Healthcare Newsletter

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Welcome to the summer edition of the BHP Healthcare Newsletter.

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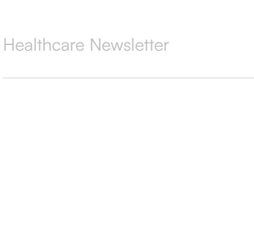

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In recent months I have presented two webinars on Primary Care Network (PCN) limited companies, both of which have generated a large amount of interest. In this article, I summarise some of the main reasons that many PCNs are now considering this alternative business model.

VAT on staff costs
The potential for irrecoverable VAT on PCN staff costs is always at the forefront of my mind when talking to my GP practice clients. Where staff are employed by one practice and shared across the network, this normally attracts 20% VAT, subject to the VAT registration threshold of £85,000 for each practice. Despite the VAT exemption for healthcare services, this applies for both administration and medical staff.

Setting up a limited company, which employs the PCN staff, allows the PCN members to benefit from a VAT exemption by operating as a Cost Sharing Group. As you may expect, this is subject to certain conditions, which are set out in legislation.

Risk
PCN member practices should be joint and severally liable for network matters. However, many practices, particularly those operating as a lead practice and employing many of the network staff, worry about being left to pick up the bill for potential redundancy costs in the future. Operating as a limited company, a separate legal entity, means that any liabilities, including redundancy costs, would be met by the company, and limited to the funds held by the company.

Taxation
Generally, member practices include the PCN surplus in their own practice accounts resulting in the GP partners paying tax on this, usually at 40% plus another 3.25% of National Insurance. This applies regardless of whether the surplus funds are actually paid out to individual practices. It is often the case that funds are retained by the network to be spent in subsequent periods. A limited company brings the possibility of retaining funds within the company at lower tax rates, currently 19%.

A limited company brings the possibility of retaining funds at lower tax rates.

Are there any downsides to having a PCN limited company?

1. TUPE
When network staff are transferred to the company, TUPE, Transfer of Undertakings (Protection of Employment) rules apply. This means that they must be transferred on the same terms and conditions which apply currently, although this can be addressed over time, if required.

2. Temporary NHS pension access for staff
Staff employed by the PCN limited company will be afforded temporary access to the NHS Pension scheme via the Direction/ Determination route at least until 31 March 2023. The intention is for this access to become permanent, but it has not yet been written into NHS legislation, so this is currently a matter of uncertainty.

3. CQC registration
CQC registration may be required if the company takes on NHS contracts or if the PCN DES is subcontracted to the company.

4. Set-up and running costs
There will be additional legal and professional costs in both the set-up and running of a company including ensuring that the conditions for a Cost Sharing Group are met.

In summary, many of the financial and regulatory issues that PCNs face are aggravated by lack of a separate legal entity. However, the use of existing federations may be sufficient in some cases.

Whilst there will be factors which are common to most PCNs, every situation is different, and so each organisation should take its own advice. This article is intended to give a general overview of some of the factors involved.

If you would like to discuss whether a limited company is appropriate for your PCN, please contact Jenny Hurst or your usual BHP contact.

Partnership agreements

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A good partnership agreement should set out the obligations, responsibilities and restrictions of partners.

If no agreement is in place, then the practice is governed by the Partnership Act 1890 (partnership at will) however as the name suggests this is outdated and does not cover all the necessary aspects for a healthcare partnership.

Partnership Act 1890
Potential Problems with the Act include:

- any partner can serve notice to end the partnership at any time
- no probation period
- no specific shares of profits, losses and capital
- no effective limits on the authority of a partner to enter into arrangements which bind the partnership
- no protection for assets held by the partners individually
- no assistance in identifying how assets are to be valued and paid if a partner leaves
- no protection if there is automatic dissolution of the partnership, such as if a partner goes bankrupt
- no partner can be expelled from the partnership by other partners, for any reason
- a partner can't retire without bringing the partnership to an end
- no cover for leave and locum costs
- not much direction in terms of restrictions and duties.

Potential Problems
The absence of a partnership agreement can escalate disputes and disagreements (which can arise for any number of reasons), cause misunderstandings and often result in the need for further legal advice and costly professional fees.

Partner Changes
In the event of partnership change, either a retirement or the admission of a new partner, the agreement should be the starting point for agreeing timeframes, payment dates and the position with properties.

Decision Making
There are varying degrees of seniority within a GP partnership and the agreement can not only assist with decision making but indicates which of the partners has the authority to make the decisions. It is essential that the decision-making process is clearly outlined. In larger practices these are often made by a management board rather than across the entire partner group.

Surgery Premises Changes
Changes to the ownership of surgery premises are probably the most frequent cause of dispute that we see. The outgoing partner may want the best price for their share while the incoming partner would benefit from a lower price and a subsequent reduction in their borrowing costs. The procedure for obtaining the premises valuation should be detailed in the agreement, referring to the number, basis and timing of the valuations. In the event that there is a dispute on the valuation, the agreement should also cover how this is to be resolved. If these details are omitted, it could lead to delays in transferring the ownership and having to re-negotiate borrowing arrangements with lenders.
The document should also cover what happens in the event of the on-going partners being unable to buy the outgoing partners share. In the case of out-going partners remaining as property owners consideration also needs to be given as to whether a separate property document is required for the purpose of establishing who is responsible for which costs in relation to the premises. We have seen several instances of disputes over who will meet repair costs.

Profit Shares
The agreement should also outline respective profit-sharing agreements and first shares / charges against profit. Not only does this minimise queries and disagreements but should also assist with the timely completion of the accounts at the year end. This has become ever more important as income streams are continuously changing and GPs are becoming more involved with projects and roles outside of their clinical sessions.

New To Partnership Payment and Final Pay Controls
Clauses should be included within the agreement to cover the clawback of any New To Partnership monies (which are potentially repayable if a new partner leaves) and who will stand the costs of any Final Pay Control charges (which can be levied to a practice after the member of staff has left and when there may have been change in partners).

Personal Expenses
It is necessary to define those expenses that are to be paid by the practice and those that are to be paid personally. This enables all partners to be clear on the costs that they need to budget for personally whether this is tax payments or medical subscriptions.

Partner Absence
Partners are not employees of the practice so it is key that everyone is aware of their entitlement to any leave from the business whether it be holiday, parental leave, sickness absence or study leave as this will vary from practice to practice. In some instances, partners may also be entitled to take a sabbatical and the agreement should set out who is responsible for meeting the costs of the cover. In the event of long-term absence from the practice, whether this is planned or not, any changes to profit sharing agreements and the responsibility of which party will meet the costs should be set out. This should help to manage workloads and cashflow and minimise disruption to the practice.

Partnership agreements should be viewed as an investment in the future and we would always advise GPs to ensure that their agreement is up to date and to use a solicitor who has specialist medical knowledge. If you would like assistance with this, please speak to Claire Heathershaw or your usual BHP contact.

The absence of a partnership agreement can escalate disputes and disagreements.

IR35 - Are you affected?

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With recent high profile tax cases, as well as the changes to the IR35 legislation that came into effect in April 2021 still making the news, it is probably a good time to recap on when IR35 applies, and what the obligations are when it does.

IR35 is an extension of the long-standing employment status issue, which centres around whether a worker is an employee or self-employed. Even when IR35 doesn't apply, this is still an important point to get right, and with the recent increases to National Insurance, it is likely to take even more centre stage. National Insurance rates are lower for the self employed and employers' contributions don't apply, so if it is determined that an employee has incorrectly been treated as self employed, significant liabilities can arise. These would usually be the obligation of the contractor, or employer.

The best way to determine whether the worker is an employee or self employed is by completing HMRC's CEST questionnaire (Check of Employment Status for Tax) https://www.gov.uk/guidance/check-employment-status-for-tax
This tool is also very important for IR35.

IR35 is also known as "Off-Payroll Working" or "Intermediaries" legislation and was originally introduced many years ago to combat the growing use of Personal Service Companies (PSCs) to get around the employed v self employed question. So for IR35 to apply, there has to be an intermediary - this is often a PSC, but could also be an agency.

The change that came in from April 2021, whilst making the news, didn't really affect those operating within the public sector. It just extended to the private sector a change that was introduced for the public sector a number of years ago. This shifts the obligation for determining whether IR35 applies from the PSC to the contractor. The difference is that "small" private sector contractors are exempt, but it's important to remember that this exemption does not apply to the public sector.

So what are your IR35 obligations if hiring a worker through an intermediary such as a PSC?

Firstly you must determine whether the worker would be an employee if you had contracted with them directly. The best way of doing this is by completing HMRC's CEST questionnaire as referred to above and keeping this on file. If, when answered factually, this gives a verdict of "self employed" this is the best defence against any future IR35 challenge from HMRC.
The worker then needs to be issued with a Status Determination Statement stating the conclusion.
If the conclusion is "self employed", then payments to the PSC can be paid gross on receipt of the invoices as normal. If however the conclusion is "employee", PAYE tax and National Insurance must be applied to the payments made to the PSC.

IR35 is a complex issue and specific advice should be taken if there is any uncertainty.

Read more from Kirsty Swinburn

Basis Period Reform

Tax change on the way

If your practice has an accounting year end other than 31 March or 5 April, the Government has announced changes which will significantly affect how you are taxed on your partnership profit.

Whilst it is being flagged as a simplification, and in many ways it is, it could lead to an acceleration of tax liabilities, with some facing higher than expected tax bills in January 2025.

Currently, you are taxed based on the profits for the accounts year ending in the tax year — so if your practice has a 30 June year end, your 2021/22 tax will be based on the 30 June 2021 accounts.

From 2024/25, all sole traders and partners will be taxed based on the results for the tax year, with an apportionment needing to be made where accounts continue to be prepared with anything other than a 31 March or 5 April accounting year end.

The 2023/24 tax year will be the transition and the transitional adjustments may, depending on profit levels, increase the tax liability for that year. Using the 30 June year end as an example, in 2023/24 you would be taxed on the profits for the year ending 30 June 2023 plus profits for the period 1 July 2023 to 5 April 2024 less the "overlap relief" that you will be carrying forward. The "overlap relief" will generally have been created when you started up or joined the practice so, if that was some time ago, the value is likely to have been eroded over time.

There will be a five-year spread if these adjustments result in additional tax that would otherwise be payable 31 January 2025 but there is still the potential that the adjustments may push profits into a higher tax band, or cause a loss of the personal allowance.

The changes are being driven by the switch to Making Tax Digital for Income Tax, which comes in from April 2024, with a year's delay for partnerships.

If you are affected, your usual contact at BHP will be getting in touch with you to discuss the impact of these changes but if you have any concerns in the meantime, please contact us.

Meet the Team: Harry White

Harry White
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When did you join BHP?
I joined BHP in September 2013 after completing my A levels.

What attracted you to BHP?
I applied to BHP after talking with my A level accountancy teacher, as he had worked in practice and knew people who had previously worked at BHP. He assured me that the BHP apprenticeship programme would allow me to gain a lot of experience with clients in different industries as well as receiving a lot of support while studying for my ACCA qualification.

What is your role and what does a typical day look like for you?
My current role is Assistant Manager within the Healthcare department where I manage my own portfolio of clients, including GP practices, dental practices, limited companies, dental associates and GP locums. We offer our clients a wide range of services such as producing accounts and tax returns, pension work and drawings and cashflow calculations.

My typical day can vary quite a lot. I have clients with different year ends so working to meeting dates is frequent throughout the year as well as working towards limited company accounts, tax return and pension deadlines.

What do you like best about working at BHP?
I have been in the Healthcare department for almost nine years now and I have made a lot of friends who I work with on a day-to-day basis at BHP.

How has BHP helped you in your career so far?
Since joining BHP, I first gained my AAT level 4 qualification before moving onto complete my ACCA qualification. I would not have been able to complete these qualifications without the support that BHP has given me over the years. Having worked at BHP throughout my studying I already have a lot of experience as well as existing relationships with many clients, which has led to me being able to manage my portfolio effectively.

What are your highlights and key achievements?
My highlight so far would definitely be completing my ACCA qualification. It was a huge relief when I got my final exam result to think that I didn't have to do any more exams.

What do you enjoy doing when you are not at work?
When I am not working, I like to play sport. In the summer I play golf when I have time as well as cricket on Saturdays where I have also been roped into being the club treasurer! In the winter, I enjoy following Sheffield United home and away, however, I must admit it's not always very enjoyable!

What is your favourite type of cuisine and why?
My favourite cuisine would definitely be Italian. I love both pasta and pizza as well as Italian gelato desserts. I have also been known to enjoy an Italian lager from time to time.

What is the best place you have travelled to and why?
I recently travelled to Rome with my girlfriend and it is one of the best places I have been. The food and drink were really good in every restaurant we visited. I also enjoyed all the sights around the city and I will definitely be going back.

I also try to visit Dublin every April to watch the horse racing at the Punchestown Festival with a group of friends. We did miss two years due to covid but visiting again a few months ago made me realise that it is a great event to attend, and Dublin before and after the races is always full of life with live music.

If you weren't an accountant, what would your dream job be?
If I wasn't an accountant, I think I would like to be involved with sport in some way. If I couldn't play, then I think I would like to be a journalist following the England cricket team or covering the golf tournaments around the world.

NHS Pension Scheme

Not just a pension

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The NHS Pension is a type of Defined Benefit (DB) Scheme (more commonly known as a Final Salary/ Career Average Revalued Earnings Scheme). Historically, these were the standard pension offering for most employers, however, as people continue to live longer in retirement, many private sector employers no longer offer favourable DB Pensions and have now switched to offer Defined Contribution Pensions (a pension pot if you will).

Therefore, there is no doubt that the **key** benefit for active members of the NHS Pension Scheme is the ability to accrue a guaranteed known income in retirement that most within the private sector cannot access. However, pension accrual is not the only perk — it would sometimes be better to label the NHS Pension as a "package" rather than a scheme due to the multiple benefits members have access to.

Below, I have summarised two of these benefits which form a valuable part of your financial planning, including how these benefits differ depending on pensionable membership, i.e. an active member (making active contributions to the scheme) or a deferred member (opted out of the pension scheme).

Lump Sum on Death
The scheme allows you to nominate one or more people, or alternatively, one organisation to receive a cash lump sum on the member's death. The table below highlights the amount payable from the various NHS Pension Sections and compares the difference that membership has on the lump sum amount.

Lump Sum on Death

	Death in membership (Active)	Death of a Deferred Member (Opted Out)
1995 Section	2 x annual pensionable pay or average uprated earnings for practitioners	3 x pension payable if the member had retired on the date of death
2008 Section	2 x annual pensionable pay or average uprated earnings for practitioners	2.25 x annual pension the member would have received had they retired on the date of death assuming they did not take a lump sum
2015 Section	The higher of: 2 x the relevant earnings in the last 12 months of pensionable service or 2 x the revalued pensionable earnings for the Scheme year, up to 10 years earlier, with the highest revalued pensionable earnings	2.025 x the annual pension the member would have received had they retired on the date of death

It is worth noting that the lump sum payable is likely to be noticeably lower for a deferred member than an active member of the NHS Pension Scheme. The lump sum can be invaluable in supporting loved ones and it may help to support paying off debts such as mortgages or even supplement a partner's income to meet future expenditure. Therefore, **it is important that members ensure they have nominated their chosen beneficiary by completing the lump sum on death benefit nomination form (DB2).**

Ill Health Retirement
Everyone should consider the impact if they were unable to work due to ill health. What would happen to your income, and would you be able to support your lifestyle? Cover can be obtained through income protection policies to provide a tax-free income if such an event were to occur, however, NHS Pension members who have at least two years' membership also have access to early ill health retirement benefits.

The benefit is based upon two tiers, which vary depending upon the impact that illness has on the members ability to work:

Lump Sum on Death

	Definition/Qualification	Entitlement/Benefit
Tier 1	Unable to do current job due to permanent ill health.	NHS Pension membership already built up without reduction. No enhancement to benefits.
Tier 2	Unable to carry out regular employment of like duration to NHS employment up to your normal pension age due to permanent ill health.	Tier 1 benefits, plus an enhancement of your prospective membership to normal pension age.

Active members may apply for Tier 1 and 2 benefits subject to qualification. However, if you are a deferred member and you become too ill to undertake regular employment, you may apply to take your pension early without reduction, but your benefits will not be enhanced.

Whilst both benefits provide some security for members and highlight that the NHS Pension is not just a pension scheme, further policies may still be required to ensure that sufficient financial protection is in place.

The above information was obtained through NHS Pension Guides which can be accessed via the following links:

https://www.nhsbsa.nhs.uk/sites/default/files/2021-07/1995-2008%20Members%20Guide%20%28V23%29%2007.2021.pdf

https://www.nhsbsa.nhs.uk/sites/default/files/2015%20Members%20Guide%20%28V11%29%2007.2021.pdf

The deadline for applications to N2PP has been extended to March 2023.

New to Partnership Funding Update

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The New To Partnership Payment Scheme (N2PP) began to accept applicants from 1 July 2020 with those who accepted a first time partnership role on or after 1 April 2020 being eligible to apply. It was originally anticipated that the scheme would run until March 2022, however this deadline has now been extended to March 2023.

The requirement to apply within six months of joining a partnership has also been removed; this means that all eligible new partners who commenced in a partnership on or after 1 April 2020 are able to submit their applications to the scheme retrospectively if they have not already done so.

As a reminder, the N2PP consists of two elements:

- A grant of up to £20,000 to support establishment as a new partner, plus a contribution of £4,000 towards on costs (intended to cover tax and national insurance)
- Up to £3,000 of business training allowances to support early partnership skills development

The scheme is open to healthcare professionals with the following roles - General Practitioners, Nurses (including ANPs), Pharmacists, Pharmacy Technicians, Physiotherapists, Paramedics, Midwives, Dietitians, Podiatrists, Occupational Therapists, Mental Health Practitioners and Physician Associates.

For the funding, full time equivalent is considered to be nine sessions.

Further information regarding the scheme and the eligibility requirements can be found at:

NHS England » New to Partnership Payment Scheme

The Health and Care Act 2022

What now for primary care?

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The Health and Care Bill received Royal Assent on 28 April and is now The Health and Care Act 2022. In this article, Ross Clark explores what has changed since the Bill was first published and what the future holds for primary care in this new landscape.

What has changed?
The Health and Care Bill received Royal Assent on 28 April and is now The Health and Care Act 2022.

The new structure remains broadly unchanged, with Integrated Care Boards ("ICBs") replacing CCGs and commissioning services across the whole Integrated Care System ("ICS"), assisted by Integrated Care Partnerships ("ICPs") advising at a strategic level. The focus remains on integration between providers of health and social care services, but the "go live" date for ICBs was pushed back (it was originally 1 April) and will now take effect from 1 July 2022.

One important change has been the introduction of measures to tackle the Covid backlog and rebuild services badly damaged by the pandemic. These are to be funded by the injection of £36 billion over the next three years, raised from the Health and Care Levy (a 1.25% increase in National Insurance contributions which commenced in April).

However, despite the efforts of the House of Lords to amend the Bill, there has been a lack of progress on workforce planning, one of the most significant factors currently affecting the NHS, where there are currently circa 110,000 staff vacancies. Chris Hopson (Chief Executive of NHS Providers), cited this as "the major, missed opportunity to introduce a statutory duty to ensure proper long term workforce planning in the NHS".

It's all about integration
However, whilst the structure will be in place for 1 July, the real underlying challenge is the integration that is required to deliver on the objectives of the new system. This can be considered within the three distinct levels of the ICS:

- System (whole of ICS): at this level the focus is likely to be on horizontal integration between NHS Trusts to form pan-ICS hospital trusts or at least to integrate service provision.
- Place (likely to be co-terminus with local authority boundaries): this is where vertical integration is likely to occur, with place-based provider collaboratives agreeing how NHS Trusts (ie hospital care) can integrate with the delivery of primary care, mental health, community nursing, social care and the services offered by charity and third sector organisations.
- Neighbourhoods (co-terminus with PCN areas): this is likely to be the area that is the "engine room" for the delivery of integrated care to patients and will also see a need for horizontal integration between primary care and the other community based providers of health, social and support services.

This is not going to be easy. As GPs have found when seeking to merge or where they have come together within PCNs it takes time to build trust and confidence when working together, and this is the cornerstone of good and productive integrated working. Trying to expand the success of PCNs into a wider collaboration with a much broader and more diverse range of providers is a real challenge. And the pressures from the pandemic and the workforce crisis only exacerbate the difficulties of successful integration at Neighbourhood level.

What now for General Practice?
However, leaving aside the pressures from the pandemic, the issues surrounding the employment of ARRS staff within a PCN company and the possibility that DES funding will disappear into the general ICS budget at the end of the current five- year contract framework in 2024, there are other forces at work on General Practice.

The 2022 publication by Policy Exchange "At Your Service", with a forward by the Secretary of State for Health, gives an insight into the possible direction for General Practice. In looking at the role of General Practice in the future, this publication proposes:

- "reform is required to ensure it thrives in the future. The current model is neither adequately staffed, nor optimally planned"
- "reform to the underlying model of general practice should not be regarded as a distraction (from the workforce crisis).... elements of the partnership model and how it is reimbursed contribute to the current challenges"
- "This report calls for a model predicated upon 'layers of scale'. The objective is to ensure that the agglomerated benefits of scale... are realised."
- "To achieve this, we envisage the phase-out of the small-scale independent contractor model across much of general practice."
- "This ... should be regarded as a ten-year transition, with ... alternative contracting models introduced and running in parallel to the 2024/25 five-year framework. "
- "Under this arrangement we expect to see an increasing number of GPs salaried or employed by scaled providers."

In particular, the suggestion of GPs employed by "scaled providers" suggests the vertical integration of General Practice within NHS Trusts, unless General Practice can build its own at scale models.

In his forward, Sajid Javid cites "the potential of the NHS working 'as one'", claims there is "an exciting future for primary care" and concludes "this report offers some credible ideas and insights...I welcome the report as a pragmatic contribution to this vital debate on the future of the NHS."

So, the direction favoured by the centre seems to be clear and, at present, there seems to be little in the way of a unified national voice representing General Practice against these proposals. They are only proposals and are not inevitable but the structure of the ICSs under the Health and Care Act 2022 does seem to provide a framework for this to take shape.

Ross Clark is a partner in the primary care team at Hempsons. He advises GP practices, provider companies and primary care networks on partnership and company law issues, NHS contracting, collaboration and governance arrangements. Hempsons is a leading health and social care law firm ranked as one of the best specialist law firms in England and Wales in 2020.

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

The new healthcare landscape 2022

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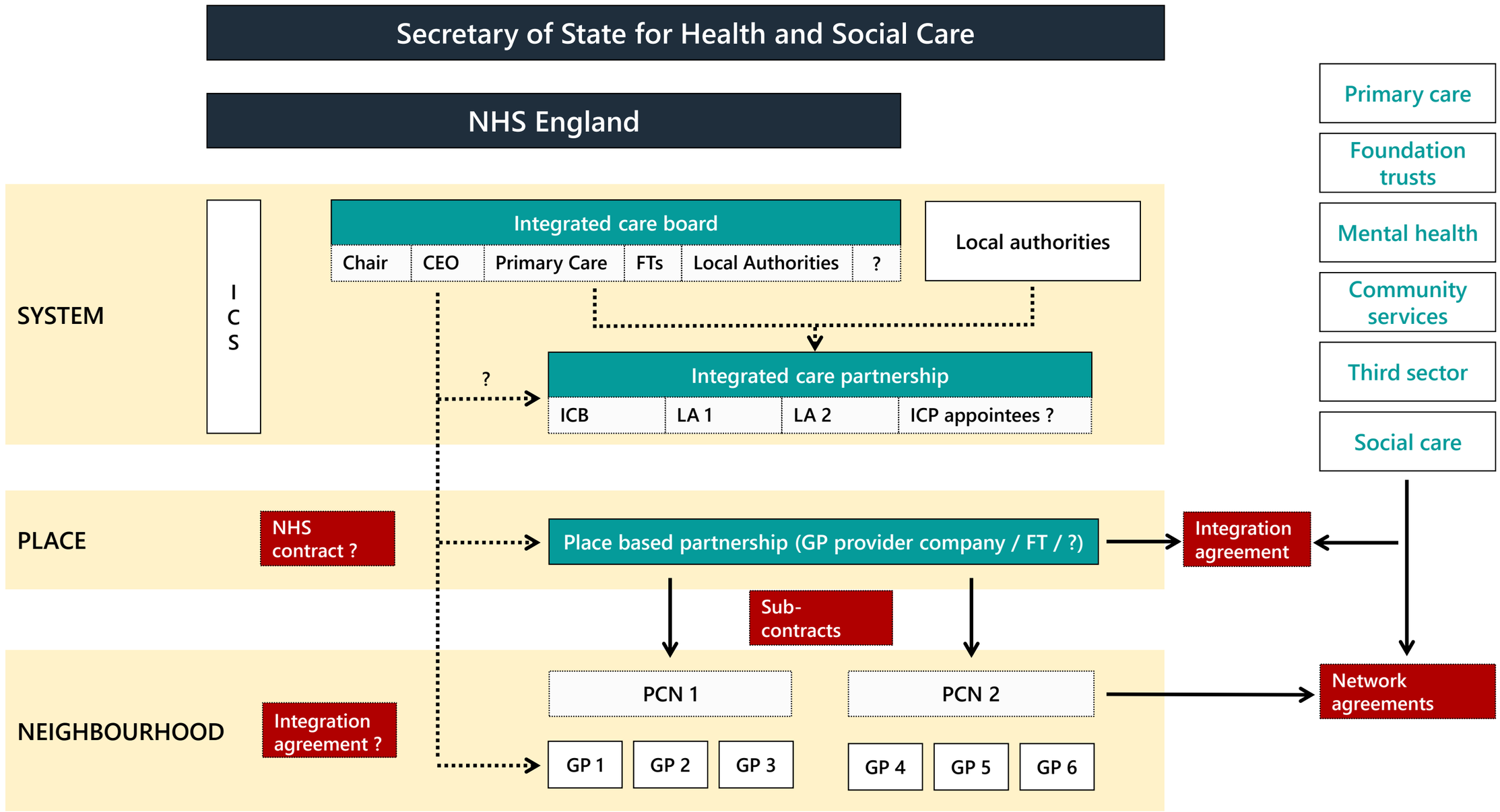

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