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association of independent specialist medical accountants

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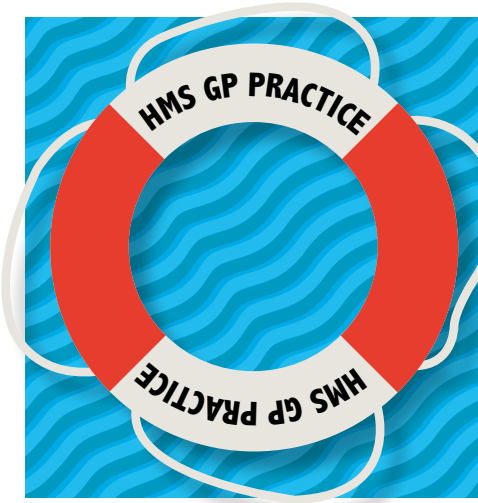
AISMA Doctor Newsline

At the heart of medical finance...

How to keep your head above the water

Change is constant but there is no need to drown. **Fiona Dalziel** shares some secrets from the practices who get ahead.



GP practices all breathe a sigh of relief around this time each spring. The financial year is at an end, the QOF rush is over, and the flu season is behind us.

It is so tempting to take the foot off the management accelerator a little. Sometimes, we do not regain momentum until September, especially if no other events intervene.

However, we live in fast-moving times. This demands a different approach. I have found that practices who sustain development and cope successfully with change all behave in a similar way. What's their secret?

Scanning the horizon

I often meet practice managers who say: 'We're drowning! How can we plan? Everything keeps changing!' They are right. Everything does, indeed, keep changing and it will continue to do so.

The practices who cope best are those who look ahead for what might be on the horizon, both in the practice and externally, and then plan for how they will handle the change. I will consider here the changes which come from sources outside the practice.

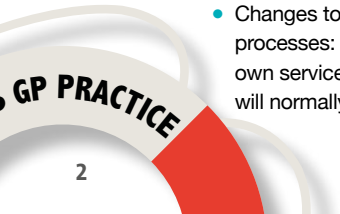
Identify main external sources of change

Apart from emergencies such as sudden illness, flooding or an IT catastrophe, we are generally able to see that a change is coming. Everything else is handled through your Business Continuity Plan.

Some of the main sources of external change are as follows:

- National changes to NHS policy: These are usually accompanied by a comprehensive policy document.
- Local NHS changes: These are often consequential upon the national policy changes. Local arrangements may differ, for example English STPs. These changes are managed by your CCG/CHP/Health and Social Care Partnership/Board.
- Changes to payments and claims processes: Each UK country has its own service for this. Your service will normally provide information (for example, online or by newsletter) to inform practitioners of deadlines for claims, correct documentation to submit to ensure payment and other helpful information on, for example, superannuation contributions.
- Contract changes: Although the UK countries have diverged on the content of the contract, the process for its negotiation and notification of changes follows roughly the same cycle each year.

  The BMA publishes updates on its site, emails members to notify of changes and often arranges local meetings for consultation or information. Changes are notified from roughly November onwards.
- Practice IT systems: Each country runs its GP IT systems differently, but all change from time to time. Changes are notified well in advance, giving time for transitioning to the new way of working. A good current example



of this would be SNOMED.
- CQC regulations and processes: Practices who are assessed by the CQC must stay abreast of changes to their requirements. Some changes in regulations may mean significant change in the practice to be able to satisfy the criteria.
- Changes to legislation: Employment law legislation changes regularly, along with other significant national legislation. The most recent and important is the current introduction of the General Data Protection Regulation (GDPR) for 25 May.

Sites such as ACAS provide updates along with useful information sources on HR topics and the law. The Information Commissioners of each country provide information on the GDPR changes. Detailed information on how this should be implemented in GP practices was not universally available at the time of writing.

Actively staying 'in the swim'

Coping practices resist the temptation to have a break until September. They use the time to get informed and regroup.

An effective practice manager is ideally placed to ensure this process happens in the practice. So, what steps can the manager take?

1 **Establish sources and get informed**
Subscribe to online networks and bulletins. Go to local managers' meetings. Establish a network of managers who are interested in the areas in which you may be weaker and pick their brains. Seek out opportunities to attend training. Ask a GP who is a BMA member to forward you any useful emails.

2 **Read the policy documents/ guidance/documentation/ newsletters/emails**
Although not everyone's preferred method of learning, this is essential. Become an expert.

3 **Consider the impact of the change on the practice**
Look for opportunities as well as threats.

4 **Summarise the change and its impact for the practice's management team to consider.**
This may involve the manager in writing a paper and/or presenting to a partnership meeting or other decision-making forum. The paper may include financial or organisational impacts and suggested next steps.

5 **Agree a plan of action**
This moves everyone forward together and gives a sense of control.

Practices which take this positive action minimise the risk of having to be reactive to externally-generated change. They position themselves to be able to recognise and take opportunities and try out new solutions.

Plans made in a rush may be poor, wasteful, or incomplete, resulting in unintended organisational and financial impacts. Knowledge is power – or, at least, helps keep our heads above water.

Fiona Dalziel runs DL Practice Management Consultancy.

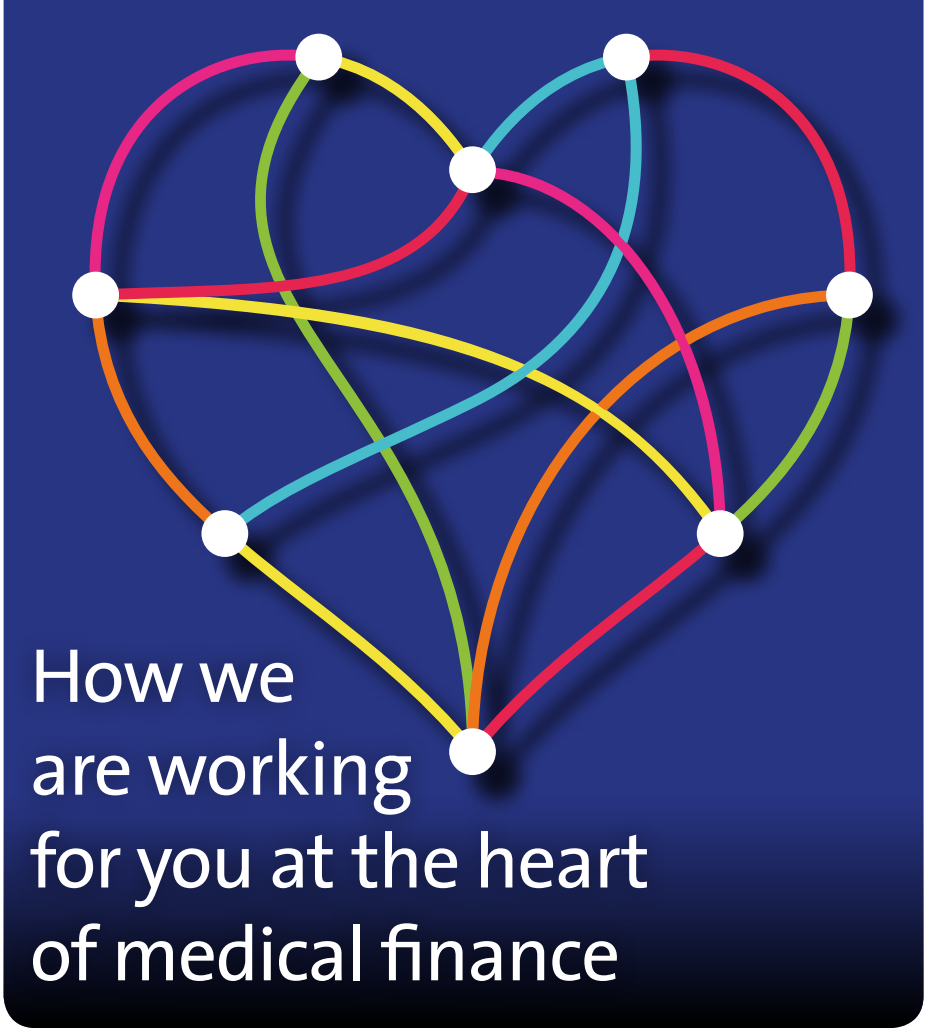
Useful websites

www.bma.org.uk/

www.digital.nhs.uk/SNOMED-CT-implementation-in-primary-care

www.acas.org.uk

www.ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/



How we are working for you at the heart of medical finance

AISMA's general practice clients are going through a period of significant change and face many difficulties - be it around contracts, pensions, taxation or payment issues.

But behind the scenes our members have been actively involved in discussing these problems and the impact on the NHS. **Andrew Pow*** sets out just some of the areas we have been actively working on recently to ease the burden on GPs

GP payment issues and pension processing

Many GP clients face significant problems with payments and processing of pension deductions in England.

AISMA has briefed both NHS England and the BMA to highlight the many

issues being faced. Regular meetings with Primary Care Services England (PCSE), NHS Employers (NHSE) and the BMA are held.

Input from AISMA provided examples of where things were not working and this was welcomed by both the BMA and NHSE.

NHS Pensions

The incorrect processing of pension payments can lead to cashflow issues for practices and incorrect calculations.

In the North of England AISMA member firms helped develop the online submission system of end-of-year returns with PCSE's predecessors.

The current system has taken a backward step but it is hoped that PCSE will introduce a more robust and easier to use system next year. AISMA will be seeking to meet PCSE soon to ensure that new systems are fit for purpose

Salaried and locum GPs are required to submit Type 2 pension certificates each year. But member firms reported significant problems with the 2016-17 form - a position which was also reported by the BMA.

The issues with calculations have been discussed with NHS Pensions and with input from the BMA the submission deadline of 28 February 2018 was abandoned while the process was reviewed.

Annual Allowance issues

The pension annual allowance problems hit home in January 2018.

AISMA has lobbied HM Treasury

and provided NHSE with a briefing document on how Annual Allowance issues are leading to restrictions on how much high earning professionals can work while still contributing to the pension scheme.

We also identified problems with the scheme pays elections which initially restricted how much of the resulting tax charge could be paid by the NHS Pension scheme to alleviate cashflow problems for client GPs.

So far there has been no change in England, but Scotland did change its rules.

Scottish contract

Big changes are afoot in Scotland with a new contract under way.

A special Scottish *AISMA Doctor Newsline* set out what it means and AISMA's Scottish members have been at the forefront of briefing clients.

There is a big concern over the impact in practices which serve rural areas and significantly deprived areas.

As with any large contract upheaval things are likely to change and AISMA members will be on hand to advise their clients on this.

Listening at local level

At local level AISMA member firms across the country provide talks and advice to LMCs, doctor and practice manager groups.

Not only does it help get across good financial practice, but these forums allow members to learn more about the issues GPs face. Many also provide training to the GPs of tomorrow.

New models of care and scaling general practice

AISMA members frequently talk to their clients about how they can work with their neighbours to provide a better service.

This is core to what we do within AISMA – sharing and developing ideas across the four countries.

"Many GP clients face significant problems with payments and processing of pension deductions in England."

Last autumn the AISMA New Models of Care group launched a 30-page briefing document to member firms to guide them through the many issues of scaling up general practice.

It shared the learning from all over the country where many different strategies are being adopted.

And finally.... AISMA's annual conference

Every May, AISMA member firms meet for a two-day conference. It allows us to not just update ourselves on technical tax and pension issues, but we also hear from GP leaders about national issues and learn from case studies of practices who have gone through different problems.

Other professionals from the healthcare banking, legal and property sector also come along to present on topics that GPs face day in day out.

It also is a great networking event to share ideas with people who lead on providing advice to GP practices across the UK.

So, behind the scenes, at the heart of medical finance, AISMA is actively promoting the interests of general practice. And we are lobbying where we don't think things are working. Putting the interests of our clients first.

Super practices – so, are they really less risky?

OPINION

Bob Senior
Chairman, AISMA

There has been much comment in recent years about the problems of GP succession. The focus has largely been on the number of GPs retiring, perhaps early, and the shortage of new doctors entering general practice.

Less has been said about the increasing nervousness, particularly in young doctors, over exposing themselves to financial risk.

Unfortunately running your own business is inherently risky, and to a great degree risk is unavoidable. But a desire to minimise the risk to personal assets is perfectly understandable, particularly in a normal partnership environment where liability cannot be limited.

Business risk comes in many forms, but the principal aspects that most concern young doctors relate to premises.

If the practice occupies a surgery owned by a third party, then generally a lease will be required and that gives concerns about the length of the lease and what would happen if the practice failed.

If the surgery is owned by the partners then the concerns switch to what happens if interest rates rise or surgery values fall.

Arising from both of those worries is what happens if the practice cannot recruit new partners and a few remaining partners get stuck with the full liability.

That nervousness has led a number of practices to seek comfort in numbers. Being one partner in a practice of eight could easily become being one partner in a practice of four or five partners.

Sharing risk with, in this example, seven other partners is one thing. Getting to a point where risk is shared with three or four other partners is very much another.

Those thoughts have led some GPs to respond with: 'Well if we merge with a super practice we can share the risks between many more partners. So that is not so scary.'

If the way the partnership is structured then allows each surgery a reasonable amount of autonomy, perhaps with the clear majority of their income being based on the profits earned by their surgery, well that is an ideal result.

Or is it? While it is perfectly straightforward to develop a profit sharing arrangement that allows surgeries to ring-fence large parts of their profits and allow them a fair degree of independence in how they operate, the partners need to realise that they cannot be ring-fenced entirely from losses elsewhere in the partnership.

Why would losses arise? Probably the most likely reason would be because the doctors in a surgery left and could not be replaced.

If the surgery could not continue, then any redundancy costs or ongoing rental payments would have to be covered by the remaining partnership.

The costs of one failing surgery may be just about bearable. But if more than one fails then that would be very different!

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*Andrew Pow is an AISMA board member

VAT's the matter for federations

GP federations are throwing up new issues for practices to get up to speed on. Jonathan Main reports.

The fact that VAT is a cost of running a GP practice is of course nothing new. The large majority of services delivered to patients are exempt from the tax, which prevents its recovery on the costs of providing those services.

Most GP practices are therefore not required to be VAT registered. But beware. The assumption that VAT does not play a role in this sector, except as a cost, no longer holds true.

The advent of GP federations, established to bid for CCG contracts, brings several new VAT issues into play:

1 Has the GP federation considered the possibility that any funding received to cover its first (say) 12-18 months operating costs will be liable to VAT?

This money is unlikely to be a payment for a provision of healthcare services although it may be for research or studies into the provision of healthcare in the local area. It will therefore most likely be liable to VAT.

Has the federation correctly identified the date from which it should therefore be registered for VAT in relation to this receipt of funding, provision of consultancy or research services?

2 On the assumption that the local CCG is the counterparty for these services, have both parties considered the potential need to charge VAT?

CCGs are entitled to recover VAT on specific types of expenditure and that should be considered in relation to these contracts.

3 Is there a cost sharing arrangement with individual practices to cover the operating costs of the federation? If so, has the VAT treatment of the

recharges been considered?

As most of the day-to-day costs are likely to be salary related, the recharge of these costs can effectively result in the creation of VAT out of thin air.

There is, however, an opportunity for an efficient means of dealing with the cost sharing arrangement between individual practices, and I discuss this below.

Cost Sharing Exemption

Both EU and UK VAT law contains legislation designed to relieve VAT on the recharge of costs between 'independent groups of people' who make exempt or non-business supplies.

The UK legislation was introduced in July 2012. This is therefore a basic provision of UK and EU law, which furthermore does not require HMRC permission. It can also be applied on a retrospective basis.

Where a legal entity is established, referred to in UK law as a cost sharing group (the CSG) set up to provide services to its members, then those services are exempt from VAT when certain conditions are satisfied. In this case, the CSG would be the GP federation.

Conditions

- **The CSG must be an independent entity supplying services to its members**
- **The members must carry on activities which are either exempt from VAT or non-business**
- **The services must be directly necessary for the members exempt/non- business activities**
- **The CSG must only recover the exact cost of the services from its members**
- **The application of exemption must not cause a distortion of competition.**

Let's take each condition in turn:

The CSG must be an independent entity

A GP federation is typically an entity limited by shares, with each GP practice holding an equal share. As such, the GP federation is clearly independent from each of its members, as none of them has a controlling interest.

The members must carry on exempt activities

This condition is clearly satisfied by the individual GP practices.

The services must be directly necessary for the members' exempt activities

In this case, the members are of course the GP practices. This is quite an involved test, as in some cases it will require an analysis of the members' exempt and taxable activities to ensure that the exemption from VAT only applies to the recharge of costs to support the members' exempt activities.

As a GP practice rarely makes any taxable supplies, this condition will clearly be satisfied in this case.

The CSG must only recover the exact cost from its members

In simple terms, the CSG must not seek to make a profit and must be able to demonstrate that it applies a methodology which supports cost recovery from its members. A detailed analysis through the federation's management accounts would provide appropriate support.

The application of the exemption must not cause a distortion of competition

In practice, this condition will always be satisfied providing it is clear that the federation is a closed loop, only seeking to support its member practices. In other words, this is not a commercial

" Where a legal entity is established, referred to in UK law as a cost sharing group (the CSG) set up to provide services to its members, then those services are exempt from VAT when certain conditions are satisfied."

outsourcing concern in competition with other third parties.

The last issue to consider is the employment of staff by the federation. In my experience, senior staff can be seconded to the federation in its first few months to deal with issues arising from NHS pensions arrangements.

For the cost sharing exemption to work, all staff will need to be employed by the Federation or seconded in a manner that will satisfy an HMRC concession to relieve the secondment from VAT.

To ensure the CSG incurred its own staff costs without VAT it would be necessary to do one of the following:

- Change the entity employing the affected staff so that the CSG becomes the legal employer
- Establish joint contracts of employment between the CSG and the current employer(s). Again, this change would need careful consideration of any employment or pensions issues, or
- The CSG would pay the affected staff directly, including payroll taxes and pension so that the staff are treated as seconded to the CSG. The CSG can then recharge these costs back to its members in the required proportions.

It would be perfectly acceptable for the federation to bid for contracts from the CCG and still be separately eligible to operate the cost sharing exemption.

In this case the federation would need to show appropriate separation of costs relating to CCG business and that relating to the operation of the cost sharing exemption.

As I've already mentioned, the services supplied by the federation must be directly necessary for the members' activities and therefore by association any costs it incurs must only be those relating to the services provided to its members.

It is possible for a federation to discover that it satisfies the cost sharing exemption effectively by accident, purely because of the way it interacts with its members. This leads to the final issue, whether to alert the HMRC, particularly if the federation wishes to apply the exemption on a retrospective basis.

There is no requirement to seek approval from the tax authories, but it can demonstrate good governance to notify them that the federation is operating the exemption, without seeking written approval or inviting an audit.

This would provide the federation with a greater level of certainty in relation to its VAT affairs in the future.

In the event of challenge, no penalties should apply as long as the federation has taken reasonable care, most likely by seeking professional advice into its VAT affairs.

Jonathan Main, MHA Mtaxco, specialist VAT advisers.

Legal issues for GP shopping overseas

Gillian Burns explores some of the issues around recruitment and employment of salaried GPs with a focus on those from outside the EEA

Uncertainty about the continued free movement of European Economic Area (EEA) and Swiss nationals in the light of Brexit means that UK practices may have to look more widely to recruit GPs.

Here is what you need to know:

Employers' duties

Under the Immigration, Asylum and Nationality Act 2006 (the '2006 Act'), employers have a duty to prevent illegal working.

By carrying out appropriate checks to confirm a person has the right to work in the UK, they can establish a statutory excuse which limits their exposure to civil penalties if it later becomes apparent that their employees do not in fact have the right to work.

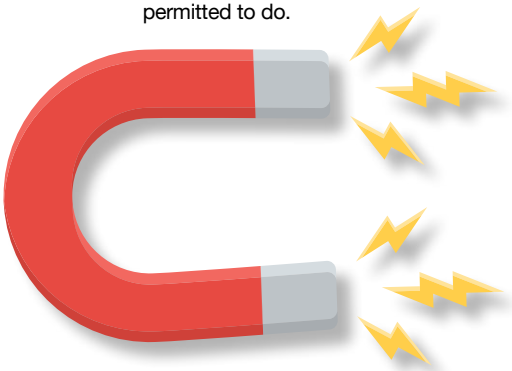
It also seems unlikely, if appropriate checks have been undertaken, that

an employer could be charged with a criminal offence for employing migrant workers when it had 'reasonable cause to believe' that the employee had the right to work.

These checks should be carried out on all prospective employees, not just those that an employer has actively recruited from outside the EEA.

The checks need to demonstrate that a prospective employee:

- is not subject to immigration control, or has no restrictions on their stay and has an ongoing right to work in the UK; or
- has been granted leave to enter or remain in the UK for a limited period of time either with or without restrictions on the work they are permitted to do.



Employers of employees who fall into the second category should carry out further right-to-work checks well in advance of the expiry of their employees' time limited visas.

In carrying out these checks, an employer must ask for an appropriate original document or combination of documents, take reasonable steps to verify that documents provided are genuine and relate to the person the employer is intending to employ, and check that the document permits the person to do the work in question.

The employer must also retain copies of the documents in a format that cannot be altered later.

When recruiting GPs from outside the UK, a practice will also need to ensure that the person in question is able to satisfy the GMC's requirements for inclusion on the GP register before they commence work.

This will involve checking that the person has gained the necessary competencies through an approved training scheme in their country.

From 11 June 2018, primary medical qualifications from outside the EEA will have to be independently verified. Further information is available on the GMC's website: www.gmc-uk.org/doctors/registration_applications/routeG.asp

The person will also need to be eligible to join the NHS Performers List.

The Government publishes guidance for employers on their responsibilities under the 2006 Act: www.gov.uk/government/uploads/system/uploads/attachment_data/file/304793/full-guide-illegal-working.pdf

Immigration Points System and Visa Sponsorship of non-EEA workers

The UK has a points-based five tier visa system for migrants from outside the EEA to come here to work, study, invest or train.

Skilled workers from outside the EEA with a job offer in the UK generally need a Tier 2 Visa. This category includes skilled workers where there is a proven shortage in the UK, and would apply to non-EEA GPs coming to work in the UK.

Salaried GPs wanting to come to work in the UK on a Tier 2 Visa need to be employed by a licensed sponsor and GP practices that want to sponsor a non-EEA salaried GP to work at their practice will need to obtain a sponsor licence.

Sponsors have a responsibility to ensure that the non-EEA salaried GP has the intention and ability to meet the conditions of their visa.

There are also a number of reporting duties that apply to sponsors: for example, sponsors must report to the Home Office if their non-EEA employees fail to turn up for their first day of work or if their employment ends prematurely.

Further information about immigration sponsorship is available on the Home Office website: www.gov.uk/uk-visa-sponsorship-employers

NHS England International GP Recruitment Programme (IGPRP)

International recruitment of GPs from the EEA has been a primary strategic focus of the Government and NHS England since the autumn of 2016, when an initial target of recruiting at least 500 suitably qualified doctors in general practice by 2020 was set.

That target has recently been increased to 2,000 international GPs and the geographical spread is now much wider than the EEA, and now includes Australia – so Tier 2 visas under the UK's points-based system would likely be necessary.

NHS England's approach is set out in the guidance document, General Practice Forward View: International GP Recruitment Programme (IGPRP) (October 2017).

This outlines the IGPRP, which includes:

- Establishing a GP International Recruitment Office with responsibility for a range of tasks, such as recruitment (including sourcing and selecting applicants), training, relocation and accommodation costs
- Procuring a national framework of approved recruitment, relocation and training companies to support the programme
- Encouraging the 4,000-plus current international medical graduates who register to practice in the UK each year to consider applying for GP training places
- Connecting to local practices, and
- Recognising qualifications and experience beyond the currently recognised GP training of EEA doctors to other countries' GP training, extending automatic recognition for GMC registration purposes.

Under the NHS England scheme, it is proposed that NHS England will be the proxy employer for visa sponsorship purposes for employment of non-EEA salaried GPs requiring a Tier 2 visa, thereby removing the burden from local practices to negotiate with the UK Visa and Immigration at the Home Office to become licensed sponsors themselves.

Overseas doctors recruited under the scheme will be supported by dedicated training programmes and given help with language requirements and meeting the standards of the NHS induction scheme.

However, it is anticipated that whilst the IGPRP will play a role in matching recruits and practices, this programme is designed to increase the pool of GPs available to be recruited directly by practices.

Practices will remain responsible for salary and employment costs and practices will still have a responsibility to comply with the 2006 Act.

Applications to join the NHS England programme are invited on an area basis (typically on a Sustainability and Transformation Partnership footprint) rather than by individual practices.

The deadline for the most recent wave was 23 March 2018, with the decision due to be taken on 20 April 2018.

Gillian Burns is a solicitor in the employment team at Ward Hadaway, a top 100 law firm with a national reputation for its healthcare practice. She advises on all aspects of contentious and non-contentious employment law with a particular interest in immigration law.