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AISMA Doctor Newsline

At the heart of medical finance...

Where's my money!?

Understanding the pros and cons of the different ways of distributing GPs' drawings is vital for new partners – and some older ones too. **Fiona Dalziel** guides you through the maze

NHS Digital figures show the full-time equivalent number of GPs in England dropped by 3.1% between June 2020 and June 2021 – but partnership is still an option favoured by many.

GP partners want to offer medical care long term to a defined community but partnership comes with a range of other complexities and many of these are a mystery to new partners.

One of these complexities is partnership finance and, based on my experience, this area is also a bit of a mystery to some not-so-very-new GP partners.

A regular mystery of new partnership is the calculation and payment of drawings.

Coming from a world of salaried jobs with a pay scale, all new partners want to know how much they will earn as an independent contractor and how this will be calculated. Of course, this is especially acute for those with large mortgages and young families.

Not only new partners need this understanding. Some established GPs and even some practice managers only have a hazy insight into what seems like a dark art.

Because the practice is a business, there will

always be staff and bills to be paid and a need for money to be set aside for future outlay such as tax. This means that partners always find some of their money is tied up in running the practice.

The calculation of monthly drawings needs to take this into account and practices take various approaches to this.

1 Clearing out the kitty

Some partnerships like to pay out the 'surplus' money in the bank monthly, making allowances for upcoming financial commitments.

Advantages:

- As much cash as possible is in the partner's bank account, not the practice's.
- It is a possible benefit for those with an offset mortgage where bank savings are set against the money owed.

Disadvantages:

- Drawings fluctuate monthly and this can be significant. If something unexpected happens or an anticipated expense was underestimated then there may not be much to share out in some months.
- Calculations really should consider partners' individual anticipated tax liability (if paid by the practice rather than the individual direct), superannuation payments and capital accounts. Otherwise variations may build over the year and cause the need for significant correction. This requires an in-depth understanding of practice finance and calculating partners' drawings.

2 Regular drawings and 'pay-outs'

Many practices adopt this method of managing drawings. A standardised monthly amount for each partner's drawings is identified.

This is often guided by the practice's accountants once finalised accounts for the previous year have been prepared and variables influencing drawings, such as capital accounts, tax and superannuation, have been calculated.

During the year, perhaps quarterly or bi-annually, the balance of money in the bank account available to be paid out is divided in accordance with partnership share. This cycle then repeats once new accounts are available.

Advantages:

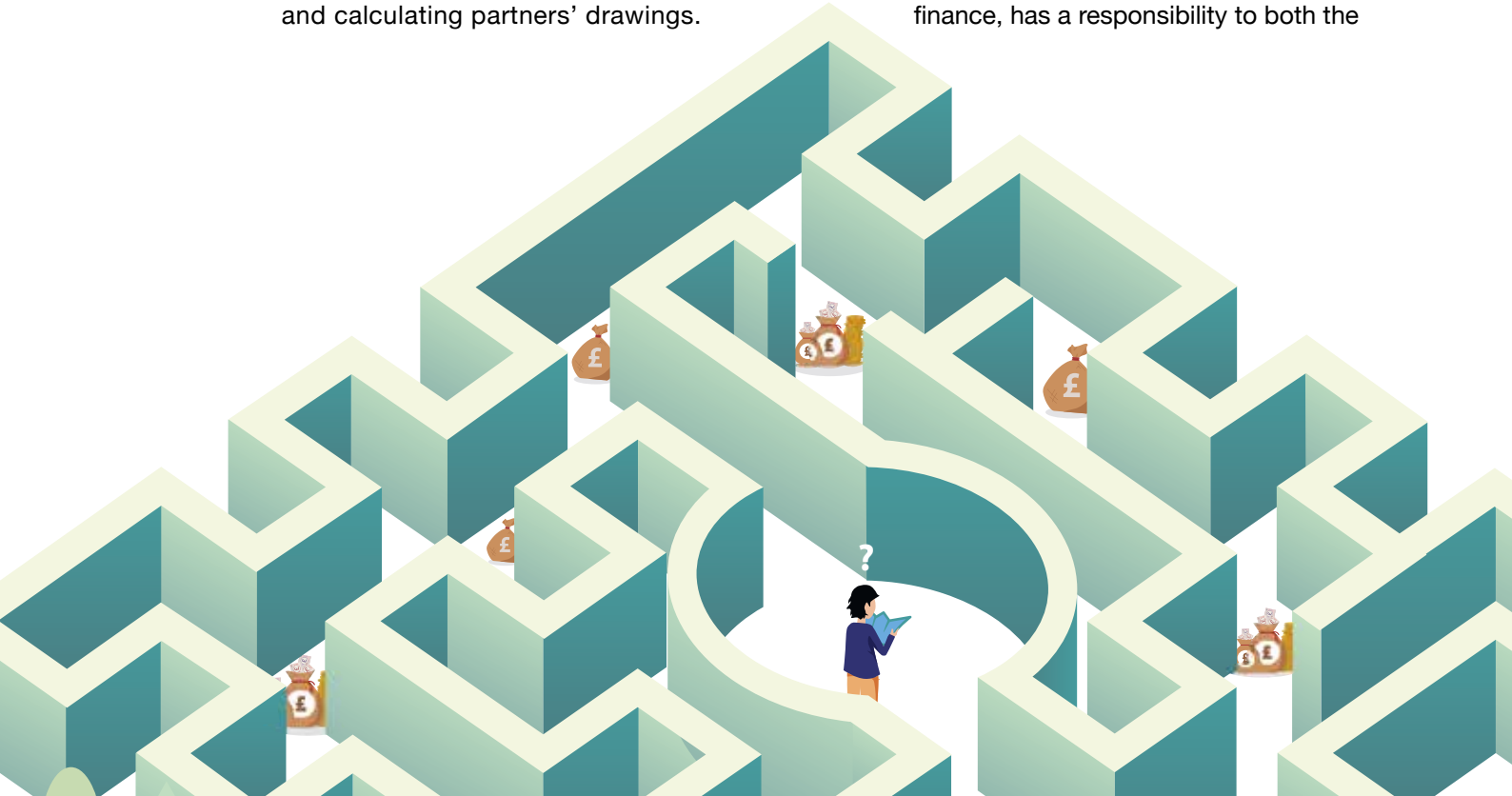
- Partners can predict how much money they will be paid each month.
- There are no monthly income fluctuations.
- Periodic pay-outs can coincide with more expensive times such as Christmas and holidays.
- The risk of significant corrections to capital accounts at the end of the year is minimised.

Disadvantages:

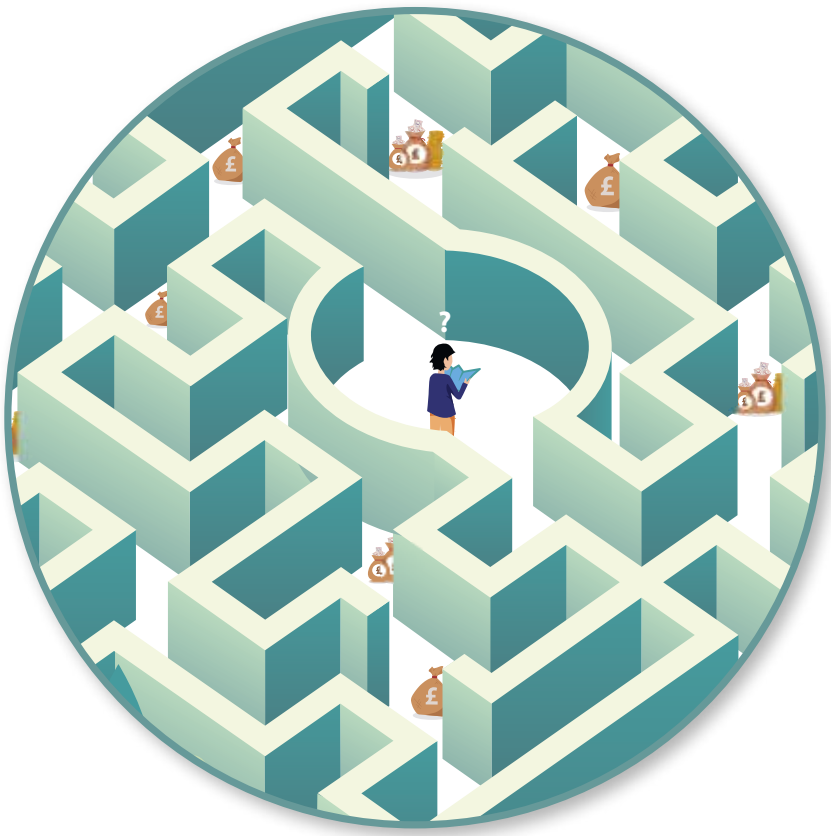
- Monthly drawings may be lower, although this evens out over the full year.
- Your money may be sitting in the practice's current account at a time when you need it.

Getting it right for everyone

Whoever manages the practice's finances on a day-to-day basis, which is often the practice manager along with a partner responsible for finance, has a responsibility to both the



"The practice's finance team should consult closely with the practice's accountants"



partners as individuals and to the practice as a business.

Whichever method the practice chooses for paying out drawings, the financial management team needs an in-depth understanding of how money comes into the practice and how it goes out.

What to take account of

Whether clearing out the kitty (calculating drawings monthly) or making planned pay-outs (calculating drawings annually), allowance must first be made for what income will be due and what expenditure must first be met.

The following all come into consideration but the list is not exhaustive and will vary from practice to practice:

Income

- Monthly contract value
- Enhanced services income
- Quarterly payments
- One-off payments (for example, flu)
- Income which is for an individual (such as golden hello or money paid to the practice bank account which is treated as personal in the partnership agreement).

Expenditure

- Staff salary costs including planned pay awards for the year and on-costs
- Partners' tax liability
- Partners' superannuation contributions
- Property costs
- Equipment

Getting informed

The practice's finance team should consult closely with the practice's accountants to ensure that, whichever method they choose to calculate drawings, their understanding of income and expenditure and partner finance is good enough. The secret is 'no surprises!'

Get familiar with:

- How and when partners pay their tax.
- When the accountants can give you that figure.
- How superannuation payments are calculated and made.
- How you can plan for superannuation balancing payments or refunds and when the certificate of superannuable profit is drawn up.
- What income comes in when, what appears automatically, what needs to be claimed and when, and the date it is due to be paid.
- In particular, get familiar with the Statement of Financial Entitlements (there are different versions for each country).

The *AISMA Guide to Becoming a GP Partner* is a good starting point and briefly covers some of the points in this article. But it is not a substitute to liaising with the accountants and developing an understanding yourself whether you are a new partner, existing one, or a practice manager.

Find out more

Ask your AISMA accountant for a copy of the *AISMA Guide to Becoming a GP Partner*

Fiona Dalziel runs DL Practice Management Consultancy

AISMA is well prepared to assist GPs in the most challenging of years ahead

OPINION **Andrew Pow,*** AISMA committee member

When AISMA members met for their annual conference this year we were treated to talks covering commissioning, practice management, tax, pensions and all matters financial for GPs.

The event highlighted more than ever the huge range of issues in general practice now as well as the diversification we are starting to see as the devolved nations approach issues differently.

Demand on general practice has been higher than ever but that is not being met with an increase in resource at practice level to deal with it.

Below inflation contract rises will leave practices struggling.

Staff recruitment and retention is no longer just a GP issue. It now covers all staff levels because the NHS has failed to match pay increments seen in other sectors of the economy.

But unlike airline companies, GPs cannot cancel services when staff numbers fall.

Primary Care Network (PCN) investment continues to increase in England but dissatisfaction with these groups is growing as they begin to deviate from the original intention. VAT is a significant risk for many PCNs.

If organisations do not get their compliance in order then there will be tax problems. Our legal colleagues at the conference pointed to other risks inherent within PCNs and we all concluded that a more robust framework is now needed.

In the background we had the Fuller report, setting out a stocktake of general practice in England. It puts PCNs and not practices at the heart of the new primary care framework as part of the new Integrated Care Systems.

The next two years will be challenging to see how general practice reacts.

In Scotland we still await development with contracts for general practice. It is a case of wait and see and in Northern Ireland too, as a continued political impasse means everything is put on hold. Arguably only Wales currently has a clearer future.

Pension issues continue to be a problem. Our conference heard from PCSE about updates to its online system - but significant frustrations remain for both practices and accountants.

A recent response by Health Minister Edward Argar in Parliament confirmed that up to 20,000 GPs currently do not have their pension records updated.

This is a problem for doctors looking to retire soon and for a substantial number of others waiting for information on their pension growth so their pension annual allowance tax charges can be assessed.

Another immediate concern also relates to the inflation impact on the pension annual allowance for GPs. The legislation as it stands was not written in the context of the sharply rising inflation we now have.

GPs who have never been impacted by this tax charge before could well get caught by it in 2022-23. AISMA drew this to the attention of HM Treasury in a letter sent on 25 May 2022. The Treasury's response, received on 4 July, did not address all the points raised by AISMA. It is disappointing that the government is failing to look at this important issue with reference to its impact on the workforce..

With significant challenges now it is important for practices to look at how they operate. We heard at the conference about how practice systems can be altered to meet demand using digital access for patients, telephone triage and changes in the standard working day to help staff work more flexibly.

We also heard from GPs and pensions experts about how doctors need to educate themselves about finance – not to replace advisors but to take control of their own position.

Dispensing claims experts revealed how to improve financial returns from drugs income while lawyers, bank and property experts demonstrated how they can help deal with the current problems of general practice.

2022 is perhaps the most challenging period ever for general practice. But AISMA accountants are well placed to assist their clients in managing the issues that lie ahead.

Find out more

https://www.aisma.org.uk/aisma-calls-treasury-take-action-avert-huge-tax-bills-thousands-gps/

Gear up for a new year end

Your financial year-end could be about to change, warns Luke Bennett. If your practice has an accounting date other than 31 March then read on to find out why and what to do**

What we know is happening and why

The Treasury has a vision for a fully digital tax system which is better able to support the emerging needs of taxpayers.

It says it wants a regime that's fair, even-handed, builds trust over time, and which works closer to real time so that people can pay the right tax with ease while they work, live their lives, and run their businesses.

Because of this it wants to simplify the rules under which profits of a business are allocated to tax years using basis periods.

Currently income tax is based on the profits earned in the accounting year that ends in the tax year. For example, profits earned in the year ended 30 June 2022 are taxed in the 2022-23 tax year.

But for the tax year 2024-25 and thereafter, income tax will be based on the profits earned in the 12 months to 31 March.

For a business with a 30 June year end this will mean taking three months of profits from one accounting year (April to June) and adding nine months of profits from the next accounting year (July to March).

2023-24 – the transitional year

2023-24 will be a transitional year where businesses move from the current system to the new one.

In the transitional year income tax will be based on the profits of:

- the 'standard part' being the 12 months from the previous accounting date, plus
- the 'transition part' being the period from the accounting date to 5 April less 'overlap relief" (*see below for explanation of overlap relief*).

However the transition part can be spread over five years.

An example:

Profit year ended 30 June 2023	£70,000
Profit year ended 30 June 2024	£80,000
Overlap relief	£45,000

2023-24 profits:	
Standard part	£70,000
Transition part £80,000 x 279 days ÷ 365 days - £45,000 (overlap relief)	= £16,151
Transition part x 20% (£16,151 x 20%)	= £3,230
Taxable profits in 2023-24: £70,000 + £3,230	= £73,230

"It is to be hoped that NHS Pensions do mirror the new HMRC rules because it would bring in yet another complication if different profit periods are used for HMRC and NHS Pension purposes"

£3,230 will be added to taxable profits in each of the next four tax years.

What is overlap relief?

Overlap relief is an historic figure of profits earned when a partner joined the practice and was used in calculating the profits earned in more than one tax year.

It is different for each taxpayer and can be found on box 14 of the partnership page of an individual's tax return.

It will be apparent from the calculation that the lower the overlap figure, the higher the amount of additional profits that will be taxed as the transition part.

Importantly, note that the new rules mean there will no longer need to be a catch-up of taxable profits when a partner leaves the practice.

Instead these new rules are accelerating the taxation of the transition profits which would otherwise have arisen in the year of retirement but is spreading them over five years.

If a taxpayer retires during the five-year period, then any remaining transition profits are taxed in the year of retirement.

Option to accelerate transition part

A taxpayer can elect to accelerate taxation of transition profits. The transition profits will then be reduced accordingly spread over the remaining years.

An example:

Transition profits of £50,000, so £10,000 profit per year (i.e. 20% per year) from 2023-24 to 2027-28	
Taxpayer elects to have additional £6,000 taxed in 2024-25:	
2023-24 taxable profits:	£10,000
2024-25 taxable profits:	£16,000
	(£10,000 + £6,000)
2025-26 taxable profits: £8,000 (£10,000 - £2,000) i.e. £6,000 ÷ 3	
2026-27 taxable profits: £8,000, same calculation as above	
2027-28 taxable profits: £8,000 ditto.	

What we are still waiting to find out?

Currently the basis period rules for determining the pensionable profit that is reported on the annual superannuation certificate match the income tax rules.

We do not yet know whether NHS Pensions will amend its rules because of the abolition of basis periods for income tax, nor if it does, whether it will also permit the five-year spreading of transition profits.

It is to be hoped that NHS Pensions do mirror the new HMRC rules because it would bring in yet another complication if different profit periods are used for HMRC and NHS Pension purposes.

What are the implications of the change?

Under the new regime, practices with non-March accounting dates are going to have to estimate profits each year. This is because the results for the period starting after the end of the accounting date until 31 March are unlikely to be available in time to meet the tax return deadline.

At the recent annual AISMA conference, attendees from member firms thought that most if not all practices will change their accounting date to 31 March.

This will avoid the need to submit estimated figures and subsequent corrections. It is also more convenient as 31 March is also the end of the NHS year.

This is going to cause logistical problems for AISMA accountants, as it means all their GP clients will have the same year end and be working to similar deadlines for annual accounts preparation and meetings.

Different firms will manage this in their own way but it may lead to more work being done on a quarterly basis to smooth the staff workflow across the year.

It will be more important than ever for practices to ensure their bookkeeping function is maintaining the records on a regular, accurate and up to date basis.

ASK AISMA!

GPs' questions about coping with a practice management crisis and inflation worries are answered here by **Abi Newbury*****

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

MANAGING WITHOUT OUR MANAGER

Q **Help! My practice manager has gone on long term sick leave and no-one else knows how to run the practice. What do we do?**

A Unfortunately, this is not a rare occurrence.

One of the initial problems in many cases is that no-one else knows how to access systems and what the log in details are. Hopefully you can speak to the practice manager to at least find out where these are kept.

Start by working out what can be covered by other practice team members. Normally a practice manager will work with other staff or partners for many parts of their role so you will be able to get a picture of what you can cover in the short term.

Income claims and paying your staff and your bills in a timely fashion should be prioritised. You need to keep your business running.

You should already have systems manuals that you need for the CQC and clinical systems. If these do not extend sufficiently to the general running of the practice, then create new manuals to cover finance, payroll, pensions and other key practice management areas.

Your accountant should be able to help with bookkeeping and payroll to free up other staff to cover practice management duties.

Depending on the expected length of absence, you may be able to appoint a temporary practice manager if there is not anyone in the current team who would be able to take it on. Often other practices in the local area may be able to spare some hours of their management team to help.

If it looks as though the practice manager will not return to work and you have to appoint a replacement then make the first job of the incoming manager to pull together a 'how we do it here' manual.

That way you know that everything has been covered, and you won't risk being in a similar situation in the future.

INFLATION INCREASES RISK OF FRAUD IN THE PRACTICE

Q **With my team and indeed partners struggling with rises in the cost of living, I want to make sure that we limit temptation. What do I need to consider?**

A Unfortunately, the risk of fraud increases when people are desperate for money – and even those who you would expect to be totally trustworthy may be tempted to 'borrow' if they need money to feed their children or heat their homes.

It is important that the partners have a good grip on the finances and know what they expect incomings and outgoings to be, and there are some 'best practice' systems that can be employed here to help minimise risk:

- Always review the payroll each month and check for unknown people or duplicates or changes in payments. If payroll is dealt with inhouse it may be harder to spot changes without asking for backing papers.

If it is dealt with outside, the provider should be able to give details of changes/overtime/joiners for you to check. It is not unknown for the staff member dealing with payroll to give themselves, or their friends, a pay-rise, or pay unapproved overtime.

- Make sure no one person can sign or approve payments in excess of your agreed limit. And ensure a partner cannot intimidate a staff member into co-signing payments or transfers that are not approved.
- For normal bills insist on seeing invoices before approving. And make sure you do not pay on both the invoice and the statement.

Check payee names carefully because it is not unknown for accounts to be set up to look like drugs/consumables on the basis that the amount will disappear within that larger expense heading and not be discovered.

- Ensure your systems for collecting cash from patients are robust and ideally use cards rather than cash wherever possible. Make sure that petty cash is regularly reconciled by someone who is not involved in making payments out of petty cash.
- Dispensing practices are more at risk so ensure prescription charges are always matched up to money received.

Regular management accounts will help you to highlight major unexpected changes. But be aware that fraud often commences with small payments that do not show up at first and then creep up over a period.

Make sure that your staff find you approachable enough to speak to you if they have really serious problems.

You may be able to assist them with budgeting, or even give them some extra hours to enable them to make ends meet. But be very wary about making loans that can cause bigger problems if staff cannot repay them.

Finally make sure practice spending is tightly controlled. If you can reduce some of your overhead costs then you may be able to use the savings for discretionary bonuses.

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The Health and Care Act 2022: what it means for primary care

Lawyer **Justin Cumberlege** digs into the Health and Care Act to consider what impact it might have on GP practices

The main thrust of the statutory provisions enacted by The Health and Care Act 2022 is a re-organisation of the top tier of the NHS.

This will impact on GP practices if the changes have the desired effect at ground level.

The most immediate change experienced by GPs is the end of CCGs on 30 June 2022 as their role is subsumed into the Integrated Care Boards (ICBs).

Although strictly the commissioning of primary care services was by NHS England, that power had been delegated to CCGs, who had increased the level of support to practices over the years since their creation under Andrew Lansley's 2012 Act.

Whether their abolition will result in that support being lost, or the personnel being kept at local level, employed by ICBs to fulfil a very similar role as before, is yet unknown.

An alternative outcome is that the abolition of CCGs will be seen as an opportunity to reduce the number of staff (as the creation of CCGs did with the demise of PCTs), with the support which GP practices often sought from CCGs being lost.

As GP practices work in PCNs there may be an expectation that they will support each other mutually. But it is probable that many practices will be left to fend for themselves and will need to seek external advice on how to manage particular situations.

At the top end, the Secretary of State will have greater powers of intervention, although during the passage of the bill through Parliament those powers were curtailed, so direct local intervention is unlikely, even if possible. NHS England remains in place and will be the usual voice and director of central government.

The creation of the Integrated Care System (ICS) is a new tier. These have been in existence on a non-statutory basis for two or three years, and their boundaries were set out in July 2021, with 42 of them covering England. These do not necessarily follow county boundaries (of which there are 48).

The ICS will comprise two parts: the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP). NHS England is required under the Act to establish the ICB.

It will be formed of a chair appointed by NHS England, with the approval of the Secretary of State, and a board comprising one representative from NHS Trusts, one representative of the local authorities within the ICB and one representative for primary care, of a 'prescribed description', who could be a GP, but not necessarily.

The ICB will hold the budget for its area and will commission services and ensure that the providers perform. It will be answerable to NHS England. Therefore, the ICB is going to be the most powerful body for each area.

GPs will need to ensure that they are able to influence its decision making to give primary care the investment it requires to have an impact on the health of patients through early intervention and preventative health and personal health management.

Having someone who does command the trust of all the GPs as the primary care representative could be essential for the development of services provided by practices.

The ICB and the local authorities are required to establish the ICP for its area, and will consist of one member of the ICB, one member from each local authority and other members appointed by the ICP.

It has been suggested that the other members

will come from a large array of organisations and groups involved in health and social care, including GPs, dentists, and opticians, and also charities, directors of children's and adult services, ambulance trusts, social prescribing services, Jobcentre Plus – the list is extremely extensive, and could easily involve 50 people.

The ICP's role is to set out the strategy for its area and 'how assessed needs in relation to its area are to be met by the exercise of functions of (a) [the ICB] and (b) NHS England or (c) the responsible local authorities'.

It is required to involve the Local Healthwatch organisations and 'the people who live or work in [the ICP area]'.

The local authorities and the ICB 'must, in exercising any functions, have regard to … so far as relevant .. an integrated care strategy prepared [by the ICP]'.

"For GPs who wish to maintain their independent contractor status and see primary care thrive, influencing the decision making at both levels and participating in the ICP will be essential"

The statutory powers and obligations only take the ICSs so far. Underlying that is a policy that organisations will collaborate at 'Place' level and 'neighbourhoods' with teams of service providers working together.

Neither areas are clearly defined to allow for local determination, but 'Place' is considered to be where people identify they live – such as a town or district and would probably be a population of 250,000 – 500,000, while a neighbourhood is probably up to 100,000. In primary care terms you may consider that GP federations cover a 'Place' and PCNs a neighbourhood.

The ICP should set the tone for collaboration and integration and may provide a forum for working closely with various organisations to have a real impact.

The fact that the Act sets out a statutory framework for the top of the NHS, and not at local level, provides an opportunity for each area locally to decide what is important for it, and what it needs to focus on.

This should then feedback to the ICB, so that it allocates the resources and commissions the services that the locality wants to deliver.

Breaking down the barriers to create collaboration, as opposed to competition, in the delivery of services is a reform of public procurement rules, which could mean the end of competitive tendering.

This could help PCNs and GP federations in obtaining contracts to deliver services, or it may lead to a perceived less risk averse decision, of awarding contracts to NHS bodies.

Alternatively, detractors speculate that it will open the door wider for private providers to become more dominant in the provision of NHS services.

Premises create physical barriers, and it is noted that ICBs can own property. In a less competitive, integrated world, it may be that ICBs will want to develop premises for that purpose, allowing different providers to occupy space at different times, depending on demand, even on different days.

'Hot desking' is common in offices, and may be explored for consulting rooms, allowing for greater flexibility and use of NHS funded premises.

While the policy of collaboration and integration suggests a horizontal integration, with PCNs, Community Trusts, and the voluntary sector working together in the community, the potential influence of NHS Trusts on ICBs could lead to vertical integration, with GPs becoming - as suggested by the Secretary of State - employees of the NHS.

Policy is intended to allow for flexibility at neighbourhood and at 'Place' level. For GPs who wish to maintain their independent contractor status and see primary care thrive, influencing the decision making at both levels and participating in the ICP will be essential.

If possible they should ensure the presence of a noted champion of primary care on the ICB.

Justin Cumberlege is primary healthcare specialist and partner at Hempsons. For more information contact 020 7484 7575 or email him at j.cumberlege@hempsons.co.uk