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association of independent specialist medical accountants

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AISMA Doctor Newsline

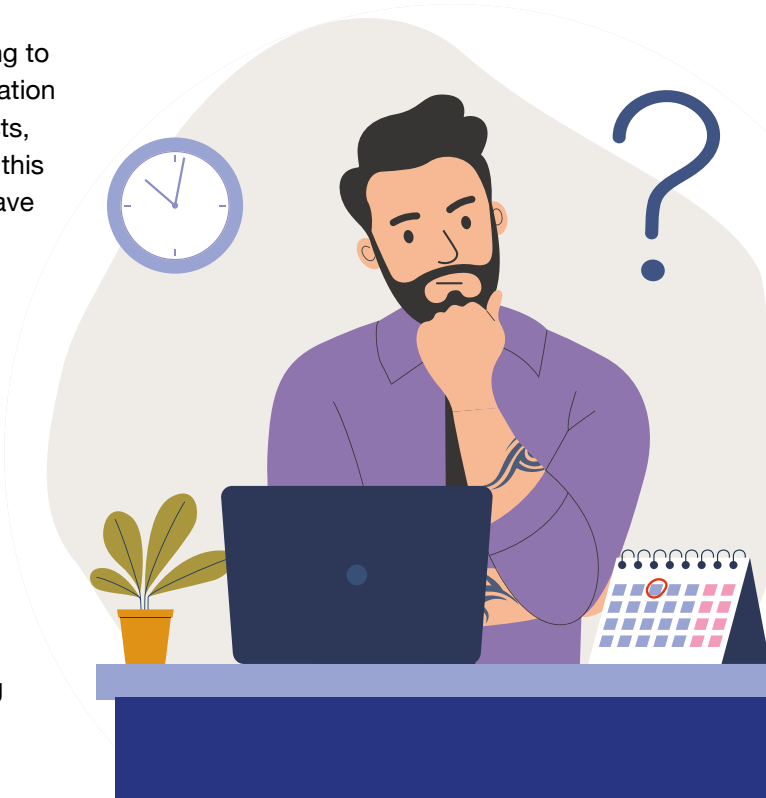
At the heart of medical finance...

10 hot tips to boost practice profits

As the financial heat burns ever bigger holes in your bank balances, **Andrew Burwood*** suggests a fresh look at spending and earnings could still help many practices ease the pain

The current economic climate is proving to be challenging for everyone. High inflation has led to significant increases in costs, and the Bank of England's attempts to curb this through raising bank base rates are yet to have a positive impact.

Those with borrowings on variable interest rates, whether for residential mortgages or business loans, are feeling the squeeze more than others.



So:

1 Try to avoid providing a gold-plated service for bronze money

The imposed contract for 2023-24 saw a paltry £2.58 increase per weighted patient to the global sum. After factoring in the resulting

rise in the out of hours opt out cost (4.75% of the global sum and temporary resident payments), the actual increase is 2.46%.

Add in other contract funding streams, such as QOF and enhanced services, and total income from core services is between £140 and £150 per patient. From that, you must fund staff, consumables, premises, and overheads.

Your individual profit share is dependent on how you spend the funding received. Therefore, you must consider how patients access the services you provide. You are running a business. But you do not receive additional funding for providing an excellent service.

2 Be mindful of staffing

The average practice spends £76 per patient on its staff. That is 74.3% of your global sum and is the largest practice expense. While the following will not boost profits overnight, they are key considerations for any business:

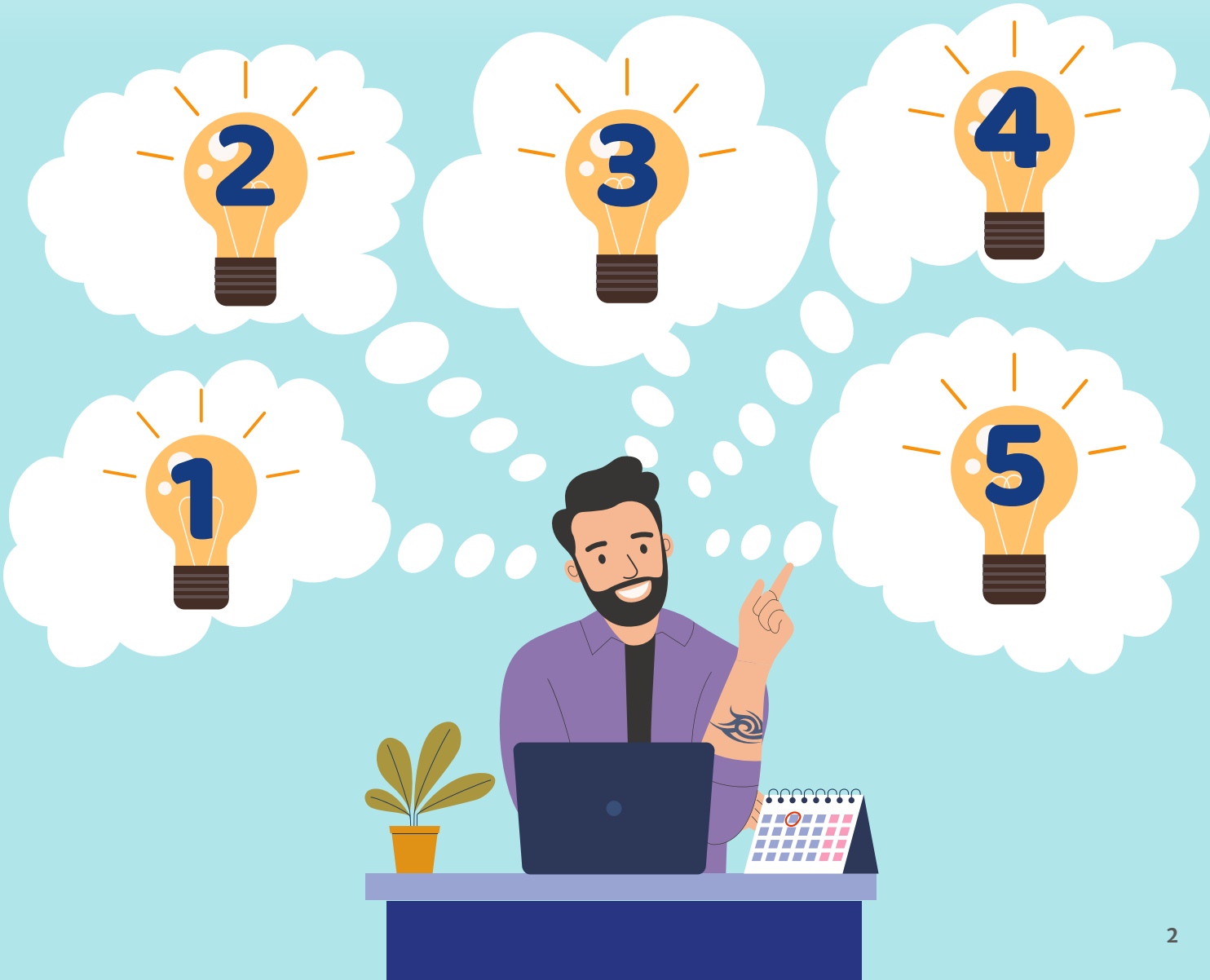
- Ensure that you are getting full value out of every team member.
- Carry out periodic appraisals and set objectives.
- When staff leave, do you need to employ direct replacements?
- Benchmark your salaries with other local surgeries; perhaps those in your PCN?
- Can staff be shared across your PCN (but watch out for VAT implications)?
- Can technology cut out some of the administrative functions?

Overtime can easily get out of hand. Ensure that appropriate controls are in place. The practice is reliant on its staff, and it needs to be invested in appropriately.

3 Limit the use of external locums

Locums are very expensive. The costs of using them are raised further if they are members of the NHS Pension Scheme, as you will also have to pay the employer's superannuation contributions of 14.38% on 90% of their locum fee.

You should consider the following before making use of them:



"Your annual meeting with your accountant should not be just about the accounts. Your accountant can get your record-keeping and management reporting in order"

- Can rotas and holidays be managed better to limit need?
- They will not necessarily be aware of your systems and could lose you further money. For example, if you are a dispensing practice they may prescribe drugs which are not profitable.
- If locums are needed to cover absence (such as illness or maternity leave), make sure you claim the NHS locum allowances available.

Review your locum insurance policy to make sure it is adequate for your practice and you personally.

4 Do not chase every income stream available

You must consider the costs versus the reward in every scenario. Examples:

- Is it worth chasing every QOF point available?
- Is that research project worth the time needed?
- Are there any income sources worth focusing on? Learning disability checks are usually a beneficial use of time (if you have the available resource and expertise).
- Outside appointments (such as GPwSI or LMC work) can be great for the individual, but will the costs of backfill exceed the income?

5 Embrace your PCN

Working at scale is the inevitable direction of travel, for now. As such, active engagement with your network is a necessity.

ARRS funding is the one area where investment has been made in primary care, so maximising this and perhaps changing how patients access your services is vital.

However, you must take advice on tax and VAT implications, and be aware that loose collaborations of network members mean that all partners are jointly and severally liable for any debts incurred.

6 Use a specialist medical accountant

Your practice accounts should detail all income streams received. How can you understand how your business is funded and ensure that all income you are entitled to is received if this is not done?

It is important to separate out income from non-NHS sources; to not do so could see your pensionable profits, and therefore your superannuation contributions, being overstated.

Profit-sharing is not always straight-forward. Separate capital accounts are needed for property, other fixed assets and working capital.

Your annual meeting with your accountant should not be just about the accounts. Your accountant can get your record-keeping and management reporting in order. They should be seen as your business partner, not an unwelcome overhead.

7 Keep your practice and personal finances in order

For the practice:

- Review income statements religiously.
- Check superannuation is being collected correctly.
- Use appropriate accounting software.
- Prepare and monitor budgets against actuals.
- Watch practice cash flow.
- Put appropriate controls in place for debt recovery.

For you personally:

- Maintain records of all expenses incurred for business purposes to reduce tax and superannuation liabilities.
- Put enough aside from your monthly drawings for your tax liabilities (assuming the practice does not pay them).
- Pass your tax information to your accountant promptly.
- Use a recommended IFA for investment advice.

8 Understand your surgery premises

If you own the property:

- Make sure that three yearly rent reviews take place.
- Consider use of third parties to potentially obtain a higher rent reimbursement.
- Be sure that the valuation clause in your partnership agreement is based on notional

rent reimbursement rather than alternate use.
- Consider how repair costs are allocated between the partners if not all partners own the building.
- Update the land registry for changes in ownership.
- Plan for partnership changes and end dates on any fixed rate loans in place.
- Claim tax relief on interest paid on business loans.

If you rent the property:
- Watch out for dilapidation and rent review clauses in lease agreement.

For both:
- Consider dilapidation provisions in your annual accounts.

9 Personally administered income

Make sure you are claiming for all income that you are due. Issues we see include:

- It can be difficult to know what can be claimed.
- There are complex processes for submitting claims.
- There can be inconsistent use of clinical system templates.
- It can be difficult to reconcile payments with claims.

"Identify potential future partners in your existing team – and within your students/registrars if you are a training practice"

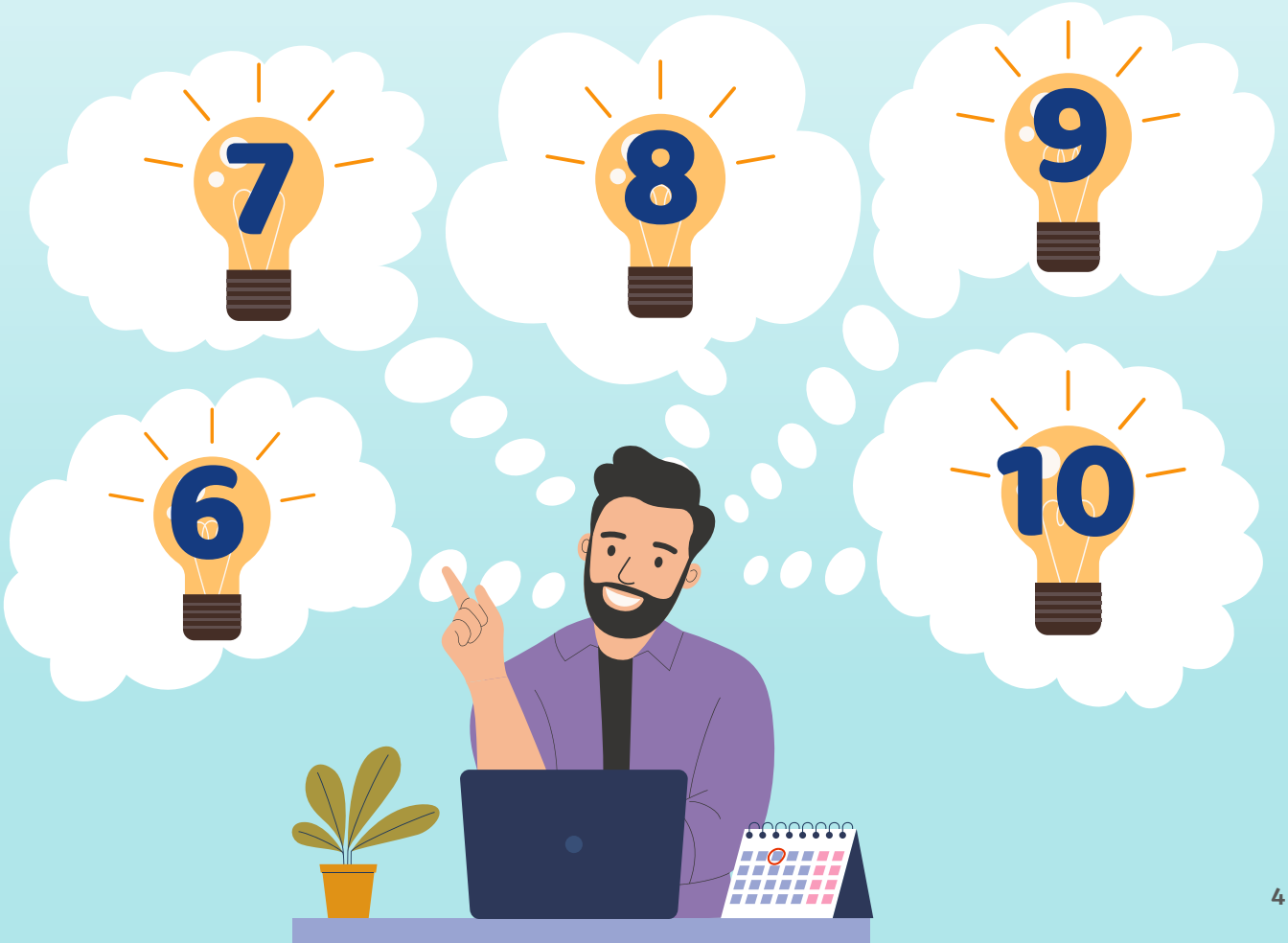
You should consider having an expert come into the practice to review and improve your procedures.

10 Look at your own partnership.

- Ensure your partnership agreement is fit for purpose and signed by all partners. Poor agreements can lead to costly disputes.
- Work as a collective and not in silos.

Be aligned on ethos and getting work/life balances right.
- Ensure that regular management meetings take place. Your practice manager is a key cog in your business.
- Watch for signs of burn-out and excessive stress in your partners.
- Plan for partner retirements.

Identify potential future partners in your existing team - and within your students/registrars if you are a training practice.



We are guiding GP practices through this uncertain era

OPINION

Andy Pow **
AISMA board member

The 2023-24 financial year has started off as a challenging one for general practice finance.

In England this will be the last year of the five-year contract deal agreed back in 2019-20. Limited uplifts were applied to the global sum, with funding changes concentrated on capacity and access within PCNs.

In Northern Ireland political stalemate has seen little progress in GP funding over the last couple of years and in Scotland we remain to see how the contract changes, if at all.

At least in Wales there is more active engagement between the political regime and general practice.

Pay disputes in the secondary care sector have been the story of 2023, impacting junior doctors working in general practice, and with wider implications of imposed settlements on other staff flowing down to practice level.

Stagnation in discussions at a political level leads to uncertainty. At a time when demand is at record levels, uncertainty is not welcome.

The immediate financial challenges remain how to manage cost increases without matching resources.

On the positive side there have been significant improvements in respect of pension taxation. There has also been movement on how pensions will be calculated for members who transitioned to the 2015 section of the scheme - known as 'the McCloud remedy'.

The 2023 Budget saw a surprise change to the lifetime allowance and rises in the annual allowance threshold. AISMA has long campaigned for changes to these tax charges.

We reported consistently to the government that these were not only impacting the retention of doctors, but were also leading to restrictions in hours worked.

High inflation was also leading to concern over the level of possible annual allowance charges for 2022-23. While the changes put in place are not perfect, they will go a long way to remove a lot of GPs and non-GP partners from the risk of high pension tax charges.

We are also getting closer to a position where the corrections needed to pension calculations can start in respect of the McCloud remedy, previously reported in *AISMA Doctor Newsline*.

Consultations on changes are coming thick and fast, with the AISMA board responding where appropriate. No doubt this will become a recurring theme over the next year.

Structural change continues apace in general practice. At our recent annual conference, attended by over 200 medical specialist accountants, our theme was a changing landscape for general practice.

We heard from PCN specialists about the challenges ahead as we now enter the final year of the initial five-year period. We heard about different models of super practices and the challenges they face with the current GMS contract, which was designed to deal with organisations at a far smaller scale.

And we also learnt about innovative changes around employee ownership of practices. The learning was that all these practices reaped benefits, but equally all had difficult hurdles to manage, particularly around contract ownership, pensions and how to run businesses at scale.

Throughout all the talks there was a common theme of uncertainty ahead, retention of staff issues, shortage of space with a lack of investment in premises and rising patient demand.

There is no magic wand to solving the current issues and each practice will need to work through its individual problems.

We may be biased but, more than ever, there is a need for practices to work with specialist advisors – lawyers, banks and indeed accountants.

Through our AISMA peer network of medical specialists we continue to support practices directly and more widely in trying to inform decision makers of issues coming ahead.

Is your team all really singing from the same song sheet?

Fiona Dalziel highlights some key action areas to help ensure everyone you work with strikes the right note

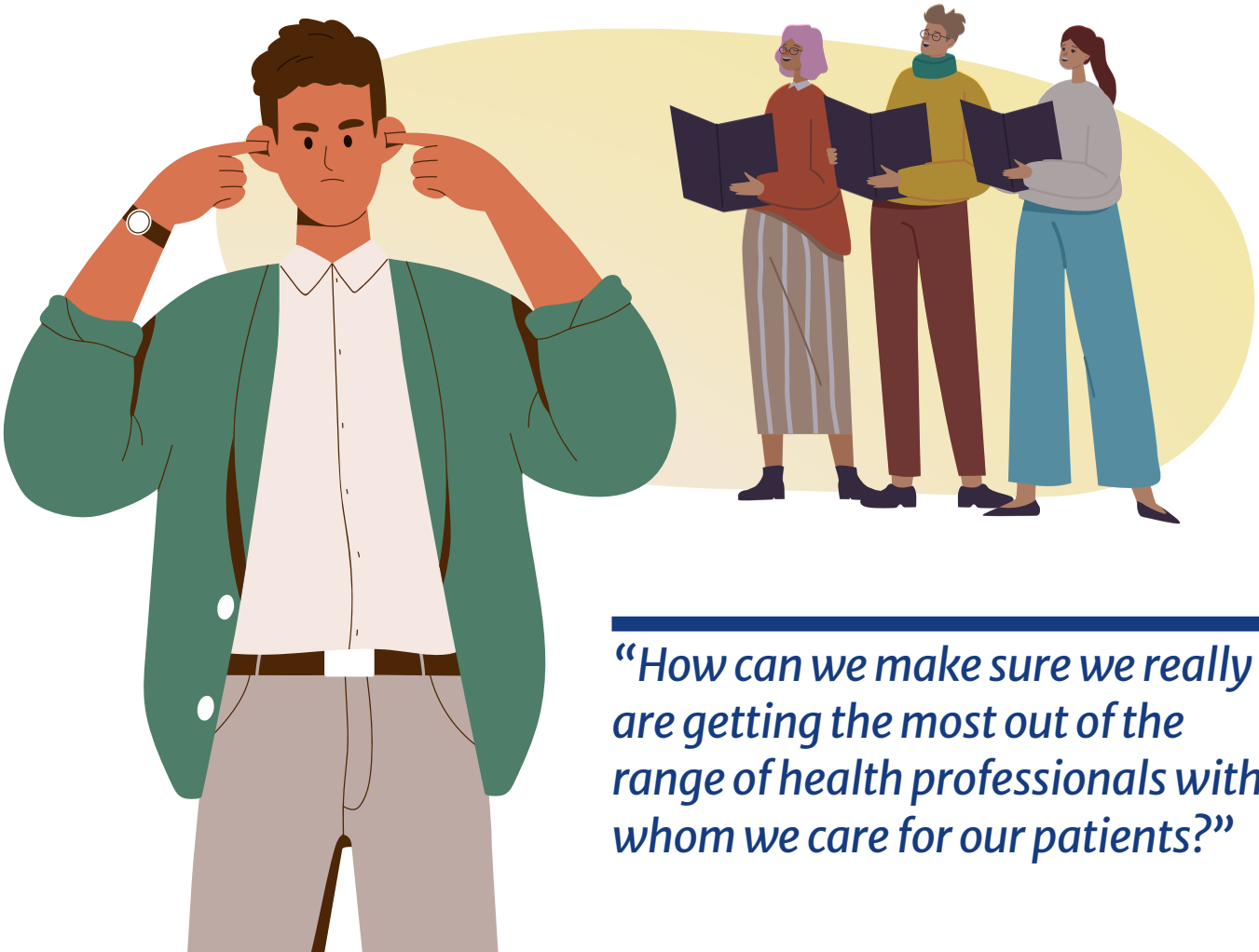
Several years after the introduction of multidisciplinary teams in general practice - and the then mysterious activity of receptionist signposting - it seems about the right time to review how that is all working out.

After all, workload pressures do not appear to have abated. How can we make sure we really are getting the most out of the range of health professionals with whom we care for our patients?

I have the privilege of singing in a community choir. As an experienced choral singer, I am in the lucky position of having time to observe what is going on around me and I'm struck by the similarities between conducting a choir and managing a practice.

People who don't have the right music are immediately at a disadvantage. People who are not strong sight-readers may need more help with their line. People who don't attend rehearsals slow down the progress of the choir's hard work.

If the conductor can't sort out what's not sounding right during rehearsals, the performance isn't going to sound good to an audience. I like to think of the practice as the



"How can we make sure we really are getting the most out of the range of health professionals with whom we care for our patients?"

"How much do the reception team really understand about your new team member's role and what might be appropriate to pass to them?"

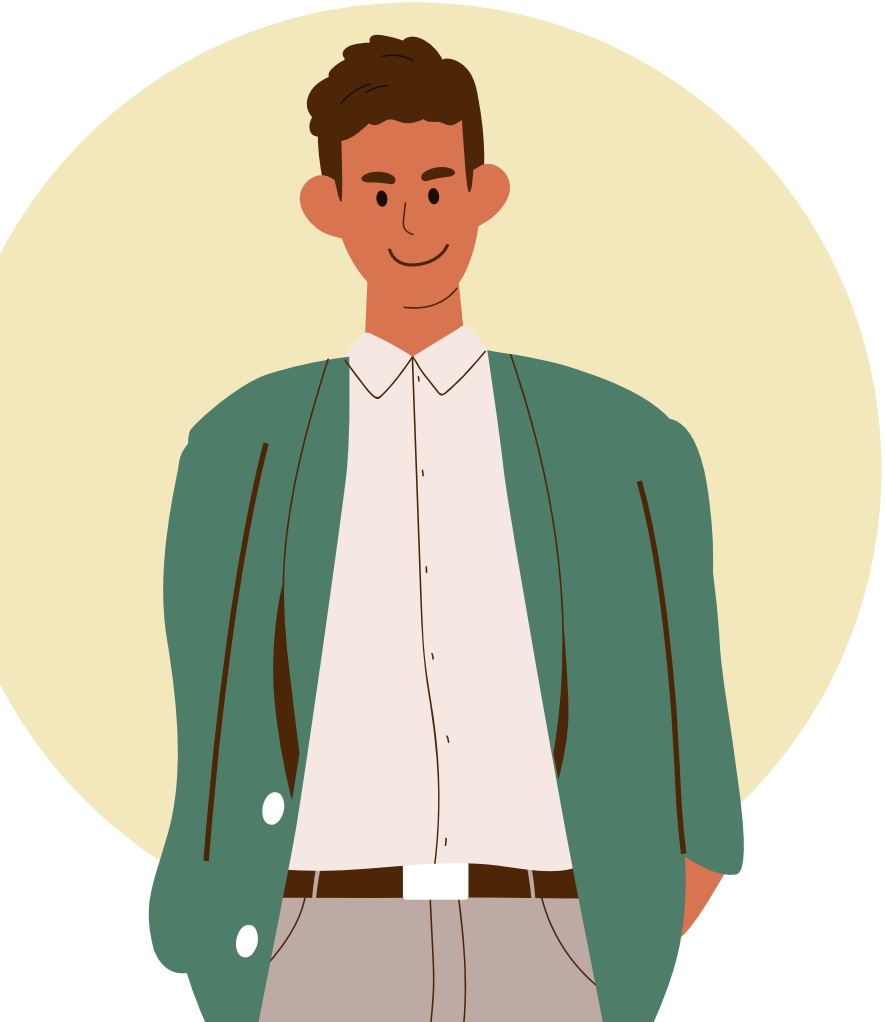
choir and the patients as the audience.

Perhaps now is the moment to review how integrated and effective our fellow health professionals are and, at the risk of preaching to the choir, have a look at some key action areas that will help ensure we're singing from the same song sheet.

Understanding roles, competencies and expectations is vital. Welcoming a new professional onto the team is often accompanied with a sigh of relief. However, sometimes the reality of their presence does not fit with what we expected to see. How can we avoid this?

Make sure everyone is expecting the same outcomes

Don't assume that your knowledge of the role and competencies of the new professional is comprehensive and up to date. Investigate.



If the professional is being supplied by your local health organisation, meet with the organisation and obtain comprehensive documentation even if the individual is not yet identified.

It may be that the health organisation already has a clear idea of the role the professional will play in your practice. What are the practice's own expectations and patient needs and how do they all match up?

What competencies will the new team member have? There is a vast difference between how you can use a practice-based pharmacist who is not a prescriber and one who is.

Importantly, if you are not going to be the direct employer of the professional, what will their hours be? What will be their actual job description, including priorities? How might their time be divided between your practice and other commitments?

Who will determine and manage the professional's workload? How will you monitor progress, identify learning needs and solve any problems?

Establish relationships with the whole team and with patients

Great! Your new physician assistant/practice-based pharmacist/physiotherapist is about to start. Receptionists will be able to signpost patients to them and patients may be seen more quickly. But wait.

How much do the reception team really understand about your new team member's role and what might be appropriate to pass to them? How are patients who had hoped to see a GP going to understand the role of the professional they are seeing?

Arrange a meeting with the relevant part(s) of the practice team so your new team member meets everyone and can answer questions directly. Don't underestimate the importance of putting a face to a name!

Consider the various ways you can inform patients about your new team member.

Perhaps a note in with repeat prescriptions will help let them get familiar with the concept of a medication review with a pharmacist.

How can your patient group help with communicating the news? What about updating the web page and having a special feature on the expanding team and what patients can expect?

Make sure you think widely about what meetings and educational events your new clinical team members should be invited to attend (including social events!)

Provide educational support

A mentor will greatly help your new team member. Even if they already have one from their own profession, possibly external to the practice, a supportive practice mentoring relationship will bear fruit in all sorts of ways.

Attendance at any kind of practice educational event will also enhance both learning and inter-professional understanding.

Additionally, a mentor will be able to monitor workload and job content to make sure issues are picked up and resolved at an early stage.

It is sadly not unusual that professionals not directly employed by the practice are in the position of serving two 'masters.'

Sometimes, this can lead to stress and practices may find they have established a new relationship only to lose the individual to re-prioritisation or re-assignment.

The better you are able to establish your new team member, the more you minimise this risk both to the individual and the practice.

Back in my community choir, we all now have the right music and we have note-bashed until everyone is confident of what they are meant to be singing. Everyone values rehearsing and therefore attends; they can hear the results.

The conductor has ironed out the tricky bits. We will enjoy our performance and so will the audience. Music to everyone's ears!

Helpful links

GPs' and pharmacists' views of integrating pharmacists into general practices: a qualitative study

- Ameerah S Hasan Ibrahim, Heather E Barry and Carmel M Hughes
British Journal of General Practice 2023; 73 (731): e407-e417.

Working differently together: Progressing a one workforce approach

Health Education England

Practice-based pharmacists: considerations for general practices

British Journal of General Practice 2023; 73 (731): 249-250

Fiona Dalziel runs DL Practice Management Consultancy

ASK AISMA!

GPs' questions about the complexities of withdrawing money from the practice are tackled here by Abi Newbury***

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

I'M WANTING INTEREST ON WHAT I'VE GOT IN THE PRACTICE CURRENT ACCOUNT

Q **I'm the senior partner in our practice and over the years I've built up about £75,000 of investment in working capital – my 'current account' balance in the accounts.**

The new partners are lucky if they have a positive balance at all and want to draw maximum out of the practice to fund their costs of living.

Am I being unreasonable in asking for interest on my balance?

A No, it's not unreasonable to be recompensed for money you have left in the practice in excess of what the other partners have.

These funds could either be giving you additional income (investing in savings accounts, where rates are very much higher than they have been) or saving you other interest charges, for example reducing offset mortgage balances, paying off credit card balances on which high interest rates are charged or other loans).

And while interest rates have been very low, it has not been so much of a problem, but now they are rising it will be more important to you.

So, it would seem fair as you are funding the practice instead of using the money elsewhere, that you are paid for the privilege. After all, if the practice had taken a loan then all partners would be expected to bear the cost, including arrangement fees.

Your first port of call – if the partners don't just say 'yes we'll pay you what you would have got in a bank or building society account' – is your partnership agreement.

Some agreements will provide for interest to

be credited as a pre-share of profits for sums in excess of a defined amount, paying you 'interest' for the practice borrowing those funds.

Other agreements will say that excess current account balances can be drawn each year when the accounts are finalised.

Of course, if the practice doesn't have sufficient funds for you to do that, the question is can the other partners find sufficient funds to put their share in, so you can draw yours out? If they can't, are they prepared to be reasonable and recompense you for the fact that they've drawn too much out?

For the future, drawings should be at a level to leave the agreed working capital in the practice. And, ideally, don't let funds build up as you have done.

Apart from it being a potential cause of partnership friction now, it will be a shock to them when you retire and they have to find money to pay you out.

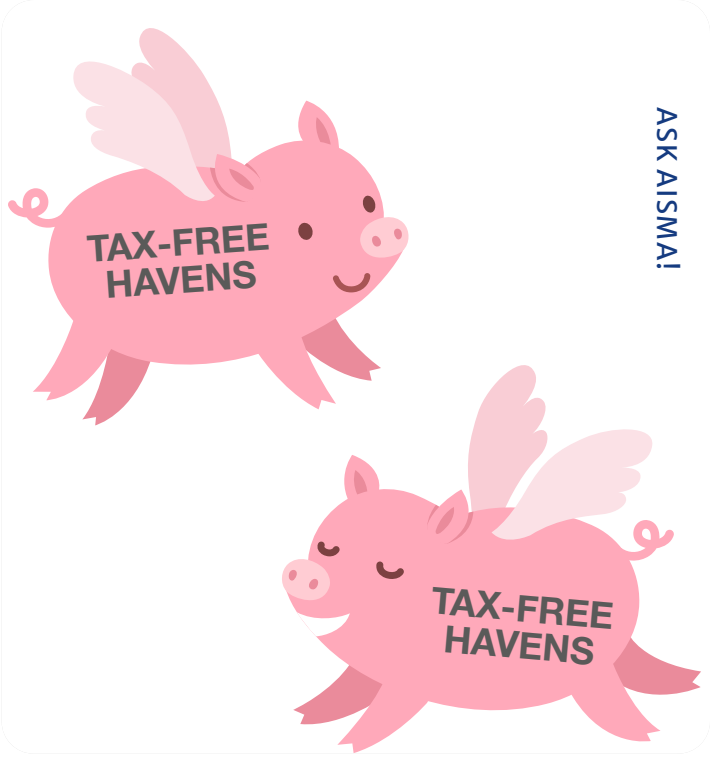
BE CAREFUL WHEN YOU LOOK FOR TAX-FREE HAVENS

Q **I wanted to take some excess funds out of the practice and put them in a savings account because I thought it would be tax free. It seems that is not necessarily the case?**

A If you are a basic rate taxpayer then the first £1,000 of savings income is taxed at 0% - but this won't apply to most partners.

If you are a higher rate taxpayer then only the first £500 is taxed at 0% - and this is what most have been used to.

But the figure to watch now is the additional rate band. This used to be £150,000 but has now been reduced to £125,140, and once you reach that there is no 0% band for savings.



Certain savings income is tax free – such as ISA accounts, some old NS&I savings certificates, and winnings from Premium Bonds.

Investment bonds (and insurance policy holding investments) are often sold as 'tax free' – but they are not.

You can withdraw five per cent a year (deemed capital) tax free – but the gain catches up with you in the end if you are still a higher rate taxpayer when the investment is fully surrendered, or on your death.

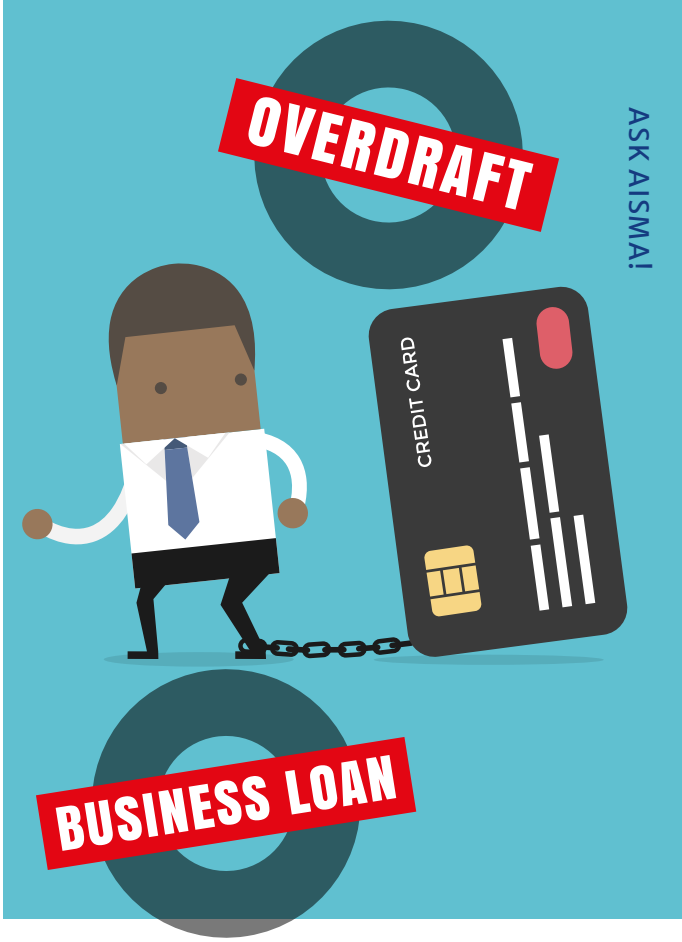
"If your spouse is not a taxpayer, or not a higher rate taxpayer, you could consider giving funds to them to earn interest"

Remember also that the 0% band for dividends used to be £2,000 last year, but this has been reduced to £1,000 for 2023-24 and dividends are taxable at a higher rate than they used to be – so 8.75% for a basic rate taxpayer, 33.75% for a higher rate taxpayer and 39.35% for additional rate taxpayers.

If your spouse is not a taxpayer, or not a higher rate taxpayer, you could consider giving funds to them to earn interest and potentially be taxed at a lower rate.

But remember the commercial risk – you have actually given your savings away and you can't legally ask for them back!

KNOW THE PLUSES AND MINUSES IF YOU HAVE A PRACTICE OVERDRAFT



Q **Our practice has never had a bank overdraft but the newer partners say we should have one, so they can draw all the money from the practice. What are the pros and cons of this?**

A With rising interest rates, it will cost more to borrow money now. However, if partners are relying on credit cards that they can't pay off each month to meet their living costs, that will probably be more expensive than the overdraft rate, net of tax relief, that the practice would have to pay.

There is a good argument for having an overdraft facility if it is just to cover 'low spots' during the month. However, if the overdraft is used all the time then sometimes a business loan will be better. Indeed the bank may insist on a loan rather than an overdraft facility.

It's a good idea to plot the high and low bank balances each month on a graph, so that you can get an idea of how much overdraft you might need – and how much cash that would free up.

A budget is also essential, so you can look at practice income and outgoings, and with your accountant's help, your tax and superannuation liabilities. You can then calculate what you can safely draw out of the practice profits on a regular basis.

A loan is not the answer if you are just taking money out of the practice that you are not earning.

Taking a loan out for a specific purpose, to pay out an outgoing partner, or to buy expensive equipment, should be manageable. Taking a loan out to cover overdrawing is dangerous without a firm plan to rectify the situation.

'Reverse' budgeting can be useful sometimes. Look at how much you need to have in hand, then work backwards to see what you need to do to achieve that.

It concentrates the mind for the non-financial partners if they are told if you want x you have to do y. They may then choose to accept less income. There is always a balance between earnings and quality of life!

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At the heart of medical finance

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Five action points for a PCN to prepare for the future

Reviewing things now will help ensure PCNs have the framework and flexibility to evolve and develop to meet the demands of 2024, advise lawyers **Justin Cumberlege** and **Robert McCartney**

PCNs have become the conduit for a significant proportion of funding into primary care and the management of this has resulted in a new way of working for many GPs.

This includes shared clinical teams, large numbers of new staff and the potential for securing additional revenue streams. However, the current five-year contract framework plan for PCNs ends on 31 March 2024, and potentially the loss of funding.

There remains no official statement on what will replace the current GP contract in April 2024. The current contract included the most significant changes to the way primary care has worked since 2004.

At its heart was a focus on developing and promoting a new way of collaborative working across practices in the form of PCNs.

However, practices through their PCNs may be facing significant liabilities and be forced to restructure how they work if the new contract does not offer the assurances required.

Some have taken precautionary measures, sometimes in conjunction with their federations, who have helped deliver PCN services, or by forming PCN service companies.

The *Delivery plan for recovering access to primary care* published by NHS England in May 2023 confirmed that working at scale in general practice, improved integration, and increased focus on communities and patient designed care, will remain at the heart of future NHS England plans.

But it did not provide certainty on PCNs specifically and stated the following:

'The 2024-25 contract provides an opportunity, after the 2019 five-year framework ends and the PCN DES was introduced, to reflect on successes and lessons learned.

'We will explore alternative approaches that can work alongside the partnership model and explore additional opportunities to better align clinical and financial responsibilities in primary care, enabling primary care teams to shape NHS services in their area and reinvest savings in frontline services.'

While this review is welcome there is little sign that it has commenced, and the clock is ticking for the negotiation, publication and implementation of a new contract in April 2024.

This is a risk but it is easy to forget that, regardless of the outcome of this review, primary care is in a stronger position to adopt future changes than it was in 2019.

There were then exceptions such as those areas supported by the National Association of Primary Care's Primary Care Home concept. But across the country there was little incentive to work collaboratively or to explore new methods of working at scale.

This is no longer the situation, and PCNs provide

the basis of how each area will adapt to future changes.

Here are five areas to review which will help ensure PCNs have the framework and flexibility to evolve and develop to meet the demands in 2024.

1 Contracting

PCNs have multiple complex relationships and it is essential for these to be properly formalised. A suitable contract will give certainty and provide the mechanisms needed to develop the relationship, or possibly terminate it as more clarity about the future is revealed.

The first step is to assess which relationships may benefit from having contracts. These are three key categories of relationship:

A Contractual relationships between PCN members (not least the network agreement itself)
B Sub-contracted services with third party providers
C Contracts with suppliers

Are agreements in place for each category? If not, each PCN should consider entering contracts to establish certainty for the relationship for this year, and a template in the future.

In agreeing the terms of the contract the following questions should be asked by each PCN:

- Are there clearly defined service delivery requirements and how are these monitored?
- What mechanisms exist to ensure delivery is to the appropriate standards?
- Is the contract based on a published specification, and if so, is the whole of that specification applicable, or only part? How is that part defined, and does it fit neatly with the provision of the other part?
- Are there key performance indicators and reporting requirements that match NHS requirements?
- How do the finances work and how is this tracked?
- Can you be assured of, and measure, the quality of the service you are receiving?
- Does the timeframe for the contract match your requirements for the service: how can it be terminated early and can it be extended?
- How do you manage issues if problems arise and, in more serious matters, how are disputes managed?
- With the network's agreement – does it reflect the way you are conducting the network at present? If not, does the agreement need to be changed to reflect it, or do you need to change the governance of the network (as well as corporate, perhaps also the financial and clinical governance)?

These simple questions will help to identify areas where improvements can be made and will allow the PCN to understand how these relationships work prior to any changes which may be needed in early 2024.

2 Staffing

The NHS England Update to the GP Contract agreement 2021-2023/24, clause 1.20, made the following commitment:

'…we can confirm that the level of reimbursement already drawn down to support new staff employed by a PCN will now be guaranteed during this GP contract period…and these staff will be treated as part of the core general practice cost base beyond 2023-24 when we consider future GP contract funding, like the practice global sum…'

> *"There are questions about what will happen to any underspend and, if there is an overspend, using money from other PCNs"*

This provides some certainty that funding will be made available to support current staffing. There are questions about what will happen to any underspend and, if there is an overspend, using money from other PCNs. There are also questions about the meaning of 'core general practice cost base' which need clarification.

It does not necessarily mean that the core general practice will employ the staff. There is a credible argument for contracts to be awarded to the 'best provider' in the area, and if the PCN is dysfunctional, then it may mean another contractor being awarded the contract.

However, as a principle, PCNs can take the following steps with some degree of confidence:

A Ensure maximum use of the funding to avoid discussions about losing potential revenue in the future;
B Clarify employment terms and ensure consistency between the different employees, this is particularly important if the PCN is operating on a multiple-employer model; and
C It is likely that the uncertainty surrounding PCNs will create uncertainty in the team so undertake engagement events to give the assurances and

regular updates to alleviate these concerns. Include a 'worst case scenario' of being transferred to another employer under the Transfer of Undertakings Protection of Employment (TUPE) regulations.

3 Resolving disputes

Disputes within PCNs are becoming more frequent. These will derail your plans and the future of the PCN and collaborative working initiatives.

This year may be the final chance to bring these issues to a close and to work on finding solutions.

Knowing that you have resolved, or at least have improved relations, will give the PCN a far better chance of managing the changes in 2024, and potentially, holding onto contracts. Facing periods of uncertainty is easier when you have a good foundation.

Regardless of the reason for the dispute PCNs should consider taking the following steps:

A Properly define the problems: this can be achieved through improving engagement and communications and tools such as a root cause analysis may help to bring matters to light which are deeper than those currently under dispute;

B Seek informal support: LMCs are particularly useful and although they cannot take a side or participate in a formal dispute resolution process, they can facilitate discussions and help to find resolution;

C Use the mechanisms available in your network agreement and if necessary, engage experts to help, including lawyers, mediators and arbitrators;

D Only in extreme circumstances consider restructuring your PCN. This will include working closely with your ICB and local PCNs who may be affected.

4 Governance

Underpinning many disputes is the quality of the governance within your PCN.

Governance can be misconstrued as over-complicated processes and creating documents for the sake of it. In practice it should simply be a system by which everyone involved in the PCN can feel assured that it is being managed appropriately.

At the most basic level it should show how, where, when and why decisions were made. This is a simple way of showing people had the opportunity to participate and that the decisions reached were reasonable based on the information available.

Many potential disputes have been resolved by a clinical director providing the discontented party with evidence that they were asked their view and had the chance to participate but failed to do so.

As these systems develop people have greater trust in the individuals and the relationships grow stronger. This will underpin success when the new contract is released.

5 Finances

Transparency is fundamental, particularly when it comes to the receipt and the payment of funds. All PCNs should now have a separate bank account into which the PCN funding is paid, albeit that it is controlled by the nominated practice.

The financial position of the PCN should be clear. Not knowing how monies are spent and not having a clear understanding of the financial consequences of decisions such as extra recruitment or using a third-party supplier leads to disputes in many cases and may lead to genuine errors placing the PCN at risk of losing money.

Robust financial governance, such as developing a budget and a system to report against the budget on a regular basis will help resolve this issue. Limitations on what can be spent and by whom will provide some assurance to the members.

If a PCN is facing financial difficulty early engagement with its specialist accountants is essential to work through these issues and to understand the risks. The revenue of PCNs has reduced following Covid and it is important this has been accounted for in future expenditure plans.

Historical issues are important to resolve and PCNs need to ensure the current finances and future expenditure are treated separately. This will be the strong building blocks for the future. Past issues can then be resolved knowing that they do not impact on the future.

The future of PCNs is uncertain but looking at each of these areas will provide PCN leaders with the infrastructure, relationships and assurance required to face this uncertainty in a strong position.

Any announcement in advance of April 2024 should be met with confidence, by having an understanding that the PCN can manage this change and retaining its contractual and financial position.

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