aisma
association of independent specialist medical accountants

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AISMA Doctor Newsline

At the heart of medical finance...

Ouch! It's going to feel more than 'a little scratch'

Big financial changes are on the way this year for GPs. **Luke Bennett*** gives a round-up of where Chancellor Jeremy Hunt's prescription will hit you most - and spells out some important implications

Taxes up for high earners

The higher 45% tax rate from 6 April 2023 will start at £125,140 rather than the current £150,000. The reason for the very precise figure is because this is the point at which the personal allowance is fully withdrawn.

Total tax payable for someone earning £150,000 will increase by £1,243 and the average tax rate increases from 35.0% to 35.8%, as shown in the table (page 2).

Where practices pay the tax on behalf of their partners then, the higher tax charge may result in a need to reduce drawings.

Heftier annual allowance charges

The reduction in the additional rate threshold will also make it more likely that annual allowance charges will be taxable at 45% rather than 40%.

It is GPs with income in the region

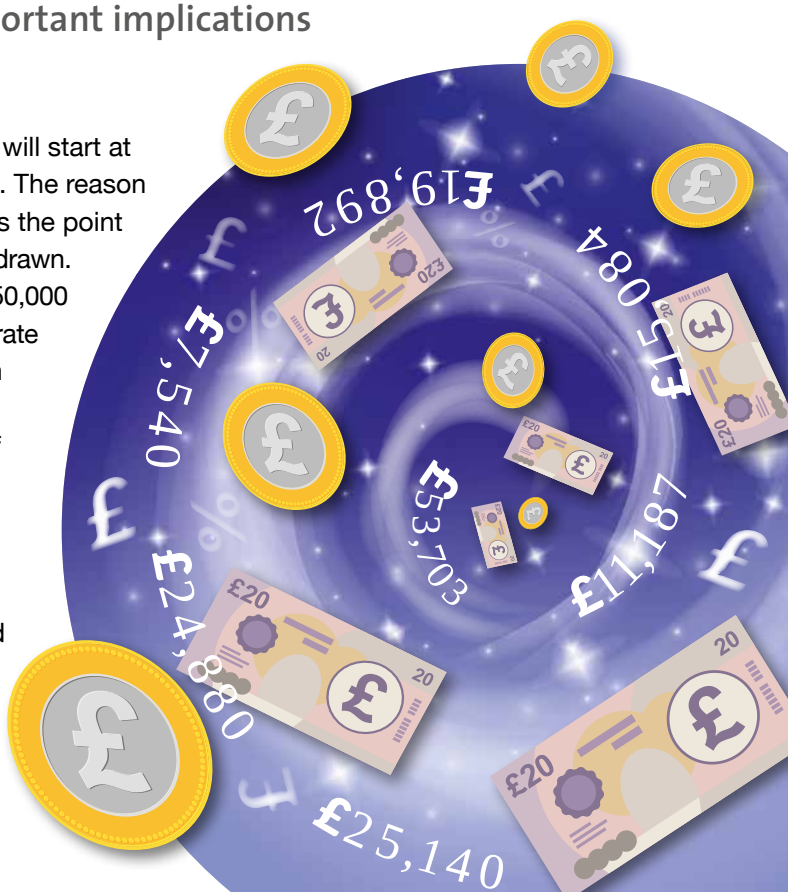


TABLE 1

2022/23 tax bands				2023/24 tax bands			
Band of income	Cumulative income	Tax rate for band	Tax paid on band	Band of income	Cumulative income	Tax rate for band	Tax paid on band
£12,570	£12,570	0.0%	—	£12,570	£12,570	0.0%	—
£37,700	£50,270	20.0%	£7,540	£37,700	£50,270	20.0%	£7,540
£49,730	£100,000	40.0%	£19,892	£49,730	£100,000	40.0%	£19,892
£25,140	£125,140	60.0%	£15,084	£25,140	£125,140	60.0%	£15,084
£24,860	£150,000	40.0%	£9,944	£24,860	£150,000	45.0%	£11,187
£150,000		35.0%	£52,480	£150,000		35.8%	£53,703

of £125k to £150k that are very often incurring annual allowance charges.

Capital gains tax increases

The capital gains tax exemption is reducing from £12,300 to £6,000 in 2023-24 and to £3,000 in 2024-25.

Capital gains tax rates vary between 10% and 28% so the maximum increase in capital gains tax payable in any one year is £2,604*. Partners often make small gains when property sharing ratios change, for example when a new partner joins.

But the lower exemption will make it more likely that computations will be required to calculate and report capital gains tax liabilities.

Tax-free allowances dropped

The tax-free allowance for dividend income is reducing from £2,000 to £1,000 in 2023-24 and to £500 in 2024-25.

This further eats away at the tax advantages of routing private income through a limited company.

Pensions delayed?

A review of the state pension age is going to be published in early 2023. The normal retirement age in the 2015 NHS Pension Scheme is linked to the state pension age, so if this is pushed back it will mean GPs will have to wait longer to draw their 2015 Scheme benefits.

Alternatively there will be a larger reduction in benefits if they are drawn before the normal retirement age.

Inflationary issues

Inflation is predicted to average 7.4% in 2023, although it is the rate at September 2023 that is used for uplifting NHS Pension benefits.

A graph issued by the Office for Budget Responsibility suggests inflation is predicted to be around 6% in September 2023. The reduction in the inflation rate will mean lower annual allowance tax charges in 2023-24.

And what wasn't announced...

Developments were expected on some topics but nothing was forthcoming.

- The most important was any announcement on the calculation of annual allowance tax charges for 2022-23.

Therese Coffey, the short-lived Secretary of State for Health and Social Care, announced on 22 September 2022 in the policy paper *'Our plan for patients'* that: *'We will incentivise our most experienced GPs to stay in practice by correcting pension rules regarding inflation.'*

Despite some months having passed since this announcement was made, as I write this no further information has been provided on what this means or how it will be implemented.

So that makes it impossible for GPs to know what action if any is necessary to mitigate the high anticipated annual allowance charges for 2022-23.

- The lifetime allowance has been fixed at £1,073,100 since 6 April 2021 and is to stay at that level until 5 April 2026. There had been suggestions that this would stay at that level even longer, but the absence of any announcement on this point means that it should increase in line with inflation from 6 April 2026.

STOP PRESS!

A consultation proposing changes to NHS Pension Scheme rules will close on 30 January 2023. If implemented these changes will reduce 2022/23 annual allowance charges.

*The maximum rate of CGT is 28% so the maximum additional CGT is £2,604 (£12,300 less £3,000) x 28%.

Changes too fast to reap success

OPINION

Jim Duggan**
AISMA committee member

The world is constantly evolving and changing and if we do not adapt and alter with it we will fast become outdated, ineffectual and confined to the history books, whether written or not.

This was never more apparent than over the past two years when the Covid-19 pandemic forced us to adapt and change to a new reality, which thankfully we did.

We also saw the power of collaboration when researchers worldwide worked together tirelessly to produce, in record time, vaccines that were distributed and ensured we could return to near normality within timescales far beyond our expectations.

But not all change needs to or should be swift and reactive. How we implement change should be mindful of what we are changing and must be planned and implemented accordingly.

You will all be aware of the need to combat climate change and how governments are putting in place measures to make sure the world's goals are to be achieved.

It is therefore frustrating to see that many changes implemented in the NHS over the last 17 years have brought little benefit other than political capital.

In 2004-05 a new GP contract was introduced. But before the ink was long dried we began to see wholesale changes due to bad planning and an obvious lack of understanding of the work GPs do daily or the human psychology when it comes to target achievement.

At the same time changes to the NHS pension, coupled with a lack of communication between government departments, meant the administration of the pension scheme and the taxation of a GP's income has become more complicated and more costly.

This position has not been enhanced by the introduction of tapering. Designed to combat large company contributions, this ill-thought solution has seen many medical professionals experience unexpectedly high tax liabilities.

More recently, the delays seen in England with the processing of pension returns and the inevitable difficulties in obtaining up-to-date pension information have created an uncertainty that is undermining confidence in the system.

These decisions, along with a concerted campaign conducted in the press, have created such disillusionment within the medical profession that we have seen the NHS drained of resources because of early retirements and fewer considering medicine an attractive career.

So here we are now with a severely depleted workforce dealing with an increasing demand as well as the backlog resulting from Covid-19.

We are asking the medical profession to work longer hours and take on additional lists to see the waiting lists reduce.

Throughout the pandemic we clapped and praised the NHS for the commitment shown and the sacrifices made by NHS staff on our behalf, only now to vilify them because of partisan press reporting half a story. In every workplace under resourcing leads to delays.

This author is therefore dumbfounded by the requirement for the naming of medics earning more than £156,000 (2021-22).

You don't have to be a rocket scientist to realise this will have the opposite effect on recruitment and retention thus undermining efforts to recover from the impact of the pandemic.

Apart from the disincentivising impact of this decision we must question the principles behind this requirement and whether it is really fit for purpose in this current climate.

It is a simple equation, if you have a budget or a contract for working specified hours but due to resourcing issues you work more, it means you earn more.

Before imposing reporting requirements two things need to happen:

- Comparisons of earnings should consider the hours worked, thus someone working 60 hours a week (not uncommon in today's NHS) would only report earnings over £234,000 (assuming the original threshold is for a 40-hour week); and
- We need to get our resourcing right so the people we rely on when we are truly ill are only expected to work a normal week.

We hear about the numbers of new doctors and nurses coming through the system but not that it takes at least three years to train a nurse and far more to train a doctor.

This will not be a quick fix and therefore I question any logic that puts in place measures that reduce an already stretched resource further.

There may be a time for this policy in the future, but it most certainly is not now.

When I began working with medical professionals, the NHS was 50 years old and already on its eighth 10-year plan, but at least each one was given the opportunity to succeed. The frequency of the changes in the last 17 years has meant that no plan has time to settle and develop before the next one is introduced.

All this tells us is the plan before wasn't thought through properly and therefore not considered fit for purpose. How can we expect a system to succeed if it is not given the opportunity to settle?

We are told the changes are meant to improve and protect the NHS but from this viewpoint they are achieving the exact opposite. Perhaps it's time for a different approach.

How to motivate without money

Earnings are only one of the factors considered by most staff to be important in their job. Fiona Dalziel considers what can you do to better understand their needs

The cost-of-living crisis is hitting GP practices as much as any other small business.

In this climate where everyone is pulling in their horns financially, all businesses are contending with rising costs, trying to make savings, and staff who see their earnings disappearing fast.

Explaining to staff that one of the benefits of working in a practice is that they will have an NHS pension does not solve the problem of the costs of day-to-day living.

Practices are understandably anxious that their precious staff will look elsewhere for work that is better paid. What on earth can be done to retain staff when pay demands cannot be met?

In fact, money is only one element in a series of motivators. Abraham Maslow, an American psychologist, based his theory of human motivation on a hierarchy of 'needs.'

He suggested that people are motivated to advance up the hierarchy once they are able to meet their needs at a lower level of the hierarchy.

If living and operating at a higher level, and suddenly a lower-level need is no longer being met, then the individual will move back down the levels to meet that need before progressing back up the hierarchy again (see illustration on page 5).

Here's an example of how this works. When a friend of mine's son moved on his own to London, without a job and without permanent accommodation or many friends, he was operating at the base of the hierarchy. He was moving from friend's flat to friend's flat, getting temporary work. He was anxious about money and living out of a suitcase. You could say he was trying to meet his needs at the 'safety' level.

Eventually, he got regular employment and income, found longer-term accommodation and started to feel more secure. He began to establish contacts and find time to meet old friends and make new ones.

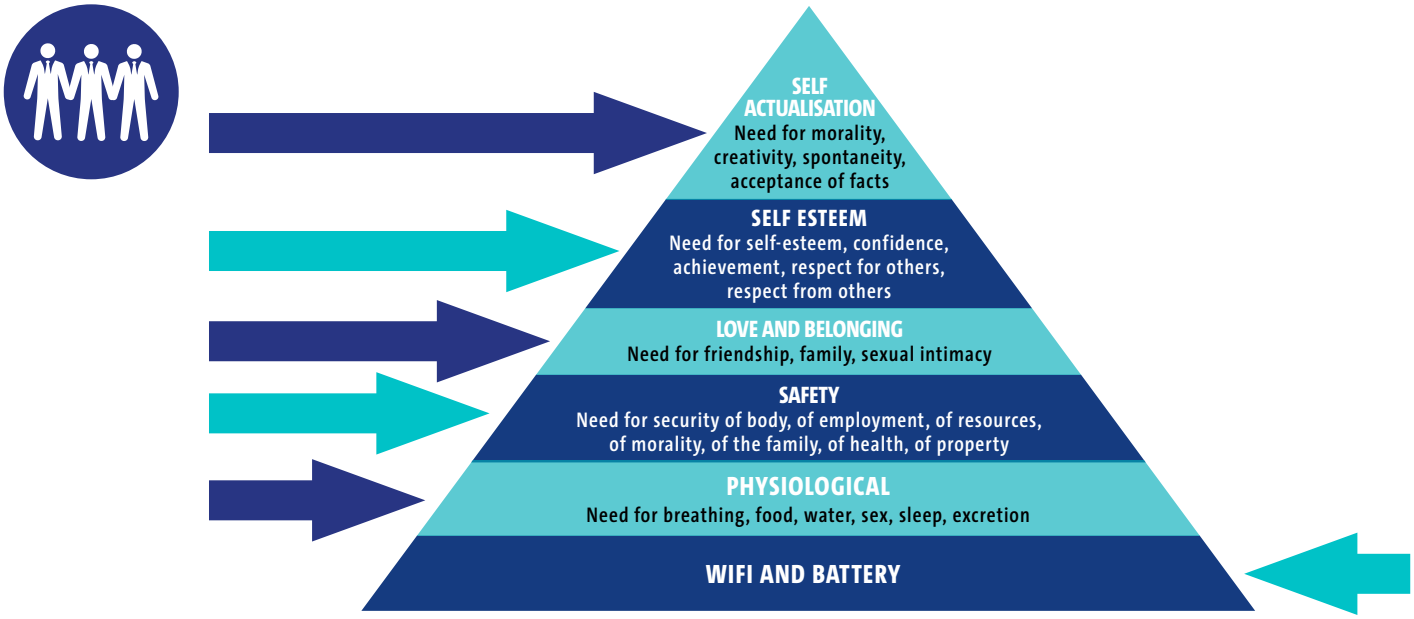
He was sorting out his needs at the 'love and belonging' level now. As time went on, he started to gain a reputation as being effective and was approached regularly to take on new, interesting projects.

He was part of a team and his confidence began to grow ('self-esteem' level.) He understands the world of his work and himself now and is more contented. Some of the time, he is operating at 'self-actualisation.'

However, job security is limited in his chosen area of work. From time to time, he has to search for alternative employment. At that point, he reverts to 'safety' until work and financial concerns are settled once more.

Maslow's hierarchy works on a smaller, task-based level as well.

In deciding whether to do something, every person does a quick mental calculation: What



MASLOW'S PYRAMID OF HUMAN NEEDS

are my needs and does this meet them? Does it help me be part of something, achieve a goal, give me more power or money?

Every individual has their own set of needs depending on where they presently are on the hierarchy, even if they do not know of its existence.

People also consider, again based on the hierarchy, how much effort, energy and emotion they want to expend on a job.

What results are expected? What standard has been set for the job (if any)? Is the standard clear and achievable? What will be the reward and is it a reward that will satisfy a need I have? (Charles Handy, Understanding Organisations, Penguin).

The important element to understand here is that, in managing and motivating staff, every individual is operating at a different level and money is not necessarily a top motivator for everyone (although its influence is increasing!).

Individuals are also motivated by:

- A chance to control their work
- A need to belong
- A need for feedback and appreciation
- A need to feel valued, and
- A need to feel respected.

It starts to become evident that understanding each individual's needs and motivators is key to giving them as much job satisfaction as possible if you want to maximise the chances of hanging onto them as staff.

Maybe you cannot offer more money, but perhaps you could work to understand each individual better.

Now consider the questions in the box opposite.

Interestingly, Charles Handy reminds us that pay increases given at regular intervals do not work as a motivator; they are seen as a right. Alternative methods of motivating and rewarding staff may never have been more important.

Note: the sharp-eyed reader will spot the new bottom level of needs in the Maslow illustration.

Fiona Dalziel runs DL Practice Management Consultancy

Consider these questions

- When did you last have a bit of a chat with everyone individually?
- When did you last do meaningful staff appraisals?
- What can you consider by way of staff development opportunities?
- What elements of job design might you be able to change to suit individual 'needs' (see above)?
- How good are you at stating in advance of a task the standard you expect?
- How good are you at trusting staff to get on with a task?
- How good are you at giving feedback?
- What do you do to make staff feel valued (not just nights out!)?

AISMA staying busy behind the scenes

Doing the best for our GP clients does not just mean we are limited to accounts and tax issues. Andrew Pow* reports**

The primary purpose of our organisation is to provide a peer network for medical specialist accountants to allow us to provide the best level of service to our GP and other medical clients.

Our success in this also gives us a platform to work behind the scenes to try and tackle issues facing general practice.

Areas we have been involved with recently cover a wide range of issues:

British Medical Association – a small group meets the BMA quarterly to talk through key issues around contracts, PCNs, pensions and premises.

An example of where this helps was during the first wave of Covid-19 when we supported the BMA with submissions showing how general practice finances were being impacted. This led to the Covid-19 support payments coming into existence.

PCSE – the ongoing issues with PCSE are well documented and accountants struggle just as

much as practices. We have now started a forum with PCSE to raise general issues and feed into them recommendations for future system changes. It is a slow process but you must start somewhere!

PCN issues – AISMA has had protracted dialogue with HM Revenue and Customers (HMRC) about PCN issues.

PCN contracting has led to clinical director PAYE, as well as VAT issues, due to how the money flows through the system.

We also discuss these with both the BMA and NHS England periodically.

PCN accounting also raises issues at practice level. To assist our members, we recently held a training morning for all AISMA accountants, covering various PCN problems and how to tackle them.

Lawyers – there are a growing number of specialist medical lawyers working with general practice. AISMA works closely with the National Association of Specialist Solicitors Advising Doctors ***https://nassad.co.uk/***, the legal equivalent of AISMA, to ensure lawyers and accountants are aligned when advising the profession.

Responding to the government - legislation usually involves several stages of development, with the lawmakers asking for input prior to finalising changes or issuing documents.

AISMA actively responds to these. Most recently we fed back our views to the consultation on changes to final pay controls and we contributed to *The Future of General Practice* report from the Health and Social Care Select Committee.

GP pensions

We have also constantly advised government since 2015 on the issues impacting general practice from the pensions annual allowance and lifetime allowance legislation.

The Future of General Practice report references accountants' concerns and we will be watching closely if anything comes from the government's indication that it will look into what changes it can make.

The Association also liaises with NHS Pensions to ensure they are updated on changes that need to be considered for members of the scheme. Recently this has included advice relating to the potential impact of Basis Period Reforms on the way practitioners' pensionable earnings might be calculated in 2023-24 and ensuring that PCN staff have access to the NHS Pension scheme.

GP earnings publication

We also have made our views clear to NHS England about concerns over the publication of GP earnings.

Acting nationwide

In the home countries we have separate leads: Pauline Hogg in Scotland, Libby Pritchard in Wales and Seamus Dawson in Northern Ireland.

This allows AISMA to share its views with the representatives in the devolved health and pension systems.

In the media

We also continue to support other organisations working with general practice and you can regularly see our members responding to requests for opinions from the medial press.

Into the future

General practice is going through a significant period of change at the moment and the pressures are challenging. Behind the scenes we work hard as an organisation to ensure those making decisions are informed about the financial impacts.

ASK AISMA!

GPs' questions about payment shortfalls, inheritance tax worries and premises dilapidation provisions are answered here by Abi Newbury****

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

HELP - WE'RE NOT BEING PAID FOR EVERYTHING WE DO

Q **My accountant says it doesn't look as though we're getting paid for everything we do. How is that – doesn't it all just come off the computer system now?**

A Yes, a lot of claims come directly from your computer system, but to do so, things must be recorded appropriately in the first place.

We frequently come across practices where some doctors don't know how to record certain things, or don't code correctly or use the specific templates, having little or no understanding of the cash effect of what they do or don't do.

And it is not just the doctors – but all members of your team. If your practice makes heavy use of locums for example, they may not know your system well enough to get it right – so following up what happened with their appointments can be worth the time.

Settling with locums who know the practice can be more cost effective but beware complacency and make sure they are aware of what is needed.

So, here's what can you do to minimise missing income:

- First, look at your systems to check you have all the relevant templates in place and everyone understands what they need to do to ensure computer information is correct and manual claims are picked up and actioned.
- Look at your disease prevalence figures compared to other local practices.

Can differences be explained by different practice population types? If your practice has a predominance of elderly and deprived patients you would expect your disease prevalence to be much higher than for a practice with mainly healthy working age patients.

If it doesn't feel right – check how you are recording things.

- Have you ticked all the relevant boxes? Are there variations between partners about how they are recording things? Have the rest of your team been updated and are they aware of any changes?
- Some sources of income do not come direct from the computer system and still need manual claims. Make sure you have a system in place to see this happens on a timely and consistent basis.

Once claims have been made you need a robust system to ensure that what is expected to be received is received. Ensure someone has control of the system and follows up discrepancies (in either direction).

Every year we find 'missing' money that practices weren't even aware they were missing. And it can be big sums! Our biggest one-off amount was nigh on £200k!

While it's very satisfying for accountants like us to find money for practices who didn't know they were missing it – it's much better if the practice systems ensure you are getting paid for what you do and nothing slips through the net!

HOW CAN I REDUCE INHERITANCE TAX?

Q **I'm worried about inheritance tax (IHT). Can I give money away?**

A The simple answer is yes, you can give money away. The more practical answer will make you aware of the tax consequences.

What can I give away?

- You can give any amount to your legal spouse without any immediate tax consequences
- You can make gifts up to £3,000 a year with no tax consequences (and a further £3,000 for the previous year if not used then)
- You can make any number of gifts under £250 per person (but not someone getting some of the £3,000) – usually used to cover Christmas and birthday presents
- You can make gifts in contemplation of marriage (the amount depending on how closely related or not to either party to the marriage you are)
- You can make 'normal payments out of income' provided it doesn't affect your own standard of living. This is often used for helping with mortgage payments, school fees, or life assurance. You will need to keep records to show that it is out of income
- You can give anything you want away – and provided you survive seven years from the date of gift it will not cause any tax liability. You could take out insurance to cover the potential risk – but this may be expensive.

You can stop the IHT situation getting worse by suggesting parents leave money to your children rather than to you. They may wish to look at trusts to stop young people having access to too much too early.

Be careful giving anything away that would create a capital gain or you may have tax to pay but with no sale proceeds to help you pay it.

Before you get too carried away with giving your hard-earned savings away, first consider:

1 Is there actually going to be a tax liability? If everything is left to the surviving spouse there is no tax on the first death.

On the death of the survivor, if the value of the house is left to direct descendants, there are additional allowances available before any tax is paid.

2 What capital do you need to protect yourself in retirement – what if you needed long term care? What expensive plans do you have for retirement that would eat up your capital?

3 Do you want to protect your share of assets, should the surviving spouse remarry, to ensure your planned beneficiaries get what you want them to have?

You need to consider will planning and possibly the use of trusts – but that is a rather bigger question than 'can I give money away?'

PROTECT PARTNERS WITH A 'DILAPIDATIONS PROVISION'

Q **My accountant says we should have a dilapidations provision. What does that mean and why should we have one?**

A Dilapidations provisions are common where premises are leased and the idea is to ensure funds are put on one side to cover liabilities under the lease, and particularly at the end of a lease.

For example, if the lease says premises must be decorated every five years then every year 1/5th of the estimated cost would be put on one side. This might be actual cash or purely a book entry in the accounts reducing partner profit shares drawn.

In normal times many practices have kept on top of general property maintenance so that repairs costs came in evenly over the years.

But Covid-19 and the associated workload have meant more cases of things being put on hold and the work needed has built up.

Where a practice premises is in dire need of substantial redecoration, for example (rather than doing a bit each year), this could mean an outgoing partner escapes having to pay for the work that needs doing, and an incoming partner must pay for a lot of work that all arose before they joined.

To provide fairness to all incoming and outgoing partners it is reasonable to make a provision for repair work that needs doing at the end of each year, or a proportion of a cyclical type of property maintenance. This ensures the partner using the premises at the time the wear and tear arises is the one who pays for it.

Check what your partnership agreement says, and if it is silent on the matter, make an agreement at a partners' meeting about what will happen and arrange for the partnership deed to be updated at the next change.

Ensure your accountant is aware of this because the provision needs to be reflected in the practice accounts.

Note that you only get tax relief when there is a contractual liability to do something, not when there is just a desire to earmark some money against future costs. So you can't use these provisions to manipulate taxable profits between years.

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AISMA Doctor Newsline is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK.
www.aisma.org.uk

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Is it worth GP practices becoming employee owned?

Should GP practices consider becoming employee-owned businesses? Some practice managers are increasingly looking at the 'John Lewis' model. But they need to be very clear about why they are doing it, what the objective is and what it involves, warns solicitor Justin Cumberlege

Many businesses aspire to achieve the 'John Lewis' model. It is seen as a way of treating employees fairly and allows them to share in the successes rather than have a few owners or partners benefiting from the profits.

By being a part owner it is thought employees will be incentivised to work harder because they will benefit.

The concept was encouraged by The Finance Act 2014 which introduced tax incentives to create Employee Ownership Trusts (EOT).

Employees became eligible to receive £3,600 a year as a tax-free bonus and owners who transferred most of their shares into the EOT would not pay Capital Gains Tax (CGT) on the disposal.

So how does it work?

The model is not well understood and the structure is too complex for a small organisation to adopt. But it is worth looking to explain why it will not work for them.

John Lewis is owned by a Trust, the partners are the beneficiaries and the trustees are the Board. Employees (or 'partners') form a partnership council. The company's website states: 'The Partnership Council represents all Partners, reflecting their opinion, to ensure the business is run for and on behalf of all Partners. It shares responsibility for the Partnership's health with the Partnership Board and the Chairman.

'Its role is to hold the Chairman to account, influence policy and make key governance decisions such as choosing the Trustees of the Constitution, select Board elected directors, change the Constitution with the Chairman's agreement and dismiss the Chairman.'[1]

Then there are four committees: the Audit and Risk Committee, the Nominations Committee, the Remuneration Committee and the Ethics and Sustainability Committee.

These report to the partnership board which has a mix of appointed and democratically elected partners. The board's elected directors are there to ensure partners' opinions are reflected in the business's management.

The board's chairman 'carries personal responsibility for ensuring the Partnership retains its distinctive character and democratic vitality with a responsibility for delivering the ultimate purpose in Principle 1[2].

'As the senior executive in the Partnership, the Chairman is ultimately responsible for the Partnership's commercial performance and so twice a year appears before the Partnership Council to answer questions on [the John Lewis Partnership's] performance.'[3]

Partners' opinions are reflected in an in-house magazine. The chairman appoints their own successor and the deputy chairman, overseen by the Nominations Committee.

The set up means the ultimate responsibility for decisions rests with the chairman.

Perhaps the John Lewis culture makes this work. The power is very concentrated and the 'partners' have less power - but more influence - than the shareholders of many companies. They could not, for example, replace the board if they did not like what it did.

How could an employee ownership trust model work for a GP practice?

Yes, a simplified employee ownership trust (EOT) model is possible for a smaller business of perhaps a GP practice's size.

As with John Lewis, there would be a company with the shares held in a trust. The trustees should all be employees, as well as representatives of their colleagues, and staff would be beneficiaries under the trust.

Employees, via the trustees, would have oversight of the company's board, and could ultimately replace it.

Advantages for employees are that they:

- ensure the company is run to be sustainable for the long term and to preserve jobs
- feel that the success of the business is their success and they receive rewards as a result
- have a say in and influence the way the business is run
- may qualify for tax-advantaged share schemes such as EMI options (individuals) or share incentive plans (all employees)
- qualify for income tax-free bonuses of up to £3,600 annually (National Insurance Contributions apply) where there is an EOT owning the shares
- if the company is sold later then employees will share in the sale proceeds.

They should feel they are participating in the business. This leads to improvements in the company's morale and in higher productivity and profitability.

But complying with the GMS or PMS requirements with an EOT structure is not straightforward, due to section 86 of the National Health Service Act.

This states[4] that for a company holding a GMS contract at least one share is required to be 'both legally and beneficially owned by a general medical practitioner.' Any other shares are 'legally and beneficially owned by persons referred to in section 2(b)'. Those include employees of a GMS holding practice.

Conditions in the Act are subject to requirements in the Regulations[5], and these are mirrored by the PMS regulations.

Insertion of the word 'both' in 'both legally and beneficially' is an issue when considering an EOT structure. Trustees hold the legal interest and the beneficial interest are the employees.

The argument which must be put forward is that the trustees are all eligible shareholders and so are able to hold the shares, and all the beneficiaries would be eligible shareholders.

"They should feel they are participating in the business. This leads to improvements in the company's morale and in higher productivity and profitability"

Trustees, along with others, would have a beneficial interest even if not the whole beneficial interest. Provided all employees also fulfil the shareholding criteria then the expectation is it will not be challenged.

There still would need to be one shareholder who is the general medical practitioner but that share may have no entitlement to vote or receive dividends.

The value of the CGT benefit in creating an EOT for the selling partners is unlikely to be great given the value of GP practices, unless they sell to the EOT the surgery premises at the same time.

It is important that on any sale of the practice no payment is received for goodwill because this would breach sale of goodwill regulations in NHS GP practices[6].

Due to these issues the EOT governance structure is somewhat strained as well as legally uncertain, and the risks need weighing up against the benefits.

Alternative options

An alternative to setting up an EOT to hold a practice's GMS contract or PMS agreement is for the practice to have an APMS contract.

This is because eligibility requirements for APMS contracts are far less restrictive. But they do come with the uncertainty that the practice will win the APMS contract when the contract is put out to tender initially and when it is renewed in the future.

And this means the incentive for an employee-owned practice, that it will enjoy longevity, is lost.

Another option is that the contract is held by GP nominees and then sub-contracted to the employee-owned company.

This avoids being entangled in the statutory requirements but it is dependent on a contractual relationship and the practice is at risk if the nominees decide to go off on their own.

Also, access to NHS pensions long term is not guaranteed for the sub-contracted employees, and a structure to secure the rent and rates reimbursement adds complexity.

Further things to consider with EOTs

Having found a way of owning the practice through an EOT, employees should share the benefits. There must be a question why a successful, profitable business is offering itself to its employees as opposed to passing it to other GP partners.

Employees buying in, even at a modest amount (assuming that it is a GMS or PMS contract, so no payment for goodwill can be made), should conduct their due diligence. Although they may have been working for the practice for years, they probably do not know what has been going on financially.

Making money out of a professional services firm is difficult when competing with others for talent who can become partners of their own practices and reap the rewards without sharing them with employees, so this is not likely to be a silver bullet to get over the recruitment crisis for GPs.

When the dividend comes in, this should be a welcome boost to morale and staff incomes, particularly for low paid staff.

Unfortunately, there could be a sting in the tail here for those claiming benefits, such as family credit, because they will have to declare the dividend and this may mean the benefit stops for a period.

If we start at the beginning with the practice incorporating to set up an EOT for its employees, the first step has been to novate the GMS contract to the company.

The commissioner - strictly speaking this is NHS England but it is delegated to the Integrated Care Board in nearly all cases - must take a view about whether the contract should first be put out to tender. That could then result in the contract being lost to a third party, which is probably the worst result for partners and employees alike.

If the commissioner decides it does not need to go out to tender then the second question is whether this will be for the benefit of patients.

While an EOT structure looks appealing, careful consideration of the financial benefits and the legal requirements need to be made to ensure the benefits will truly be delivered.

[1] ***John Lewis Partnership*** *- How we share power accessed 15 August 2022*

[2] ***WORKING IN PARTNERSHIP FOR A HAPPIER WORLD:***
Our Partnership is an ongoing experiment to find happier, more trusted ways of doing business, for the benefit of us all. We work together to create a successful business and a fairer, more sustainable future for Partners, customers, suppliers and communities. Our Partnership is owned entirely in trust by Partners which means we are more than employees; we share knowledge, power and profit. Our Purpose inspires our principles, drives our decisions and acts as our guide.

[3] ***John Lewis Partnership*** *- How we share power accessed 15 August 2022*

[4] ***section 86 National Health Service Act 2006***

[5] ***Regulation 5 (b) The National Health Service*** *(General Medical Services Contracts) Regulations 2015 and...*

[6] ***The Primary Medical Services*** *(Sale of Goodwill and Restrictions on Sub-contracting) Regulations 2004 and s259 and Schedule 21 of the National Health Service Act 2006*

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