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Your essential guide to the 2020-21 GMS contract changes

With the 2020-21 financial year about to get 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

Following a draft consultation relating to the next phase of the PCN DES specifications issued just before Christmas, which was not well received, NHSE/I and the BMA's GPC worked together to publish the 2020-21 agreed contract arrangements in a joint document dated 6 February 2020.

This updates the existing five-year GP contract, *Investment and Evolution*, through to 2023-24, but note that following its rejection by

A message of support

The Association of Independent Specialist Medical Accountants would like to express thanks and appreciation to the doctors, nurses and practice teams who will be working so hard over the coming weeks to care for their patients during the Covid-19 pandemic.

The Association will be continually monitoring the financial implications of the crisis so that AISMA members are able to advise and support their practice clients during this difficult time.

Please contact your AISMA accountant if you have any concerns about how your practice could be affected.

Bob Senior
AISMA chairman

the March LMC conference, at the time of writing it may be subject to change.

The agreement reached covers the following main areas:

1 **Enhancing the Additional Roles Reimbursement Scheme (ARRS)**
2 **Increasing the number of doctors in general practice**
3 **Improving access for patients**
4 **Reform of vaccination and immunisation payments**
5 **Updating the Quality and Outcomes Framework (QOF)**
6 **Pay transparency**
7 **Primary Care Network delivery specifications**
8 **The Investment and Impact Fund (IIF).**

TABLE 1

The Additional Roles Reimbursement Scheme (ARRS)		
The roles are:	**Agenda for Change band**	**Maximum annual reimbursable (with on costs) £**
Clinical pharmacists	7-8A	55,670
Social prescribing link workers	up to 5	35,389
Physicians associates	7	53,724
First contact physiotherapists	7-8A	55,670
Pharmacy technicians	5	35,389
Health and wellbeing coaches	up to 5	35,389
Care co-ordinators	4	29,135
Occupational therapists	7	53,724
Dieticians	7	53,724
Podiatrists	7	53,724

Here are the main financial aspects of the agreement with specific reference to changes implemented for 2020-21.

Enhancing the Additional Roles Reimbursement Scheme (ARRS)

Workforce expansion is a top priority to reduce workload pressure and maintain sustainable primary care, while improving patient access to appointments and moving towards greater integration of care.

Two new national workforce targets have been set: 26,000 extra staff from the ARRS and 6,000 more doctors in general practice. The aim is to secure 50m more appointments.

The scope of the ARRS has been extended to give PCNs more flexibility and there will now be 10 roles available in 2020-21 instead of the original four proposed last year ***(see Table 1)***.

Reimbursement is only for roles added since 31 March 2019 as agreed between PCNs and CCGs.

If the PCN obtains the services of its social prescribing link workers from a third party, such as the voluntary sector, a £2,400 contribution can be claimed for additional costs beyond the salary and on costs, but within the overall maximum reimbursable amount per one whole-time equivalent.

From 1 April 2020 PCNs can substitute between clinical pharmacists, first contact physios and physician associates.

Additional funding has been identified to increase the budget for the ARRS from 2020-21 up to 2023-24, with the aim of funding 26,000 staff instead of 20,000 as originally planned.

All roles will be 100% reimbursed at actual salary plus on costs up to the maximum reimbursable amounts. This releases the £1.50 per head PCN payments for management,

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	1,027m	1,412m

development and transformation and can be used to enhance payments for the clinical director role.

The overall guaranteed investment in the scheme is shown in Table 2.

Each PCN is allocated a single combined maximum sum based on the weighted patient list.

Funding is built in for the five years of the contract so there is still concern about employer liability beyond that date. Latest contract documents indicate that staff employed through this funding will be treated as part of the core general practice base costs beyond 2023-24 when negotiating future global sum contract payments.

If all practices comprising a PCN decide to hand back the PCN DES, then the CCG must find an alternative provider and staff will follow the service under existing TUPE arrangements.

CCGs are encouraged to offer direct support from their own staff to help with recruitment for the ARRS.

Where a CCG identifies underspent ARRS resources then the funding should be made available across the relevant PCNs for the benefit of general practice. The figures involved will be determined in conjunction with LMCs, including estimates, by the end of July 2020. They can be made available across other PCNs who bid for the funding for additional recruitment under certain specified criteria.

There is a workforce planning timetable for 2020-21.

Concern has been expressed regarding how space will be created in general practice to house these additional numbers of staff. Short term solutions may be available via community provider partners.

There will be a requirement to develop a vision of fit-for-purpose estate between general practice and other providers so that capital funding can be allocated to support the PCN model.

Increasing doctor numbers in general practice

Practices will be able to make more generous offers of enhanced shared parental leave to employed GPs in 2020-21.

Funding will go to HEE to increase GP trainee places to 4,000, and NHSE/I is increasing the budget available for recruitment and retention schemes.

All international medical students entering general practice training will be offered a fixed five-year NHS contract covering three years training plus two years on a fellowship programme.

The RCGP has proposed changes to the training programme from 2022 so that GP trainees spend two years in practices during training.

> *"From 1 April 2020 there is also a New To Partnership scheme, enabling new partners to get a £3,000 training allowance and £20,000 per full time equivalent GP"*

The Targeted Enhanced Recruitment Scheme (TERS) is used to attract doctors into under-doctored areas. This provides a one-off incentive of £20,000 to the individual and it is intended that 500 such places will be offered in 2020-21.

For newly qualified doctors and nurses entering general practice there is a new two-year fellowship programme which guarantees funded mentorship, CPD, and rotational placements.

From 1 April 2020 there is also a New To

Partnership scheme, enabling new partners to get a £3,000 training allowance and £20,000 per full time equivalent GP.

This will be in loan form and will convert to a permanent payment after a fixed period as a partner. On costs can also be claimed by the practice with the funding going to the individual. It is available to GPs, nurses and pharmacists who have never been a partner.

There will be a Locum Support Scheme to enable CPD funding for sessional GPs if they commit to providing a minimum number of sessions per week to a group of PCNs. It is intended to support at least 500 such doctors in 2020-21.

The National GP Retention Scheme continues and may be updated.

The Induction and Refresher Scheme continues and is likely to be expanded and enhanced. From April 2020, GPs on this scheme with children under 11 will be able to make a claim for up to £2,000 per child towards childcare costs. There is £1,000 available for those on the Portfolio Route.

Experienced GPs working at least three sessions will be offered the chance to mentor newly qualified GPs via the Fellowship Programme for one session, with reimbursement funding paid to their practices to release the time. This aims to support 450 GPs.

Various initiatives will commence to consider how unnecessary bureaucracy can be reduced to leave clinicians with more time for their care role. This will cover things like training, revalidation, appraisal, systems, performers list, NHS standard contract and coding requirements

There is also work underway to digitise paper records and free up space within practices.

The NHS Community Pharmacist Consultation Service is expected to relieve pressure on GPs.

The Time for Care programme is continuing to support productivity and resilience.

Improving access

An improved appointments dataset will be introduced.

A new measure of patient experience will be designed and tested with incentivising performance improvement funding amounting to £30m a year.

A major new GP Access Improvement Programme will be established working with PCNs.

Vaccinations and immunisations

There will be an investment in these services of at least £30m by 2021-22.

Vaccinations and immunisations, currently an additional service, will become an essential service offering all routine, pre and post exposure vaccinations and NHS travel vaccinations.

New contractual core standards have been agreed covering five core components.

For 2020-21 there is a continuation of MMR catch up in 10-11-year olds with an item of service (IOS) fee for delivery, not for recall. The IOS fee is standardised at £10.06 fixed for the remaining period of the five-year contract.

PCNs will be funded to take the lead on flu vaccination coverage with £8m being made available for over 65s with an aligned incentive in the Pharmacy Quality Scheme.

Quality and Outcomes Framework (QOF)

A QOF review was published in July 2018 and further improvements relating to that have been agreed for 2020-21.

97 of the existing 559 points are being recycled into 11 more clinically appropriate areas.

An additional £10m is being added to QOF to cover eight more points.

"Effective from October 2020, contractors and sub-contractors will be required to submit self-declarations annually if their NHS superannuable earnings exceed £150,000 a year, starting with 2019-20"

For 2020-21 the new Quality Improvement modules cover:

- Improving care of people with a learning disability, and
- Supporting early cancer diagnosis.

Points and payment thresholds for unchanged indicators remain the same as 2019-20.

The value of a QOF point will be adjusted in 2020-21 to reflect population growth and relative changes in practice list size using data at 1 January 2020.

Based on the data at January 2020 compared to January 2019, there has been an increase in average list size from 8,479 to 8,799. This means the QOF point value will rise from £187.74 to £194.83.

Pay transparency

Effective from October 2020, contractors and sub-contractors will be required to submit self-declarations annually if their NHS superannuable earnings exceed £150,000 a year, starting with 2019-20.

The earnings threshold will increase in line with CPI. The declarations will be aligned with the pension certificate process to be provided by February 2021.

This will also apply to salaried GPs and locums.

Company directors, employees and others engaged through companies that are contracted or sub-contracted to provide primary medical services, however they are remunerated, will also be expected to self-declare based on the definition of NHS earnings as GP pensionable income.

It is also intended to develop a way of reporting anonymous data on NHS earnings for all GPs and their whole-time equivalent status.

Delivering PCN specifications

Three specifications are agreed for 2020-21:

- Structured Medication Review and Medicines Optimisation
- Enhanced Health in Care Homes; a new £120 per bed per year is introduced when this service starts from 1 October 2020
- Supporting Early Cancer Diagnosis.

Every PCN will have a social prescribing service in place in 2020-21.

All funding for services previously funded by local CCG schemes which are now dealt with in the PCN DES, must be reinvested into primary care.

PCNs do not carry any contractual responsibility for failure by community service providers to deliver their part of the service specifications and vice versa.

The Investment and Impact Fund (IIF)

This is a reward for PCNs meeting the NHS Long Term Plan objectives and GP contract requirements worth £40.5m in 2020-21. The original fund was for £75m and the balance has been put into the wider GP contract to support the new elements of post-natal checks, care home premium and new QOF points.

It is set up like QOF with eight indicators for 2020-21 relating to seasonal flu vaccination, health checks for those with learning disabilities, social prescribing referrals and prescribing.

A detailed table of targets and thresholds and payments attaching has been published within the contract update documentation.

Money derived from the IIF must be used for workforce expansion and primary care services.

Seniority

No further changes regarding seniority have been announced so it is assumed that as previously agreed, seniority payments ceased on 31 March 2020.

The money from the seniority pot is recycled into the global sum.

Other 2020-21 changes

The new global sum per weighted patient is set to rise by £3.48 from the 2019-20 figure of £89.98 to the current year's figure of £93.46.

The out-of-hours deduction has changed from 4.82% to 4.77%.

From 2020-21 a non-contractual requirement is introduced for GPs to offer referrals to weight

TABLE 3

Confirmation of planned funding allocations (excluding ARRS)

	2019/20	2020/21	2021/22	2022/23	2023/24
	£	£	£	£	£
Contract baseline as at 17 July 2019	8,116m	8,392m	8,771m	9,194m	9,675m
Care homes premium		27m	55m	55m	55m
Practice funding including QOF, post-natal checks		20m	20m	20m	20m
IIF		40.5m	TBC	TBC	TBC
Total	8,116m	8,480m	8,846m	9,269m	9,750m

management services for obese patients.

Several improvements have been applied for maternity services, including moving additional services to essential services, and £12m is provided via the global sum to support the changes, including a six to eight-week post-natal check for new mothers.

The network participation payment continues at £1.761.

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.

What now

As ever practices must be fully aware of these many 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

Update to the GP contract agreement

https://www.england.nhs.uk/wp-content/uploads/2020/03/update-to-the-gp-contract-agreement-v2-updated.pdf

Letter detailing financial implications

https://www.england.nhs.uk/wp-content/uploads/2020/02/update-to-the-gp-contract-financial-implications-letter.pdf

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A Spring of tension and uncertainty

OPINION

Bob Senior
AISMA chairman

Well, 11:00pm on 31 January 2020 came and went; the sun rose next morning and life, in the main, continued as usual despite the UK no longer being a member of the EU.

Many then expected everything to go on as normal and for GPs that included worrying about what the Budget on the 11 March might do about the problems of the Annual Allowance.

Some might have been aware of a bit of a health scare taking place in China over something called Covid-19. By 3 February practices were starting to get calls from patients asking if they should be worried.

Just a few astonishing weeks later and the UK and large parts of the rest of the world are in lockdown. The NHS is effectively on a war footing with clinicians once again having put their lives on the line with inadequate Personal Protective Equipment.

As I write, the Government is frantically trying to source more supplies but since the rest of the world is doing the same it is not an easy task.

The globalisation of the supply chain for a wide range of products has in recent years enabled prices to be contained but the present crisis highlights its weaknesses. A clear example is the case of paracetamol.

Most of the world's production comes from India, which in turn heavily depends on China for supplying some of the raw materials.

Both of those countries locking down at the same time and retaining their supplies for their own populations is perhaps something that was never anticipated by the Government's emergency planners.

When the emergency has settled down a long hard look will have to be taken at the lessons learned.

The Government has recognised that dealing with the Covid-19 epidemic will mean that practices will not have the resources to devote to the normal QOF and enhanced services work.

It has therefore agreed to make payments to practices irrespective of actual outcomes. Quite how the fine detail of that works remains to be seen.

Pensions

The NHS came up with a sticking plaster to help with the pain of clinicians' 2019-20 Annual Allowance charges. It guaranteed for that year the NHS would fully cover the cost of using the Scheme Pays scheme when the individual comes to draw their pension.

Quite how resilient that guarantee turns out to be, perhaps many years in the future, remains to be seen.

That option is currently only available for 2019-20. Last month's Budget increased the income threshold for annual allowance tapering to apply for 2020-21 onwards.

While this will undoubtedly help most GPs it may not be a complete solution for all. Whether or not the Government goes on to also introduce flexibility regarding how much of a doctor's NHS income has to be pensioned is still unclear.

PCNs

We are now twelve months into the life of PCNs and the release of the initial proposals for enhanced services specifications for 2020-21 gave rise to widespread adverse comment from all parts of primary care.

The response from NHSE/I that 'it was only a consultation document' did not calm GPs' fears completely. Matt Hancock's subsequent comments that the Government wants 'value for money from PCNs in GP contract negotiations' did nothing to help the situation.

Although PCNs cannot simply sort out the problems of the NHS, they perhaps have the potential to help make GP practices more sustainable by taking work from a reducing number of doctors.

Rather than the Government immediately wanting to see 'value for money' from PCNs it should see them as a means of supporting the service until their many-times-promised additional doctors start to enter the profession.

Don’t neglect your partnership

With GPs focusing on Primary Care Networks (PCNs) and integrated care systems – and so much more - it would be easy to take your eye off the need to maintain a robust partnership agreement, warns Alison Oliver

A partnership is formed when two or more people trade together with a view to making profit. You do not have to make a profit, but the intention to do so is the main rationale for the relationship.

This distinguishes partnerships from other types of unincorporated organisations, such as clubs and societies, which are not trading businesses.

Unlike an incorporated structure - such as a company - which has its own distinct legal identity from its members, a partnership does not have its own separate legal personality. This means it cannot employ staff or own assets in its own right. It is the individual partners who enter contracts, own partnership property and bear the partnership’s liabilities.

Legal framework

With no agreement between the partners a partnership is subject to the Partnership Act 1890 and these terms are unlikely to suit those in a modern-day medical partnership.

The Act allows any partner to dissolve the partnership on notice to the other partners. This could have catastrophic consequences for the practice’s NHS contract. An acrimonious partnership dissolution will result in the contract being terminated unless the outgoing partner is prepared to nominate that the contract continues with the other partners.

It is therefore imperative that you have an agreement in place setting out the terms of the partnership and preventing dissolution at the whim of an individual partner. The agreement should be reviewed regularly to ensure it continues to be relevant to the practice’s needs.

Partnership property

As the partnership itself cannot own assets, partnership property will be owned by some or all the partners on behalf of the partnership.

Partnership property should be recorded in the partnership accounts, noting the respective interests of the partners. However, the fact that property is included in the accounts is not necessarily definitive. There have been occasions when the courts have not accepted the evidence of the accounts.

To avoid ownership disputes arising, your agreement should state which items belong to the partnership as well as the respective interests of partners in partnership property.

This is particularly important for property of high value, such as partnership premises. Your agreement should include provisions governing what happens to the partnership property if a partner dies or retires. Will the continuing partners automatically acquire the outgoing partner’s interest, or is this subject to the exercise of an option? How will property be valued? These matters are a common cause of dispute and a good agreement will minimise the risk of disputes arising. It is often appropriate for the premises arrangements to be set out in a separate deed of trust.

Where assets are owned by individual partners but used by the partnership, the terms of use should be agreed and documented.

Hempsons’ David Naughten’s article ‘GP refinancing: the value of preparation’, in the Winter 2019-2020 issue of *AISMA Doctor*

Newsline, considered issues around partnership premises in more detail.

Profits and losses

Subject to agreement to the contrary, partners are entitled to share equally in the partnership profits and bear equal liability for partnership losses.

In general practice, this is rarely what the partners intend, with profit shares and liability for losses usually being shared according to workload. It is important that the principles governing how profits and losses are to be shared are set out in your agreement as well as the actual profit shares at the date of the agreement. Mechanisms for varying profit shares should also be agreed.

Partners' obligations

Your partnership agreement should define the obligations and duties of the partners. Certain duties are implied between partners - most notably a duty of good faith - but there will be numerous other obligations with which GP partners must comply to ensure the practice's success.

For example, GP partners should be expressly required to maintain their professional qualifications and registration, fulfil their required sessions and comply with the practice's contractual obligations.

The partners' obligation to contribute to partnership capital should also be clear – is this obligation shared equally or in the same proportions as profit shares, for example?

Consequences of a serious or persistent breach of obligation should be set out in the agreement. Ultimately, the partnership should be able to expel a partner who seriously or persistently breaches their obligations. Without an express provision in the agreement you will be unable to expel a partner whose conduct or performance is putting the practice at risk.

Leave

Your agreement should set out the holiday and study leave entitlements of partners as well as entitlements to leave for maternity, paternity, adoption, sickness, sabbatical and compassionate grounds.

It should make clear whether a partner is entitled to their usual profit share and drawings during periods of leave for different purposes, how locum costs will be funded, and any applicable procedures, such as how competing requests for leave will be dealt with.

As partners are not employees, employees' statutory employee leave entitlements do not apply so it is important to consider and define these entitlements in the partnership agreement.

Risk and liability

Partners are all agents of the partnership with authority to bind it in relations with third parties. They are jointly and severally liable for the acts and omissions of any partner in the ordinary course of business. A third party could therefore sue partner A for loss caused by an act or omission of partner B.

Your agreement should record the extent of the authority of individual partners to bind the firm. Where individual partners act outside this, it would be usual to provide that they will indemnify the others against losses caused by those acts.

It is also usual to provide that individual partners indemnify the others against losses caused by their own clinical negligence and/or breach of the partnership agreement.

> *"The partners' obligation to contribute to partnership capital should also be clear – is this obligation shared equally or in the same proportions as profit shares, for example?"*

Outside occupations

Partners roles outside the practice are a common cause of disagreement and dispute. Sometimes these are taken on behalf of the practice, as with the CCG or PCN. Other roles might relate to the practice's work but are not necessarily undertaken on the practice's behalf, such as the PCN clinical director role or private medical work.

Yet other roles could be unrelated to the practice, such as media work. Even jobs done outside a partner's usual hours and not directly related to the practice's work have a potential impact.

It is important that your agreement makes clear what partners are and are not permitted to do both inside and outside their usual hours of work.

"Consider if your agreement needs updating to reflect the practice's PCN membership. Is the extent of authority of your practice's PCN representative clear? Is your practice a nominated payee for your PCN or is one of your partners the PCN clinical director? Changes to the agreement might be needed to deal with these matters."

There should be a mechanism for partners to agree:

- what time partners are permitted to devote to external roles within usual practice hours (if any)
- whether income from those roles can be retained by the individual or be treated as partnership earnings, and
- whether the other partners can require a partner to give up an external role if it is having a negative impact on the practice.

New partners

It is essential that if you admit a new partner, even for a probationary period, that they sign a deed of adherence to the partnership agreement. When a new partner joins, a new partnership is formed and the existing agreement will not bind the new partner unless they agree to be bound by it.

The deed of adherence should include any variations to the terms of the agreement relating to the new partner (such as their capital contribution) or arising from their joining (such as changes in session allocations and profit shares of the partners).

When offering a new partner the position your offer should make clear that it is subject to them agreeing to be bound by the partnership agreement.

Exit provisions

Your agreement should include provisions relating to voluntary retirement, including the notice period that partners need to serve, as well as grounds and procedures for expulsion or compulsory retirement.

Consider including a 'last man (or men) standing' clause so that if the resignation or expulsion of a partner would result in less than the specified number of partners, those left either opt to continue the practice or to dissolve the partnership, with the outgoing partner sharing the burden of winding up costs and liabilities.

Changes in the practice and new developments

We recommend you review and update your agreement from time to time to ensure it is still fit for purpose in the light of new general practice developments or internal changes.

Consider if your agreement needs updating to reflect the practice's PCN membership. Is the extent of authority of your practice's PCN representative clear? Is your practice a nominated payee for your PCN or is one of your partners the PCN clinical director? Changes to the agreement might be needed to deal with these matters.

We always recommend an agreement review if you acquire new premises, develop existing premises, take on a new mortgage or have any other major change in the practice, such as leasing part of your premises to a third party.

Other partnership terms

A detailed account of all the terms that a partnership agreement should contain is not possible here. We recommend numerous other provisions such as a right to suspend a partner from their duties or to insist on a medical examination or fitness to practice assessment in certain circumstances.

Partnership disputes

The absence of a partnership agreement – or an agreement that is insufficiently clear or out of date - leads to a lack of clarity about the rights and obligations of partners which in turn often results in disputes about entitlements and duties.

It also means there are no clear mechanisms for dealing with disputes when they arise.

The best way to avoid a dispute escalating out of control is to have a comprehensive, up-to-date written agreement setting out the rights and obligations of partners, that addresses the main causes of partnership disputes and includes mechanisms for resolving problems.

Alison Oliver is a partner at Hempsons

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Budget brings GPs some good news

Chancellor Rishi Sunak's first Budget at least brought GPs some financial relief in this turbulent year. Kieran Hancock** reports

PENSIONS

Annual Allowance (AA)

Things should be getting better for GPs affected by tough pension issues following the 'tapered' AA introduction in April 2017.

This was when the standard AA - the annual amount of tax relief an individual can receive on their pension contributions or growth - of £40,000 started to be 'tapered' downwards depending on an individual's earnings level.

The impact did not really hit home for many until their additional tax charges in January 2019, the deadline for 2017-18 tax returns.

This led to doctors considering their NHS pension membership options and many started looking at reducing their working hours or leaving the NHS Pension Scheme in a bid to try to mitigate additional tax charges.

Thankfully the Chancellor announced that from April 2020 the thresholds determining the tapering of the AA would be significantly increased (see below).

Threshold income is taxable income after the deduction of personal expenses and pension contributions. Adjusted income is essentially threshold income plus pension growth.

So for 2020-21 onwards, if your threshold income exceeds £200,000 and your adjusted income is over £240,000, your AA is reduced by £1 for every £2 that adjusted income exceeds £240,000.

	2019-20	2020-21
	£	£
Threshold income	**£110,000**	**£200,000**
Adjusted income	**£150,000**	**£240,000**

	2019/20 AA	2020/21 AA
Adjusted income	**£**	**£**
£150,000	**40,000**	**40,000**
£175,000	**27,500**	**40,000**
£200,000	**15,000**	**40,000**
£225,000	**10,000**	**40,000**
£250,000	**10,000**	**35,000**
£275,000	**10,000**	**22,500**
£300,000	**10,000**	**10,000**
£325,000	**10,000**	**4,000**

Despite the good news for GPs and consultants, the government announced that the minimum AA will drop from £10,000 to £4,000. Those with adjusted total income exceeding £312,000 will have this minimum limit.

There are a couple of 'buts' to add here as 'income' includes all taxable income from all sources, not just from the NHS.

While there is no change to this definition from previously, it does mean that clinicians who earn a more modest NHS income, but have significant private wealth or other sources of income, may not feel the full benefit.

A comparison of the annual allowance under the old and new rules is shown above.

This change should now see most GPs and consultants securing the full £40,000 AA.

However, the annual allowance limit of £40,000 will still affect many pension scheme members, even if they are no longer affected by tapering.

Consider a GP with 2015 NHS Pension Scheme membership and pensionable income of £135,000. Their pension will rise by 1/54th of their pensionable income, so £2,500. Multiplying this by 16 to arrive at the deemed pension growth takes the GP up to the pension limit of £40,000.

However the pension growth calculation must also consider the revaluation of all previous earnings, whether in the 1995-2008 or 2015 Scheme. As revaluation within these schemes is set at 1.5% above inflation, this will add to the deemed pension growth in the year.

It is impossible to generalise as everyone's situation differs but a clinician in their 50s could easily find £10,000 of their annual allowance used up by the growth relating to earlier years.

> *"...despite PCSE appearing to be more proactive in recent months, many GPs still find it extremely difficult to get up to date pension information"*

The issue regarding the accessibility of pension information still remains and despite PCSE appearing to be more proactive in recent months, many GPs still find it extremely difficult to get up to date pension information.

There will still be a delay in determining the true extent of any additional tax charges until this improves.

For those NHS Pension Scheme members who have deferred their membership to reduce their exposure to additional tax charges, now may be the time to look at opting back in. Doing so will also give members access to any unused AAs from the previous three tax years, as well as the limit for the current year.

Lifetime Allowance (LTA)

The Budget made no fundamental changes to the LTA (the maximum pension value before additional tax charges arise) other than an inflationary increase from £1,055,000 to £1,073,100.

It is disappointing that the AA is not also inflation linked.

Entrepreneurs' relief

Boris Johnson announced he would review Entrepreneurs' relief (ER) in last year's Conservative manifesto. Simplistically, ER reduces the Capital Gains Tax rate on qualifying capital gains to just 10%, as opposed to the more mainstream rate of 20% for higher rate taxpayers.

Individuals were also entitled to a lifetime allowance of £10m meaning all eligible gains up to this limit would still attract the more favourable tax rate.

True to pre-Budget rumours, the lifetime limit was cut from £10m down to just £1m. This change is most likely to impact owners of larger businesses and therefore GPs are unlikely to see much change to the tax rate paid on capital gains - unless a gain in excess of £1m is realised on the eventual retirement of a partner from their practice. That is not very likely, you might think.

There may also be instances where GPs and hospital consultants own shares in limited companies which are used as vehicles to receive any private income. A gain on the disposal of these shares (up to the £1m limit) will qualify for ER relief providing these conditions are met:

- At least 5% of the ordinary share capital is owned, including 5% of the voting rights and entitlement to assets on the wind up of the company
- The company must be a trading company
- The shareholder must have owned their shares for a period of at least two years

Of course ER can apply in many other circumstances but the examples above should provide an idea of the impact.

Other changes

The Chancellor announced a rise in the lower earnings for National Insurance (NI) self-employed contributions from £8,632 to £9,500 with effect from April 2020.

But the class 2 NI rate has increased by 10p per week. The net effect will be a drop in NI contributions of £73 for most self-employed individuals.

Employed staff, because they pay a higher NI rate, will benefit by £104. Employers will see a saving in their employer NI contributions of £22 per employee.

The personal allowance, the tax-free amount for those earning under £100,000, remains at £12,500 and the basic rate band also remains unchanged at £50,000.

AGONY AccoUNTant

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

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

In this issue she tackles a manager's cash flow dilemma and rising staff costs

No cash for a bonus

Q We are coming up to our year end and my partners are expecting me to pay them a bonus, but we've not got any spare cash. Nothing's changed since last year, regular drawings are the same – I don't understand why there's no cash…

A If this has come as a surprise to you, you will need to look at budgeting and reporting requirements so that you are not in this position next year.

However, let's look at how to address the current issue first.

If you have well written up and analysed accounting records, look at the latest figures compared to last year and see if there are any unusual expenses or reductions in income - this may show up any major discrepancies.

If there is nothing obvious or your records are not up to date then hopefully you know if:

- Patient numbers are down
- Services have been lost
- There has been more reliance on locums
- Extra staff have been brought in, or overtime has been paid to existing staff
- There have been changes in partners.

If the answer is yes to any of the above then can you quantify the costs?

If it is changes in partners – do you have more partners doing the same level of work as fewer partners were doing? That would mean less profit to share to each. Or have you lost partners and had to pay out even more than partner cost for locums to cover them?

Have you had to pay to out-going partners before incoming partners contribute a matching amount to working capital? This would account for lack of cash, without any change in profitability.

Do you know how much is owed to the practice for services provided? Does someone keep a check to make sure you get what is expected?

Practical steps you can take to ease the immediate cash flow shortage would include checking that you have received everything that you expect to have received – and chase up any unpaid amounts.

Secondly, check your monthly statements to ensure there are no unexpected deductions. If there are then check if they are correct. We have seen tens of thousands of pounds deducted from a practice in respect of superannuation for a doctor who hadn't been in their practice for years. It was a pure error – but not easy to get it corrected.

If these two reviews don't bring in any funds quickly, then bonuses may need to be delayed while you work out what has gone wrong.

To prevent these surprises in the future:

- Use 'cloud' based software so you can work with your accountant during the year.
- Prepare a budget for the forthcoming year and then review actual v budget on a regular basis. Your accountant can help you with this.
- Make sure that someone takes responsibility for each source of income/type of expense to ensure everything comes in on budget or better. And set up a reporting system so you know quickly if anything is out of kilter and can take prompt action.
- Make sure you have at least some basic anti-fraud systems in operation – so that for example:
  - all payment invoices are approved by someone other than the person making the payment
  - each monthly payroll is reviewed by a partner to ensure there are no unknown names or unusual payments
  - all locum decisions are made in accordance with the practice agreement, and
  - all locum invoices for payment show who they were standing in for.

Work with your accountant to compare your results to other similar practices and they can help you look for ways to improve your profitability, which is key to cash availability and potential bonus payments.

Help! Staff costs up 25%!

Q **Our staff costs are up by 25% on last year and we don't seem to have got many new staff since our new practice manager joined – what should we do?**

A Staff costs are usually the single biggest spend in a GP practice, and controlling costs here is key to maintaining practice profitability.

If you are finding you have unexpected increases in pay levels, then it is imperative that you investigate these as soon as possible, firstly to find out why the costs have increased and secondly to look at what you can do about it.

- Are you paying your new practice manager a lot more than the previous one?
- Have you promoted other members of staff?
- Have the hours worked changed? Have you replaced part-timers with full timers?
- Has there been a lot of overtime?
- Has there been a lot of sickness/other absence?
- Has the use of locums changed?
- Could there be fraud?

Once you have reviewed the staff costs carefully you will have discovered where the increases have come from. The next step is to consider if the costs are reasonable or what should change in the future.

The reason could be something simple like:

- A couple of high paid staff were on maternity leave and locum nurses were employed
- You were a partner down and locum costs reflected that
- The new practice manager was much more expensive than the old one
- You took on new staff for a new service – so whilst the costs are up, the matching income is up by a larger amount.

Or it could be less obvious in which case:

- Make sure there are controls over hours worked, overtime authorisation, use of locums
- Make sure a partner authorises the payroll each month (tedious, I know, but it prevents fraud with fictitious staff being introduced) – and it highlights changes
- Make sure that general pay rises are approved by the partnership and fall within expected levels (or accept the hole it makes in the budget)
- Make sure that funding is claimed correctly where due – such as maternity leave cover
- When staff leave don't automatically replace them like for like: consider the business need first.

On a separate note, be careful about granting large pay-rises to staff who are in the 1995 pension scheme and coming up to retirement. That could cause a huge 'Final Pay Control' charge when they do retire – a very unexpected and unwelcome increase in staff costs indeed.

Most AISMA accountants will departmentalise staff costs in the practice accounts, showing admin team and clinical staff separately to highlight year-on-year changes, but ideally the practice would already be keeping a close eye on this.

You may find the use of spreadsheets helpful here, as while accounting software will record and summarise costs, drilling down to review each staff member in terms of basic pay, hourly rates, and overtime levels may be needed and can then be used to see where increases occur.

Your accountant can help you with this and show you how to use Excel tools such as pivot tables to get the most out of this important data in terms of analysing and interpreting the staff cost data.

So, the importance of keeping a timely review of staffing costs can't be stressed enough, and if this seems like a daunting task, rather than ignore it, ask your accountant for some help.

Ten tips to maintain professional boundaries

Fiona Dalziel tackles what is often a difficult management dilemma for GPs and their teams

An invitation for me to provide staff training in a remote practice raised an important management issue that often confronts many rural GPs and their staff.

A new member of the reception team, local to the village, told me how difficult she was finding it to separate her working persona from still being a relative, a friend and a neighbour to people who had also become patients.

Her induction training on confidentiality had led to some complex questions. Suddenly, she could access a lot of clinical information.

In larger communities, separating out relationships and protecting confidentiality does require thought, but in smaller communities the issues become magnified.

So what can practices do to minimise the risk of something going wrong? By and large, we need to consider both how to manage staff and colleagues as patients and how to protect confidentiality in the community.

Staff and colleagues as patients

1 Avoid this whenever circumstances allow

A variety of risks are associated with treating staff and colleagues, principally because of the resulting conflict of interests. A staff member may wish to be signed off yet again because she is suffering stress through alleged bullying but does not want the bullying itself to be tackled.

A salaried GP may be abusing drugs, so their GP must provide care as well as consider how to protect the safety of patients.

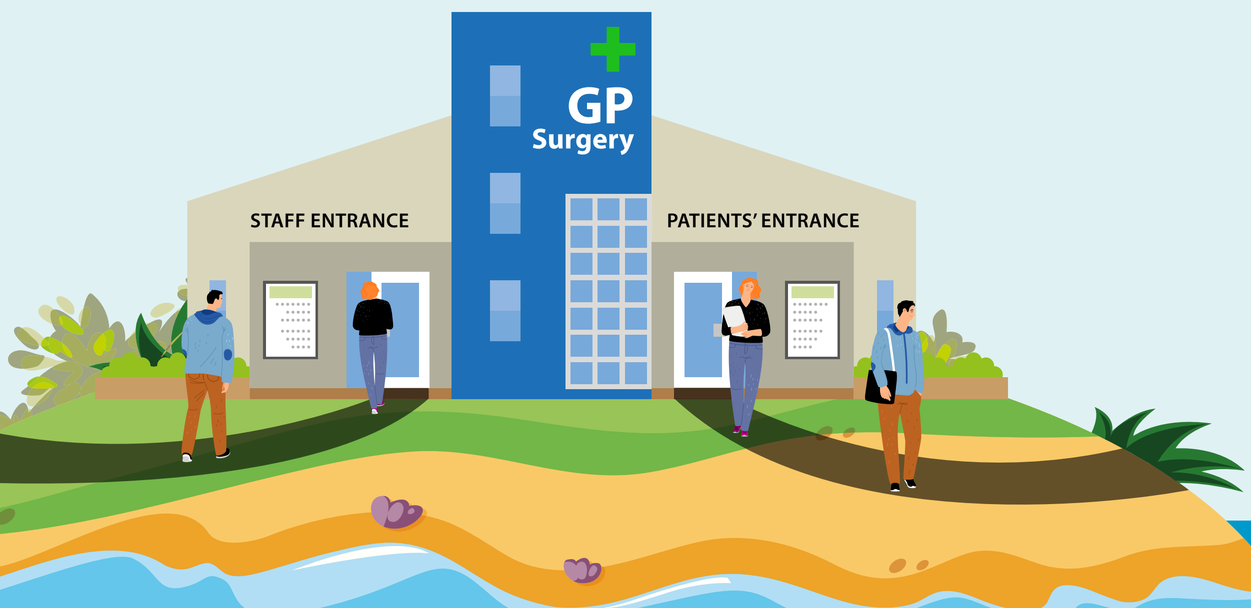
GMC guidance prevents providing medical care to anyone with whom the doctor has a 'close personal relationship' wherever possible, so unless it's a single-handed rural practice, family should consult a GP colleague.

2 Have a 'Staff as Patients' policy

Where another practice is available, staff and colleagues should register there. Patients who apply to become staff should be aware they may be asked to register elsewhere if their application is successful, unless there are strong reasons why this could cause harm to the patient.

3 Staff may only access records when there is a reason

Staff should be clear that accessing records for anything other than for a specific, valid reason



“If patient over-familiarity is an issue, a team discussion may help formulate an approach with which everyone is comfortable”

(for example to issue a prescription) breaches both confidentiality and GDPR regulations. The Information Commissioner’s Office cites a specific case where a medical secretary was fined for doing this.

4 Do not unfairly advantage or disadvantage staff who are patients

For example, avoid allowing staff to make appointments for family members, as staff have privileged access to the appointment system. Conversely, for example, do not have a policy which restricts choice of clinician.

5 Write a ‘Staff and Colleagues as Patients Policy’

Make sure new team members receive training and refresh everyone’s awareness regularly.

Staff interacting with patients

6 Stick to the business in hand

Staff need to signal to patients who are also friends or family that they are in ‘work mode’ when behind reception or on the phone.

Encourage staff not to let conversation drift into personal matters. They could say something like ‘I’ll need to go – can I speak to you about that later?’

7 Beware of getting ambushed

Not only can this happen locally but also abroad if you bump into patients. My GP husband was once ambushed in a theme park in Florida by a patient seeking a result.

Staff should simply state that they are not allowed to discuss anything outside the practice and ask the patient to phone or call in.

8 Beware of gossip

Staff may find themselves in a social but patient-related conversation when they are aware of something confidential. It is vital that staff are trained about the importance of remaining alert to the risk of a breach of confidentiality (especially if the conversation is in the pub!)

9 Consider how you address patients and colleagues

In terms of subtly underlining a degree of professional separation, this is important even though it may feel artificial.

Many practices continue to maintain separation and show respect by addressing doctors by their title rather than first name.

This kind of approach can help staff maintain a little distance when encountering patients, although its use can be limited to acquaintances and neighbours rather than friends and family!

If patient over-familiarity is an issue, a team discussion may help formulate an approach with which everyone is comfortable.

10 Reassure patients about confidentiality

Most practices will have considered this. The advent of the GDPR regulations influenced how practices inform patients about how their data is stored, used and accessed.

Additionally, signposting patients to the right team member forces receptionists to ask questions when a patient requests an appointment or advice.

Think of a variety of ways in which you can inform patients of the ways in which you protect their confidentiality so that however they interact with the practice, they can easily find reassurance, especially in a small community.

Above all, think about the risk areas in your practice, assess the risks, put in place a policy, and ensure that everyone’s training in the policy is recorded.

Fiona Dalziel run DL Practice Management Consultancy

Reference material

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