the practice that your practice manager is encouraged and supported in engaging with practice management groups locally or nationally.

Many local groups within PCNs and health and social care partnerships are extremely effective. Simply attending a group can offer significant support and reassurance, not to mention good ideas and insight.

Some groups offer a buddying system, especially for supporting new managers. But be aware that, for a new manager promoted internally, attending this kind of group may initially be daunting.

## 5 Beware the 'boiling frog'

Practice managers are extremely good at coming in a bit earlier, working late and taking work home for the evening or weekend.

Especially in today's situation, this should be seen as an early warning that all may not be well. Raise your antennae to check whether this is happening on a regular basis and, if it is, have a chat and take action if appropriate.

## 6 Start planning ahead

Nothing says 'we're moving on now' better than an opportunity to plan for the future.

Last year's changes cannot be accused of being what anyone planned, so now is an opportunity to look ahead as a practice.

Some new arrangements may be viewed as a positive benefit and you may want to keep them. Valuable ways of working may have been abandoned a year ago but you may be ready to think about reinstating them.

The whole practice will benefit from having a practice manager who is optimistically looking forward with the team at whatever 'new normal' is going to look like.

**Fiona Dalziel run DL Practice Management Consultancy**

# AGONY AccoUNTant

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

In this issue she tackles queries about use of the partnership premium, worries about paying tax on unreceived income, and a retiree's concerns about her access to unspent Covid-19 funding

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

## THE PARTNERS WANT TO RETAIN MY NEW TO PARTNERSHIP PREMIUM

**Q** **I am joining a practice as a partner shortly and I planned to use the partnership premium as a deposit on my house. But the partners say I must leave it in the practice. That's not what the rules say! How can I get them to see sense?**

**A** **Yes, the rules do say that while the partnership premium will be paid to the practice it must then be paid to the incoming partner within 28 days of receipt.**

However, the partnership agreement may well stipulate that partners must introduce or retain funds of a certain level to provide practice working capital.

Many practices historically waived the requirement for instant working capital and let partners build it up over a period because incoming partners were unable to come up with sufficient capital early in their careers. The ability to access the partnership premium would mean funds should be available.

But, while the premium would be paid out to you, you might need to pay it back in again to provide your working capital.

From the practice point of view, if you leave within five years, the proportionate balance will be taken from the practice and it would have to recover this from you.

To protect the practice partners - and that will include you when the next new partner joins - it would make sense to ensure that a partner's working capital never drops below the amount which is potentially repayable.

If you are looking at a large commitment such as a mortgage and are new to partnership, talk to your accountant about likely tax liabilities, and drawings levels too, to avoid initially over-stretching.

## MY PCN WON'T LET ME HAVE MY MONEY

**Q** **I want to retire from my practice shortly. Our PCN has built up unused funds on which I've paid tax – but it says I cannot share in the funds when I leave. How can it be right that I pay tax on income I've never had?**

**A** **You should not have to 'bear' tax on income you have never had (which is different to 'pay' tax).**

PCN accounting is new for GPs and might not always be reflected in the best way in the partnership accounts.

The funding coming from the PCN relates to the following main categories:

**1** Direct payment for specific services provided by the practice or their staff
**2** Share of funding for generally participating in the PCN, and
**3** Payments received from the PCN that are genuine surpluses not needed for future PCN expenditure,
**4** Taxable surplus retained by the PCN to cover ongoing expenditure

The first, second and third amounts are normal practice income recognised in the usual way, so that a leaving partner shares in them fully.

The final category is trickier because a tax liability has to be paid by the partners in the practice during the relevant period. If the partner leaves without actually having had a share of the surplus, then an adjustment needs to be made in the accounts to compensate the outgoing partner for that tax payment

The important thing to note is that your practice accountant can deal with this appropriately, for example by allocating the PCN surplus only to those partners who will be staying in the partnership.

A pragmatic solution will be found by discussion with the accountant and a retiring partner will be protected from a tax liability on income not received.

Ideally your partnership agreement should also consider this situation and confirm what should be done on retirement.

## I'M NOT GETTING A FAIR SHARE

**Q** **I am a partner retiring on 31 March 2021 and our practice has substantial unspent Covid funding. My colleagues want to use it to cover expected 'catch up' costs in 2021-22 so that I don't share in it. Is that fair?**

**A** **The Covid resilience funding, as opposed to funding for specific costs, was intended to protect the practice during this difficult last year and the on-going effect the pandemic will have on the practice.**

Where it is clear that this funding will be used to:

- Reward staff for the extra efforts they have already put in
- To pay for overtime or additional staff to 'catch up' with normal on-going work
- To cover extra wear and tear or extra cleaning from the effects of large-scale vaccination clinics
- And similar costs

- then it is sensible and fair to provide for these costs in the accounts. Note that the tax treatment will not necessarily follow the accounts provisions.

Where the funding is intended to pay the partners for the extra work they have carried out, then it is fair to recognise it in the period it relates to.

Care will need to be taken if funding is deferred to a future year but is taxable in the current year - in which case an equitable adjustment would normally be made between the partners.

The wording of the partnership agreement may help here, outlining how the income should be allocated. It may indicate that all funds received in the year should be treated as arising when received unless they are refundable if not spent on the purpose they were received for.

# Budget woes have only just started

**Ouch! Paying for Covid-19 will hurt for many years to come. Kieran Hancock**** gives a round-up of the Chancellor's measures**


Last month's Budget was one of the most anticipated ever. Given the year since Rishi Sunak's first one in March 2020, many more people were interested in his announcements to see how they would be affected.

In the weeks leading up to the speech there were rumours surrounding changes to the tax relief on pensions, capital gains tax rates and Stamp Duty Land Tax (SDLT), to name a few.

Given the financial impact that Covid-19 has had on our economy many people have struggled and news on additional support could not come soon enough. But did that support come and how will it be paid for?

Support was offered in several ways, from extension of the Job Retention Scheme, self-employed grants and the SDLT holiday. This is welcome news to many.

Several announcements looked at starting to recover the huge amount of borrowing the government secured over the past twelve months and to minimise additional borrowings as we move through this crisis.

These changes affected a great number of industries, but below I cover those most relevant to GPs:

## Pensions

The Chancellor announced a freeze to many thresholds, but notably the Lifetime Allowance (LTA) for pension purposes. This is the total pension fund value an individual can have without incurring additional tax changes when benefits are drawn.

The LTA was reduced from £1.25m on 6 April 2016 to £1m. The arrangement was then for this to rise annually with the Consumer Price Index (CPI), from 2018-19 onwards. Since then, this rose to £1,073,100 for the 2020-21 tax year.

The Budget confirmed this allowance will be frozen until 5 April 2026. It is disappointing for higher earners in the NHS and other public sector pension schemes because, due to the way LTA values are calculated in defined benefit schemes, they have little control over their pension pot.

It is likely that some scheme members will find themselves being subjected to additional tax charges and consider either ceasing to pay into

their pension or drawing their pension early.

If CPI was, say, two per cent each year over the freeze period, the LTA would increase to £1.185m in 2025-26, some £112k higher than the now frozen level.

To put this into context this would result in someone with a £60k pension seeing their net monthly pension reduce by £79 per month.

| | Without freeze | With freeze |
|---|---|---|
| | £ | £ |
| **Annual gross pension** | **60,000** | **60,000** |
| **LTA charge** | **-** | **(1,586)** |
| **Taxable pension** | **60,000** | **58,414** |
| **Income tax** | **(11,432)** | **(10,798)** |
| **Net pension per annum** | **48,568** | **47,616** |
| **Net pension per month** | **4,047** | **3,968** |

## Corporation tax

I recall some of my early tax exams nine years ago where there were some additional calculations to be completed to determine the corporation tax rate for companies with a certain level of profits.

In following years the government kindly simplified this and allowed accountants and tax advisers a break in our exams and jobs. It implemented a flat rate of 19% for companies across all profit levels.

The Budget 2021 has unwound these changes and confirmed that from 1 April 2023, companies will now be subject to higher rates of corporation tax.

For firms with smaller profits (£50,000 and under), the 19% rate remains. For those with profits over £250,000, the tax rate will increase substantially to 25%.

For the gap in between (£50,001 to £250,000), companies will pay a marginal rate of tax at around 26.5%.

Importantly, these profit limits are reduced if there are companies controlled by the same people.

This will not affect all GPs but in my experience more of them are involved with companies to shelter non-NHS income, or as PCNs consider incorporation.

## Tax bands

Under the Conservative government the personal allowance and higher rate threshold have been increasing gradually over a few years. This Budget saw a further increase in the personal allowance from £12,500 to £12,570.

The higher rate band has increased from £50,000 to £50,270. Both limits will remain in place until 5 April 2026.

This will reduce the annual income tax bill for a higher rate taxpayer earning less than £100k by £68.

As the personal allowance has increased, so has the band of earnings over which the allowance is withdrawn. Anyone with taxable income between £100,000 and £125,140 will be taxed at 60% on most income between those limits.

## Other changes

There were several other notable changes, some to generate more tax revenue and some to enhance investment in the economy. The most relevant are:

- The Annual Allowance for pension purposes again remains frozen at £40,000 a year for the foreseeable future.

- The VAT registration threshold will remain at £85,000 for the same period. While this may not seem a worry to many GP practices, it does need to be considered, as non-dispensing practices do make taxable supplies for VAT purposes, such as some reports, research and possibly contribution to overheads. If prices increase, this may become more of an issue.

- The Annual Exempt Amount for Capital Gains Tax remains at £12,300 a year until 5 April 2026.

- Capital allowances (tax relief available on capital items, such as plant and machinery) have been enhanced, but only for companies, not partnerships or sole traders. Some capital items purchased will receive a 130% deduction, instead of the usual 100%.

- A reminder here that the government overturned the planned reduction in the Annual Investment Allowance to £200k from 1 January 21 and kept it at the same £1m level as the period up to 31 December 2020. This will remain in place (at present) until 31 December 2021.

These announcements look to generate more in tax revenue but we still have a long period of difficult times ahead.