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GPs facing financial meltdown



Insolvency and GPs have been two words that just never appeared in the same sentence – until now. **Jeanette Brown*** looks at some alarming current issues arising in the wake of doctors' falling incomes

I have been seeing a worrying trend among doctors recently: they have not been able to pay their bills.

Until now, as a healthcare accountant and insolvency practitioner, it was rare for my two worlds of work to collide.

But my recent experience suggests a number of common themes and I thought it would be useful to highlight a couple of examples.

I have been speaking as an insolvency practitioner to a number of doctors in recent weeks where the combined effects of the January tax bills and superannuation balancing payments have caused huge financial pressure.

It is a well known issue among specialist healthcare accountants in AIMSA that large tax and superannuation payments can fall due when a GP's earnings have significantly increased year on year.

I have encountered GPs at both ends of the age spectrum with this problem.

An example at the 'more experienced' end of the age scale, is where doctors have drawn their pen-

sions under the 24 hours rule, but then carried on working afterwards.

The 'tax bombshell' has then occurred the following January after the pension has been drawn with tax deducted at source at the basic rate of tax rather than at the higher rate. Their accountants have failed to spot this in time and make the necessary adjustment to the tax code.

More junior GPs, perhaps those entering partnership for the first time, may choose to supplement their income by, for example, doing out-of-hours work or additional sessions at a local hospital.

But they may not realise that this additional income will be subject to tax or even superannuation – and when the bills finally arrive, the money is long gone and there is a gaping chasm in terms of personal cash flow!

I recently advised a young GP where her combined tax and superannuation bill had doubled year-on-year. She was unable to fund the January payment having fallen behind with payments due

from the previous year.

HM Revenue and Customs (HMRC) was sending threatening letters and the GP was naturally greatly concerned that any ensuing insolvency proceedings would severely impact on her partnership position and also have a devastating knock-on effect on her personal finances.

Using the combined knowledge of our healthcare and insolvency teams we sprang into action and organised a time to pay agreement with HMRC, projected forward the GP's tax bills for the next three years, and set a strict drawings policy for the doctor which enabled the practice manager to save up for the future tax bills.

HMRC agreed - and the GP is now back on course with her drawings plan. And happily she is still a partner at the same practice. Unfortunately the practice was not a client of our firm so we can only hope that the GP sticks to her payment plan!

GPs should also be aware that loans from some high street banks to cover tax payments became a 'no go' area for a time in recent years.

We have seen a softening in this attitude in recent months with some banks saying 'yes' to personal loans for tax.

But we have also noticed a flurry of other loan companies entering this market and openly advertising 'tax loans for your clients' to accountants and insolvency specialists.

These loans obviously carry some risk and I would advise GPs to read the small print before entering into any kind of arrangement of this type.

However the facilities are there and could potentially save a GP (and their practice) from entering financial meltdown.

But what happens if formal insolvency cannot be avoided? The following issues would be key:

1 The NHS Contract

Our legal colleagues will rightly point out that formal insolvency gives the commissioning board the right to terminate an NHS contract.

Under NHS contract regulations the definition of 'formal insolvency' is widely drafted to include bankruptcy, sequestration, liquidation or 'a composition or arrangement' with creditors. The effect of this clause can be disastrous - particularly if the GP involved is a single hander.

GPs should also not lose sight of their duties under the Performers List Regulations in that they have a duty to inform the relevant Board of 'any material change' to information which they provided with their original application to be entered onto the list.

The regulations also include a provision whereby

the relevant Board can remove a GP from the list if they are satisfied that 'the practitioner's continued inclusion in that performers list would be prejudicial to the efficiency of the services which those included in that list perform.'

Once again the regulations are widely drafted and can allow the Board to take into account such issues as the effect on public finances of the GP being allowed to stay on the list.

While I have not personally come across any case of a doctor being excluded from the Performers List due to insolvency, well informed, vexatious or angry creditors could potentially 'muddy the waters' for a GP's future ability to perform services.

Consideration may also need to be given to any effect on CQC registration, but once again, GPs finding themselves in these circumstances would need to be advised by an appropriately qualified solicitor.

2 Partnership matters

If a GP is a partner in a practice then it is likely that the practice agreement will state that insolvency will lead to exclusion. It goes without saying that the relevant partner's capital and current account may form a major part of the insolvent GP's estate.

This can lead to financing issues for the remaining partners particularly if there is, for example, equity in the surgery premises or a large amount of undrawn profits in the current account.

I have seen several situations where the financial situation of a GP has come as a complete shock to the other partners in the practice where the last thing they want is to get rid of an esteemed colleague and a valuable 'resource.'

3 Personal matters

In professional insolvency situations it is the big '3 Ps' that come into play following the appointment of an insolvency practitioner; namely - property, pensions and payments.

I regularly have to answer the same questions:

Q Can I keep my house?

This will basically depend on the amount of equity in the property and whether it is jointly owned. The mortgage company will generally look to its security in the property and would only seek to force a sale if there were substantial payment arrears.

If the property is jointly owned, the insolvency practitioner can only seek to realise the insolvent's share of the equity.

In an ideal scenario, arrangements are made with the joint owner to buy out the insolvent's share. This

must be done within a three year period and at an agreed market value.

However if the property and mortgage are substantial, and if the insolvent GP is either the sole owner or wholly responsible for making the mortgage repayments, then in all probability they will lose their family home.

Q Is my pension safe?

Up until a recent court case, the answer was 'yes.' But things changed in 2012 after the decision in the case of *Raithatha v Williamson* when it was held that a Trustee in Bankruptcy could take the benefits of a pension fund for the purposes of an Income Payments Order should the bankrupt be 'entitled' to the pension at the time.

Therefore the pension funds of GPs close to retirement could be at risk if they are declared bankrupt.

Q Can I still pay my child's school fees?

When assessing disposable income for purposes of setting levels of contributions to be made in insolvency situations, guidelines issued by the Insolvency Service are pretty clear on what will be regarded as 'reasonable' when it comes to an insolvent person's day-to-day living expenditure.

And while after school clubs and 'extra curricular activities for children' are listed as payments which may be considered reasonable, the list does not

extend to payments to private schools.

The general rule in bankruptcy is that the more disposable income you have, the more you will need to pay.

Much will depend on the ability of the GP to carry on earning an income and to an extent their ability to call on the income of a life partner or family member to contribute to their existing lifestyles.

But it seems clear that an insolvent GP would suffer a considerable reduction in the lifestyle to which they, and their families, had become accustomed.



OPINION

You and *that* pay award

Bob Senior, Chairman, AISMA

The Government's announcement of the 2014-15 pay award for GPs last month has, understandably, not been well received by GPs.

Whilst a 0.28% increase is an increase in cash terms, it in no way reflects what is happening in many practices.

The continued increase in patient demand is causing many practices to increase staff hours, either by employing more staff, giving more hours to existing staff, or by paying more overtime.

Many practices are therefore facing higher staff costs even before any annual pay increases are taken into account.

Now the major changes to GP funding that came into effect from 1 April will cause further financial problems for some.

While many practices will undoubtedly benefit

from the increased global sum funding, many others will find that once the reduction in the Correction Factor and the QOF funding are taken into account they are going to be worse off.

The Department of Health originally indicated that it would endeavour to provide some relief to 'outliers' - but more recently it has indicated that it will not now be in a position to do so.

Where AISMA accountants have clients who fall into this category we need to help them face up to their situation and plan for a managed solution. Often it will be by a merger with other practices.

If practices in this situation do nothing and simply muddle along, just hoping for the best, then they are at risk of finding themselves in the middle of a 'train crash' at some point in the future.

Adapt your practice for a federating world

The practice is a business and its future should not be decided solely on emotive preferences. **Kathie Applebee** runs through the key issues you need to consider



GP practices across the land are talking about federations. Some have already made the transition and are learning about working within a federation while others are either considering their options or trying to ignore the subject.

Key concerns are likely to include practice autonomy, membership demands and legal and financial liabilities (see Alison Oliver's article, page 6).

The purpose of federating is centred around the need to bid for services which are currently within the remit of practices - such as enhanced services - or for new services which might be provided by some, if not all, of the federation's members.

Our days of organisations such as local councils holding dozens of practice level contracts, each for a relatively small number of services, are ending.

However, behind the formalities lurks a further layer of concerns which need to be addressed.

These include the levels of interest and involvement displayed by practices in the aims of their federation and the responses within individual practices to federation requirements.

Ideally, the aims of the federation would tie in with practice aims. But the reality could be quite different.

Real commitment

Practices may be reluctant to join, either fearing loss of autonomy or simply not believing in the need for federated working.

Worse still, practices may sign up and then be unwilling to commit to federated working, with the federation management eventually being regarded as 'the enemy'.

Shared back office functions can serve as an example. The management team might source shared contracts, such as insurance, which would result in reduced costs for most of the federation's practices.

However, what of the practices which preferred their own arrangements? Their reluctance to participate might jeopardise the arrangement or make it less financially viable for their colleague practices, and ultimately weaken the cohesion of the group.



Obviously, such a scenario might be a worse-case example but it is important to consider such implications for practices that are used to making their own decisions.

If this happened repeatedly, confidence in the federation would weaken, with knock-on effects when bidding for clinical services commenced.

Management is the art of pre-empting problems within and between organisations. So it is important to explore scenarios such as these.

At practice level, individuals need to understand the pros and cons of federation membership outside the issues of structure and liability.

Unless practices are huge, they need other practices to ensure that they will be able to participate in bidding for enhanced services.

Economies of scale

There is also the important issue of economies of scale to reduce running costs and, potentially, practice level inefficiencies.

The difficulty with this driver is the variable size and infrastructure of practices, and the desire for many to remain in control of their own systems.

Sharing services with like-minded practices is very different from involvement with a group which varies widely according to efficiency, motivation and earning potential.

Federations are going to need two key attributes from member practices – the willingness to compromise and the flexibility to adapt.

Practices that are willing and able to respond positively to the joint aims and needs of the federation will minimise the demands they make on the management team.

And they will potentially derive more benefits than those which nit-pick details and seek to control or subvert developments.

Practices need to be very clear about the implica-

tions of being disruptive, or of leaving a federation, or even being excluded from one.

There may not be viable alternatives to neighbouring practices which, with all their flaws, possess the major advantage of being in the same position, businesswise, as you. Both will be seeking a way forward at a time of declining income and changes to contracting services.

If the choice lies between being positive federation members or going it alone then the risks of the latter need to be very clearly understood.

The practice is a business and its future should not be decided solely on emotive preferences. That approach belongs to the halcyon days before federations were needed for survival.

© Kathie Applebee 2014, organisation psychologist for primary care, and strategic management partner at Tamar Valley Health Group Practice

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What you need to know about ...



With the federation game the current hot topic, **Alison Oliver** gives a legal lowdown on what they are, how to go about forming one, and the potential pitfalls

So what is a GP federation?

The Oxford English Dictionary defines a federation, among other things, as ‘an organisation or group within which smaller divisions have some degree of internal autonomy’.

The existence of some degree of autonomy is a crucial feature of a GP federation – to federate does not mean to merge.

In a GP federation, individual practices are likely to continue to function independently at practice level, while the various member practices may carry out a number of activities collaboratively at federation level.

Why federate?

So why have GP federations become such a hot topic? One key factor is the change in the way that services are commissioned, meaning GP practices may have to compete to win contracts for services that they might previously have been awarded almost automatically alongside their GMS, PMS and APMS contracts.

Since the abolition of PCTs in April 2013, the NHS Commissioning Board has taken over responsibility for commissioning GMS, PMS and APMS services. Responsibility for commissioning enhanced services has now transferred to CCGs or, in the case of public health services, local authorities.

In many cases, public and NHS procurement rules will dictate that the commissioners of those services run some kind of competitive procurement process.

In addition, many practices feel that they are under more pressure than ever to do more, and all this at a time when there are fewer resources for them.

GP practices, particularly small ones, may well struggle in this environment. For this reason, practices around the country are concluding that they stand a better chance of maintaining, or increasing, their income and meeting the challenges they face if they work together than if they work alone.

What does a federation do?

There are many different kinds of activities that GP federations might carry out. Some of the main ones include:

- Collaborative service provision: the main objective of a federation is likely to be working together to deliver healthcare services to patients in its area.

A federation might, for example, apply to become a qualified provider of services that have previously been provided by practices as an enhanced service.

It might submit tenders for new community-based services, or even tender to win contracts to run general practices which become vacant. Such services might be provided by the federation itself, which may engage staff for this purpose, or might be sub-contracted out to the member practices.

- Collective purchasing: a federation might be able to reduce expenses for its member practices by negotiating deals for the collective purchase of items such as consumables, utilities, insurance and

training.

- Back office functions: the federation might be able to provide ‘back office’ services, such as payroll or human resources services in order to achieve economies of scale for member practices, although it will be important to obtain advice on the possible tax consequences of this.
- Quality improvement and support: the federation may develop clinical governance, quality and safety procedures for its member practices and provide training and education.

What type of organisational structure should a federation adopt?

There are many different types of organisational structure ranging from the very formal through to the very informal.

At the most informal level, practices can provide support to each other and work together on an ad hoc basis without any kind of formal structure. However, this is likely only to be suitable for very short term or low risk arrangements.

Generally, we would advise that federations form a corporate body that has its own legal identity so that the activities of the member practices are kept distinct from that of the federation, and so that the liability of the member practices is limited to the value of the funds that they formally commit to the federation.

Without a corporate structure, the individual partners of member practices will be exposed to the liabilities of the federation.

The type of corporate structure that a federation adopts will depend on the kind of activities that it intends to carry out. Some forms of NHS contract (for example GMS) have very strict rules about the structure that contractors are permitted to adopt.

So it is important to get expert advice to ensure that the structure is appropriate for the types of contracting that the federation hopes to undertake.

In the vast majority of cases we deal with, federations opt to conduct themselves as private companies limited by shares. In this type of structure, member practices own shares in the company, and a board of directors is appointed to run the company on a day-to-day basis.

It is essential that the company’s articles of association and shareholders’ agreement contain provisions (among many others) to prevent shares falling into the hands of people who may not satisfy the requirements of the contracts that the federation holds, or intends to hold.

Staffing and NHS Pension Scheme

At the time of writing, the NHS Pension Scheme rules are being reviewed. If the changes currently

out for consultation are adopted, it should be much easier for GP federations to provide access to the NHS Pension Scheme than has been the case previously.

Organisations that currently employ staff and second them to other organisations in order to provide access to the NHS Pension Scheme for those staff should seek specialist advice.

These arrangements will not be permitted under the new rules (if adopted) and if appropriate corrective action is not taken, staff could lose their membership of the Scheme and the employer could find itself in receipt of costly legal claims.

Competition law

One area that is commonly overlooked is that of competition law. The Competition Act 1998 prohibits activities which prevent, restrict or distort competition or affect trade. The new models of service provision in primary care make it increasingly likely that GP practices will be considered competitors; so while the federation will naturally wish to place some restrictions on practices to enable federated working, it is important to approach these with care. Examples of restrictions that require specialist legal advice and drafting include those that:

- restrict member practices from competing with the federation
- exclude practices within the federation area from joining the federation
- tie member practices into collective provision or buying arrangements for long periods.

Furthermore, if the member practices are transferring existing practice business to the federation, in some circumstances the arrangements could result in a merger of those activities.

Some mergers are notifiable to the Competition and Markets Authority (CMA), which took over the functions of the Office of Fair Trading on 1 April.

It is important to seek expert advice at an early stage to ensure that the federation structure and working rules comply with competition law and to assess whether it results in a merger of activities that should be notified to the CMA.

Conflicts of interest

Federations will need to give careful thought to how they manage potential conflicts of interest.

Member practices are likely to all be on the same CCG and the CCG should have its own rules and guidance to deal with a situation where a number of its board members have an interest in a particular scheme or service proposal under consideration by the CCG.

The federation should also have rules to ensure that directors declare their interests and processes for authorising the activities of directors who are conflicted.

Conflicts of interest will inevitably arise, and the important thing is that the federation manages these in a clear and transparent manner which is capable of withstanding external scrutiny.

Generally, we would advise that directors of the federation are prohibited from holding a position on the board of the CCG for the area in which it operates and also from holding a position on the board of another federation.

Regulatory/compliance matters

The federation will need to consider various regulatory matters. As well as the usual health and safety compliance issues that any organisation must attend to, it may also need to apply for CQC registration if it intends to provide services directly at federation level as opposed to sub-contracting services to the practices.

Once the federation's turnover from NHS services reaches (or is expected to reach) a certain level (currently £10m a year) it may need to obtain a Monitor provider licence.

Membership rules

The federation will need to ensure it has robust rules and procedures for allocating work it wins between practices and ensuring that member practices maintain appropriate standards.

Its shareholders' agreement should include a mechanism for taking action against practices which breach the membership rules and, if necessary, removing them from the federation if their conduct or behaviour is jeopardising the federation's success as a whole.

Tax and accounting issues

There will be various tax and accounting considerations for the federation, and for the member practices, which are beyond the scope of this article. It is crucial to take appropriate advice from a specialist medical accountant.

First steps

The first step is to gauge whether there is a sufficient level of interest in your area to undertake some initial work, probably by calling a meeting of practices in your area. In some areas, the LMC will be prepared to facilitate this.

If there is sufficient interest to explore forming a federation further, a working group should be appointed for the necessary preparatory work. It may wish to engage the services of a solicitor and/or consultant to help develop a firm proposal for formation of the federation for members' consideration.

Practices will need to be prepared to:

- commit financial resources for start up costs
- nominate a partner and/or practice manager to participate in the working group/management team; and
- devote time to consideration of federation business within the practice.

But the federation is unlikely to work without sufficient interest among practices.

This article is intended to be informative and does not constitute legal advice. Alison Oliver is associate solicitor with top 100 law firm Ward Hadaway. She has over eight years experience of advising GPs on commercial and regulatory matters and has assisted numerous groups of GP practices in various parts of the country to form federations

Protect your pension against the Lifetime Allowance - an update

GPs should note that since our Winter 2014 AISMA Doctor Newsline article on the Lifetime Allowance, the Government has issued its responses to the consultation on Individual Protection 2014 (IP14), writes *David Walker***.

Its preference previously was that IP14 would not on any account be available to a member with Enhanced Protection (EP).

But in a very welcome about turn it has relented to industry pressure and agrees that IP14 can be held simultaneously to EP.

EP will trump IP14, but, should EP be lost for whatever reason (new arrangement, personal pension contribution, relevant benefit accrual), IP14 may provide a valuable safety net.