CHARTERED ACCOUNTANTS, TAX CONSULTANTS & FINANCIAL PLANNERS

ALBERT GOODMAN

PRACTICE NEWS OCTOBER 2015

Welcome to the latest issue of the Albert Goodman e-Update specifically for medical practices.

If you have any feedback on the contents of this newsletter, or would like to discuss how this may affect your practice please click on the feedback link. Likewise, if you are not a client of ours and would like to see if we are the right team for you please forward Keith Miller, our medical practice specialist, your details who will be delighted to get in touch for an informal chat.

Thank you for taking the time to read this newsletter.

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GP PRACTICES PLACED INTO SPECIAL MEASURES

Two more GP practices have been placed into special measures following an inspection by the Care Quality Commission (CQC).

The part-dispensing Trent Valley Surgery in Lincolnshire and Dr NHR Simpson's practice in Loughborough, Leicestershire, were found to be 'Inadequate' after inspections carried out in June 2015.

Inspectors said the Trent practice had a vision to deliver high quality care and promote good outcomes for patients but they saw no evidence that the practice had any strategy for the future.

A report highlights a number of areas where improvements must be made including:

- The surgery should ensure all clinical staff have appropriate professional indemnity.
- Ensure that incidents, near misses and complaints are recorded correctly, investigated and any learning cascaded to staff.
- There must be suitable equipment and plans in place to enable staff to deal with medical emergencies and foreseeable events that prevented the practice functioning normally.
- The surgery must introduce an appropriate system to ensure medicines are dispensed safely.
- Ensure the provider CQC Registration is brought up to date.
- Patient records must be stored in paper format securely so to prevent unauthorised access and to mitigate the risks associated with events such as fire.

An inspector said: 'The practice did not have processes in place to prioritise safety, identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients.'

Dr NHR Simpson's Practice, at Barrow Health Centre, Barrow-Upon-Soar, Loughborough, 'did not have a clear vision to deliver high quality care and promote good outcomes for patients. The practice did not have a strategy and business plan for the future.'

A report said the following improvements were needed:

- There should be systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- The practice should ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies, protocols and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice including the business continuity plan to be updated and personalised to the practice.
- The practice should clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure that full investigations of serious incidents are undertaken and actions and lessons learned are taken to prevent reoccurrence. Also to demonstrate candour where necessary.
- Update registration details for provider, partners and registered manager.

An inspector said: '"The practice did not have a clear vision to deliver high quality care and promote good outcomes for patients. The practice did not have a strategy and business plan for the future.'

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TOP DOCTOR FACES £200K HMRC FINE OR JAIL

An award-winning NHS heart specialist, who lied about his income to avoid paying income tax and National Insurance, has been ordered to pay a fine of £200,000 within 28 days or face two and a half years in prison.

Prof Raad Mohiaddin, a consultant radiologist at the Royal Brompton Hospital and a professor of cardiovascular imaging at the National Heart and Lung Institute Imperial College London, lied for eight years about his earnings from private practice to avoid paying almost £410,000 to HMRC, which he has since paid.

Anthony Swarbrick, assistant director, HMRC Fraud Investigation Service, said: 'Until our investigators caught up with him, Mohiaddin had made no effort to pay his fair share of tax; even ignoring the opportunity to put his tax affairs in order through a campaign we ran for medical professionals.

'As an NHS specialist he knew only too well how vital public funds are to the health service and to those individuals who need its care and support – including the very patients he was employed to treat. His career and reputation are now in tatters and he faces losing his ability to practise medicine in the UK.'

HMRC said Prof Mohiaddin stole £409,611 by failing to declare any taxable income from his self-employed work in his private practice.

He chose not to take the opportunity to come forward and put his tax affairs in order using HMRC's voluntary disclosure campaign for medical professionals launched in 2010.

At Blackfriars Crown Court, Prof Raad Mohiaddin (58) of London SW19, was sentenced to 15 months in prison, suspended for two years, and fined £200,000 to be paid within 28 days or go to jail for two and a half years.

He pleaded guilty to one offence of Cheating the Public Revenue – submitting false tax returns for April 2003 to April 2011.

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'NEW GP CONTRACT' PLANS A DIVERSION, SAY DOCTORS

Much heralded 'new GP contract' plans, arising from the Tory conference, have fallen flat among doctors.

GPs' leader Dr Chaand Nagpaul called the announcement a 'diversion' and again urged for more investment in GP services.

Under a voluntary scheme groups of surgeries could take on cover for 12 hours, every day of the week, Prime Minister David Cameron said. QOF could also be dropped, as it will be in Scotland.

But GPC chair Dr Nagpaul said: 'Yet again, the government has chosen to rely on soundbites during the Conservative Party conference rather than actually addressing the fundamental issues facing general practice and patient care.

'This announcement, which was not discussed with the BMA, does nothing to address the root causes of the pressures on general practice; escalating patient demand from an aging population and care moving into the community, crippling underfunding and a chronic shortage of GPs. Nine in 10 GPs state that workload pressures are damaging the quality of patient care.'

He urged the Government to learn from its own pilot schemes where he said there had been a number of examples of weekend appointments having little or no pick up by patients.

Dr Nagpaul added: 'These proposals could waste precious NHS resources and divert staff and funds from overstretched core GP services. GPs already provide around the clock care, seven days a week – we need this to be properly staffed and funded rather than be undermined.'

QOF

On the quality framework, the GP leaded said: 'While getting rid of the box ticking of QOF is something the BMA has long been calling for, this should apply to all practices. It would be wholly wrong if this is being used as a carrot to only benefit patients for those practices considering the new GP contract.

'Crucially, we do not need the diversion of a new contract, we need proper levels of investment in GP services, and thousands more GPs and staff to keep up with the sheer number of patients coming through the door in order to provide safe, quality care.'

Dr Mark Porter, BMA council chair, said: 'David Cameron has been clear that he wants to introduce the world's first truly seven-day health service, but less clear about how he intends to staff and pay for it at a time of enormous financial pressure on the NHS. The additional money that has been pledged for the NHS is barely enough to keep existing services running and will not pay for additional care.

'It is vital that the Prime Minister is honest with the public about how he expects to pay and staff a truly seven-day NHS2 at a time when it is facing a funding gap of £22bn, hospitals and GP services are struggling to cope and there is a chronic shortage of doctors in many parts of the NHS.'

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CONTRACT THREAT CREATES BMA GOLDMINE

The BMA is claiming a huge surge in doctors joining up since its junior doctor committee decided to ballot members in England on the Government's contract plans.

It announced today that in the space of a week it recruited as many as 5,400 members – and the majority were junior doctors.

The BMA said this was is a clear indication of the anger felt at the Government's threat to impose a new contract.

A contract imposition on doctors in training is threatened from August 2016. In order to re-enter negotiations, the junior doctor committee is demanding that the Government and NHS Employers withdraw their threat to impose a new contract, and that they provide the following concrete assurances:

- proper recognition of unsocial hours as premium time
- no disadvantage for those working unsocial hours compared to the current system
- no disadvantage for those working less than full time and taking parental leave compared to the current system
- pay for all work done
- proper hours safeguards protecting patients and their doctors

BMA Council chair Dr Mark Porter said: 'These new membership figures are an indication of the anger felt by not just junior doctors, but the profession as a whole. Instead of genuine negotiations, the Government has insisted that junior doctors accept recommendations without question. This would not have allowed the BMA to negotiate over proposals we believe are unsafe for patients, unfair for doctors and undermine the future of the NHS.'

Juniors' leader Dr Johann Malawana added: 'We have consistently been clear that junior doctors are not prepared to agree contract changes that would risk patients' safety and doctors' wellbeing. The unprecedented number of doctors joining the BMA and the thousands who have attended rallies across England is clear evidence of the anger and frustration felt by junior doctors.

'Until the Government lifts the threat of contract imposition and gives the BMA the concrete assurances we require we will continue with the action junior doctors are demanding. The time is well overdue for Ministers to listen to what junior doctors are telling them.'

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NHS DEFICIT SPARKS CALLS FOR NEW FUNDING

NHS overspending reflects the 'impossible task of delivering high quality care for patients with inadequate funding', a health service commentator has warned.

Richard Murray, director of policy at The King's Fund, said overspending of the current scale could not be attributed to mismanagement or waste among individual trusts.

He said latest figures confirmed that NHS providers were heading towards an unprecedented end of year deficit. Last week's reported overspend of £930m at the end of the first quarter in England was more than the deficit for the whole of last year.

This reflected a very sharp deterioration in financial performance among all types of providers, with 96 per cent of acute trusts and more than half of mental health trusts now reporting deficits.

'On this basis, warnings of a deficit of at least £2 billion by the end of the year are well-founded. The government and NHS bodies are already taking urgent measures to reduce spending and find savings from other budgets, but it is inconceivable that an overspend of this magnitude can be covered by the end of the year.'

Mr Murray called on the Government to acknowledge it could not continue to maintain standards of care and balance the books.

He added: 'Unless emergency funding is announced in the forthcoming Spending Review, a rapid and serious decline in patient care is inevitable.'

Doctors have joined the call for more funding. Dr Ian Wilson, BMA representative body chair, said: 'The Government must wake up and take action. The NHS is renowned as the most efficient health service in the world, but it cannot continue to do more with less.

'We need a long-term funding plan rather than a short-term fixes in order to secure the future of the NHS and stop it from lurching from one crisis to another.'

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GPS WARNED OVER ILLNESS ABSENCE IN PARTNERSHIP DEEDS

Lawyers are warning GPs to ensure any absence due to illness is adequately covered in their partnership deeds.

Lockharts said in a newsletter that uncertainty could cause distress to both the sick partner and the practice if issues had never been previously discussed.

Some GP practices state that a partner must retire after a certain period of illness but the solicitors said potential disability discrimination issues meant this might not be enforceable.

Lockharts advised GPs to take advice before attempting to compulsorily retire a partner who has been absent due to illness for an extended period and be clear about who was responsible for covering the costs resulting from a partner's absence due to illness.

WHO PAYS?

It said deeds should include:

- Who is responsible for the cost of a locum to cover the absence and for what period. 'Increasingly, practices appear to be investing in a group locum insurance policy to cover absence due to illness. In these circumstances practice's instructions tend to be that 'the insurance policy will pay for the locum' but you need to bear in mind that the insurance policy will only pay after a certain period and up to a specified period, often twelve months.'

  Even if there was a group policy, partners still had to decide what would happen if there were shortfalls in the payments under the policy and who would pay for the locum for any period not covered by payments under the policy.
- Whether the absent partner is entitled to their share of drawings and profits and, if so, for what period.
- Whether holiday leave will accrue when a partner is absent due to illness.

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LEADING DOCTOR CALLS FOR CQC TO EASE-UP ON GPS

A doctors' leader has called on the Care Quality Commission (CQC) to help ease the time-consuming red tape engulfing GPs.

Responding to the CQC report into the quality of health and adult social care in England, Dr Ian Wilson – who head the BMA's annual policy-making body – said the inspectorate made it clear that doctors were working hard to deliver first rate care to patients despite the incredible pressures facing the NHS from rising patient demand, falling resources and staff shortages in key specialities.

He added: 'There are clear obstacles that need to be overcome so that we can entrench a culture of good leadership and collaboration, but we should not ignore the funding and staffing issues that are undermining the ability of hard working health professionals to deliver effective care.

'The CQC itself could help the NHS by reducing its often cumbersome regulatory process, especially when it comes to general practice.'

The CQC's annual analysis of the quality of health and adult social care in England found the majority of services were rated as good or outstanding, but the report highlighted variations in quality and safety, and identified a positive correlation between strong leadership and high quality care.

According to the CQC, the number of services rated as either good or outstanding suggests most people are receiving safe, effective care.

It said: 'Although CQC has not finished inspecting all providers, the ratings published up until the end of May 2015 show more than 80% of GP practices are rated either good or outstanding; in adult social care, nearly six out of ten services are rated good or outstanding; and 38% of hospitals and trusts, including mental health, have been rated good or outstanding.

'Our inspections have identified strong leadership as a crucial factor among those providers rated as either good or outstanding. More than nine out of 10 (94%) of the services we have rated as good or outstanding overall are also rated as good or outstanding for their leadership. Similarly over eight out of ten (84%) of the services we have rated as inadequate overall were rated inadequate for leadership.'

The CQC said having the right numbers and mix of staff was also crucial to delivering excellent care. 'This means looking at staffing in a sophisticated way which is focused on the quality of care, patient safety and efficiency, rather than just crude numbers and ratios of one group of staff. The providers who are getting this right are practising robust workforce planning informed by excellent data, alongside a willingness to collaborate with partners across the local health economy.'

But it added that there was an unacceptable level of poor care, with 7% of providers of acute, primary medical and adult social care in England rated as inadequate.

'Safety continues to be our biggest concern across all of the services we inspect. We have rated over one in 10 hospitals (13%) and a similar proportion of adult social care providers (10%) as inadequate for safety. In primary medical services, 6% of those we rated were inadequate for safety.

'Our analysis highlights a range of factors affecting safety across all of the sectors. These include: a failure to adequately investigate and learn from incidents and errors so they don't happen again, concerns around the adequacy of staffing numbers and staffing mix, failure to undertake safety checks and staff not being able to raise concerns.'

LEADERSHIP

Shirley Cramer, chief executive of the Institute of Healthcare Management, said it should come as no surprise that those services rated as good or outstanding also scored highly in terms of leadership.

She called for more to be done to develop, support and empower current and future NHS leaders. 'At present, there is a culture of blame that does just the opposite, with senior managers in the NHS routinely treated as a political football. It is little wonder the NHS has such a high leadership turnover, with an average CEO tenure of just two and a half years.'

Ms Cramer said everyone was behind the CQC's recommendation to create a culture of openness and transparency, where mistakes were identified and corrected. But this could not be done unless senior managers were made to feel they had the freedom to fail, learn and improve. 'Regrettably, many currently feel it is better simply to keep their heads down.'

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NHS CASH HIT BY SOCIAL CARE CUTS, SAY CCG BOSSES

Cuts in local authority social care budgets are adversely affecting health services, according to nearly nine out of 10 NHS trust finance directors and eight in 10 CCG finance leads.

These findings in a King's Fund's survey are reinforced by NHS performance data analysed for the report. This shows that more than 5,000 patients experienced delays in being discharged from hospital at the end of August – the highest level at this time of year since 2007.

Further analysis for the report reveals that nearly a third of these delays were caused by problems accessing social care services – an increase of 21 per cent in the past year.

With cuts in local authority budgets now having a significant impact on health and social care services, The King's Fund is calling on the Government to use the forthcoming Spending Review to protect social care from further budget cuts and reinvest the £6 billion previously earmarked to implement the Dilnot reforms (now delayed).

This quarter's survey – which was carried out in September, two months after the period covered by recent reports from NHS regulators – also confirms that the NHS is now in serious financial crisis.

- Almost two-thirds (63 per cent) of trust finance directors and 88 per cent of acute trusts are forecasting a deficit at the end of the financial year. These forecasts include additional in-year financial support for 75 per cent of finance directors in NHS trusts.
- As measures to cap spending on agency staff come into force, a quarter (27 per cent) of NHS trust finance directors say this will affect their ability to ensure safe staffing levels.
- Staff morale continues to top the list of concerns raised by trust finance directors.
- As the NHS heads towards winter, the report shows that the NHS continues to face significant performance issues. The most up-to-date figures show:
- in August 5.7 per cent of patients spent longer than four hours in A&E – the first time the target has been missed in this month since monthly recording started in 2010
- the proportion of patients still waiting for treatment after 18 weeks – the main target measure for elective surgery waits – increased to 7.4 per cent in August, just within the 8 per cent target
- the proportion of patients receiving cancer treatment within 62 days of an urgent referral from their GP fell to a record low of 82 per cent in the first quarter of 2015-16, well below the 85 per cent target and the lowest since the target was introduced in 2009.

King's Fund chief economist John Appleby said: 'The quarterly monitoring report reveals the financial crisis engulfing the NHS and social care. With winter approaching, the NHS faces a toxic mix of widespread deficits, rising waiting times and low morale.

'There is now clear evidence that cuts to social care budgets are affecting the NHS, as well as reducing services for people that need them. The Government must use the Spending Review to protect the social care system from further cuts and reinvest the £6 billion previously earmarked to implement the Dilnot reforms.'

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HEALTHCARE ORGANISATIONS JOIN DOCTORS IN APPEAL TO CHANCELLOR

Top doctors and the body representing 85 per cent of NHS commissioners and providers have joined forces to send a letter to the Chancellor of the Exchequer urging for the spending review to bring an end to public health cuts to enable a greater focus on prevention.

Alongside the Academy of Medical Royal Colleges and the NHS Confederation, the letter is also signed by a number of health care organisations including the RCN.

Rob Webster, chief executive of the NHS Confederation explained: 'There is an unprecedented consensus that we can only address the problems facing the NHS if we invest in the future of our nation's health by helping people to stay well.

'Open any report from any director of public health in any part of the country and you can see health inequalities and poor health putting pressure on NHS services and blighting people's lives.

'From our 2015 challenge to the Five Year Forward View, there is agreement that public health has a vital role to play, alongside care in people's homes, in hospitals, and in the community. Investment in public health is critical for achieving a sustainable NHS and for addressing inequalities across society.

'We need the upcoming spending review to protect public health budgets, reflecting the Government's commitment to transform and improve the way care is delivered to patients.'

WHAT THE LETTER SAYS

'Our organisations collectively represent the professional interests of the UK's 220,000 doctors, 300,000 nurses, health service leaders, public health specialists and local authority leaders.

'We welcome this Government's commitment to increasing NHS spending in real terms by £8bn between now and 2020 and to back implementation of the Five Year Forward View, (FYFV)which you refer to as 'the Stevens Plan'.

'However, it is universally accepted that to achieve the objectives set out in FYFV we will need to embark on a 'major upgrade' in prevention and public health. As we enter the final consideration of the Spending Review arguments we wanted to reinforce our concern about the decision to cut £200 million from this year's public health grant to local authorities, which was announced in June this year.

'This cut will have a direct impact on people and communities who rely on this funding, and it will have a direct impact on the NHS which will have to pick up the pieces by treating preventable ill health. The Faculty of Public Health's own analysis suggests the eventual 'knock-on' cost to the NHS could well be in excess of £1bn. By any measure then, the planned move is a false economy.

'On top of this, many of the services delivered through the public health spend via Local Authorities fund clinical NHS care. Cutting this funding reduces NHS revenues so it is misleading to suggest that the NHS budget is being protected.

'By reversing the proposed cuts to the public health grant, and investing in prevention and public health in the Spending Review, the Government should be able to reduce the wider budget deficit, which you have suggested is the aim of the proposed cuts. Reversing the proposed cuts will relieve pressure on our overburdened NHS, tackle inequalities and improve people's health and wellbeing.

'On the 15 September, your colleague Rt Hon Jeremy Hunt MP, the Secretary of State for Health, told the Health Select Committee that: "…we have to be very careful that what we are asking for is a genuine efficiency saving and not something that actually will impact on the delivery of services".

'As representatives from across the health and care community, we have made submissions to your officials that make the case for investment in this area as part of the future health and care system. Through this letter, we urge you to consider very seriously the position we have outlined, to reverse these cuts in your forthcoming Comprehensive Spending Review and give a clear commitment that no further cuts will be made to public health budgets in future years.'

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‘THE PRIMARY CARE HOME’ INITIATIVE

At first sight, The Primary Care Home sounds like a place run by GPs where you might go to visit your granny.

In fact it is a term likely to become increasingly familiar to those working with doctors – and patients too.

The phrase is an initiative publicised this week by The National Association of Primary Care (NAPC) and it aims to support the strengthening of primary care in line with the new care models outlined in the NHS Five Year Forward View.

Already endorsed by NHS England, the programme will endeavour to meet the health and social needs of a community of up to 50,000 people.

Its supporters say care will be provided by ‘a complete clinical community’, an integrated workforce from hospitals, primary care, community health services, social care and the voluntary sector.

Patients will be offered more personalised, coordinated and responsive care nearer to their home, according to the NAPC, and there will be improved care for people with long term conditions and patients needing rehabilitation.

Expressions of interest for potential rapid test sites will be announced by the Association soon.

According to NHS England chief executive Simon Stevens, the programme offers an innovative approach to strengthening and redesigning primary care, ‘centred around the needs of local communities, and tapping into the expertise of a wide array of health professionals’.

The key features will be:

- provision of care to a defined, registered population of between 30,000 and 50,000;
- aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards;
- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and
- a combined focus on personalisation of care with improvements in population health outcomes.

NAPC chair Dr Nav Chana explained: ‘In essence what we are describing is the “home” of care for a population with a tailored workforce with access to the data, tools and resources to provide high quality comprehensive care.

‘Working at this scale ensures a functional team where everyone knows each other and there is a true sense of belonging for patients, the population and the workforce.’

Association president and GP Dr James Kingsland added: ‘We want to have a strong evidence base behind us, rather than just individual or collective opinion. The Primary Care Home is about building from the registered list, which has served the NHS so well and recognises patients access the NHS through general practice. This new model of care will be more ambitious in the delivery of first contact.’

The programme will be delivered by the NAPC and the NHS Confederation with additional support and learning from the new care models programme.

Rob Webster, chief executive at the NHS Confederation said: ‘Members right across the country are developing new care models locally which break down the traditional boundaries between acute services, primary care, community health services, social care and the voluntary sector to better meet people’s needs.

‘Our Community Health Services Forum is working with NAPC to look at how deeper partnerships between community health services and primary care can develop. The opportunity to test and share evidence from the Primary Care Home model will be valuable to these efforts.’

Q and As

What are the benefits of the PCH for patients?

The key benefits of the PCH for patients are a single integrated and multidisciplinary team, working to provide comprehensive and personalised care to individuals. Working at this scale ensures everyone within the PCH team knows everyone else and the patient has a more consistent experience of care, similar to having a named GP.

How was the PCH developed?

The PCH draws on the lessons learnt from previous models of clinical commissioning in England, including: GP

fundholding and total purchasing; Primary Care Groups, Practice Based Commissioning; GP federations; and the Primary Medical Services (PMS) Plus contract. The PCH also draws on the learning and outcomes from medical groups and accountable care organisations in the United States.

What's unique about the PCH?

The PCH and MCP model share some of the same goals, such as better outcomes for patients, at lower cost, based on greater integration between primary and secondary care. However, the PCH, in particular, focuses efforts on the 'make or buy' decisions within care provision through the accountability of independently managing a capitated budget for a registered population of between 30,000 and 50,000.

It can dismantle historical organisational boundaries with multi-disciplinary clinical and social care teams working collectively through networked arrangements. The PCH will be based within modernised community healthcare premises, with access to diagnostics on site and a fully integrated IT system.

What are the key local relationships that need to be in place?

Successful PCH rapid test sites will need to obtain the buy-in of other stakeholders. This will include, but is not limited to: CCGs, patient groups, GP practices, local authorities and providers, including acute, community and mental health trusts.

What is the PCH workforce model?

The PCH enables primary care, community health and social care professionals to work in partnership with specialists to provide out of hospital care. The workforce model for each individual PCH should reflect the size and needs of the registered population, which may result in exploring opportunities to design and develop the roles of nursing, pharmacy and allied health professionals.

The scale of the population for PCH model is intended to drive a workforce model that ensures patients have a consistent and personalised experience of care.

How will PCHs be supported and connected?

The PCH is being supported by NAPC and NHS Confederation with additional support and shared learning from the New Care Models Team. PCH rapid test sites will need to have the agreement of the CCG and working, mature and capable relationships with networks in their locality.

Questions and answers supplied by NAPC

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NOTIONAL RENT BREAKTHROUGHS FOR GPS

Five 'breakthrough' cases confirm that GP practices contractually have three years in which to challenge their notional tent reimbursement, not the three months which was argued by NHS England.

The firm GP Surveyors said today that in addition to this, there are four cases pending which are expected to have a similar outcome – preventing NHS England from imposing non-contractual time limits on notional rent reimbursement appeals.

Paul Conlan, the company's operations director, explained: 'Over the past year we have taken on an increasing number of notional rent appeals on behalf of our GP clients where NHS England has refused to enter into local negotiations.

'NHS England reasoned that this was because the practices had not opened the disputes within the three month time frame which was outlined in letters to the practices following their reviews.

'However we have always reaffirmed that GP practices have three years to appeal their notional rent following a review due to the regulations outlined within the GMS contract (NHS GMS Regulations 2004) – specifically Schedule 6, Paragraphs 99 and 101.'

Paragraph 99 states that: 'the contractor and the Primary Care Trust must make every reasonable effort to

communicate and cooperate with each other with a view to resolving the dispute, before referring the dispute for determination in accordance with the NHS dispute resolution procedure.'

Said Mr Conlan: 'This means that NHS England must endeavour to discuss and resolve notional rent appeals at a local level. If an agreement cannot be reached, then the matter can be referred to the NHS Litigation Authority (NHSLA) to follow the NHS Dispute Resolution Procedure (LDRP).'

Paragraph 101 states that disputes must be taken to NHSLA within three years: 'Any party wishing to refer a dispute as mentioned in sub-paragraph (1) must send the request under sub-paragraph (3) within a period of three years beginning with the date on which the matter giving rise to the dispute happened or should reasonably have come to the attention of the party wishing to refer the dispute.'

GP Surveyors said in all five rulings, the NHSLA stated that GP practices (or their representatives) have three years to enter into LDRP if they are not in agreement with their new Notional Rent figure and NHS England must make every effort to resolve the matter before it is referred to disputes.

It said that as a result of these cases, NHS England has been instructed by NHSLA to instruct a representative to discuss and negotiate these specific cases with GP Surveyors within 30 days. 'Moreover, they have also been told that "one party cannot impose a time frame which restricts the ability for such appeals to be discussed and resolved at a local level because this is inconsistent with the Regulations"'.

ADVICE TO GPs

Mr Conlan said these 'landmark' cases will help to ensure that GP practices are given a fair and reasonable time scale in which to appeal their notional rent.

'We are now calling on NHS England to amend their standard letters to reflect the outcome of these determinations.

'We also advise any GP practices who have not checked their notional rent reimbursement due to the three month deadline stated by NHS England, to contact their specialist surveyor for a second opinion. Your surveyor will then be able to review your reimbursement and provide advice as to whether a challenge might be appropriate.'

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aisma
association of independent specialist medical accountants

Keith Miller

Keith joined Albert Goodman in 2006 from a local Somerset firm of Accountants where, having qualified as a Chartered Accountant in 1988, he had been a Partner since 1990. He recently went on to achieve further success becoming a Certified Financial Planner in 2006.

Although best described as a General Practitioner, providing financial and taxation advice to an expanding portfolio of high net worth individuals, limited companies, sole traders and partnerships, Keith specialises in assisting medical practices and solicitors on all aspects of financial and taxation advice. He leads our GP medical team and is a member of AISMA, the Association of Independent Specialist Medical Accountants.

As a qualified Certified Financial Planner, he is ideally suited to obtaining a detailed understanding of the issues facing proprietors and their personal objectives in order to make a key contribution on strategic and tax issues, as well as dealing with the very complex areas of Capital Gains Tax and Inheritance Tax planning

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