AUDIT • TAX • ADVISORY

Healthcare newsletter

Autumn 2021

Now, for tomorrow

mha

An independent member of bakertilly INTERNATIONAL

Welcome to the Autumn 2021 MHA Healthcare Newsletter

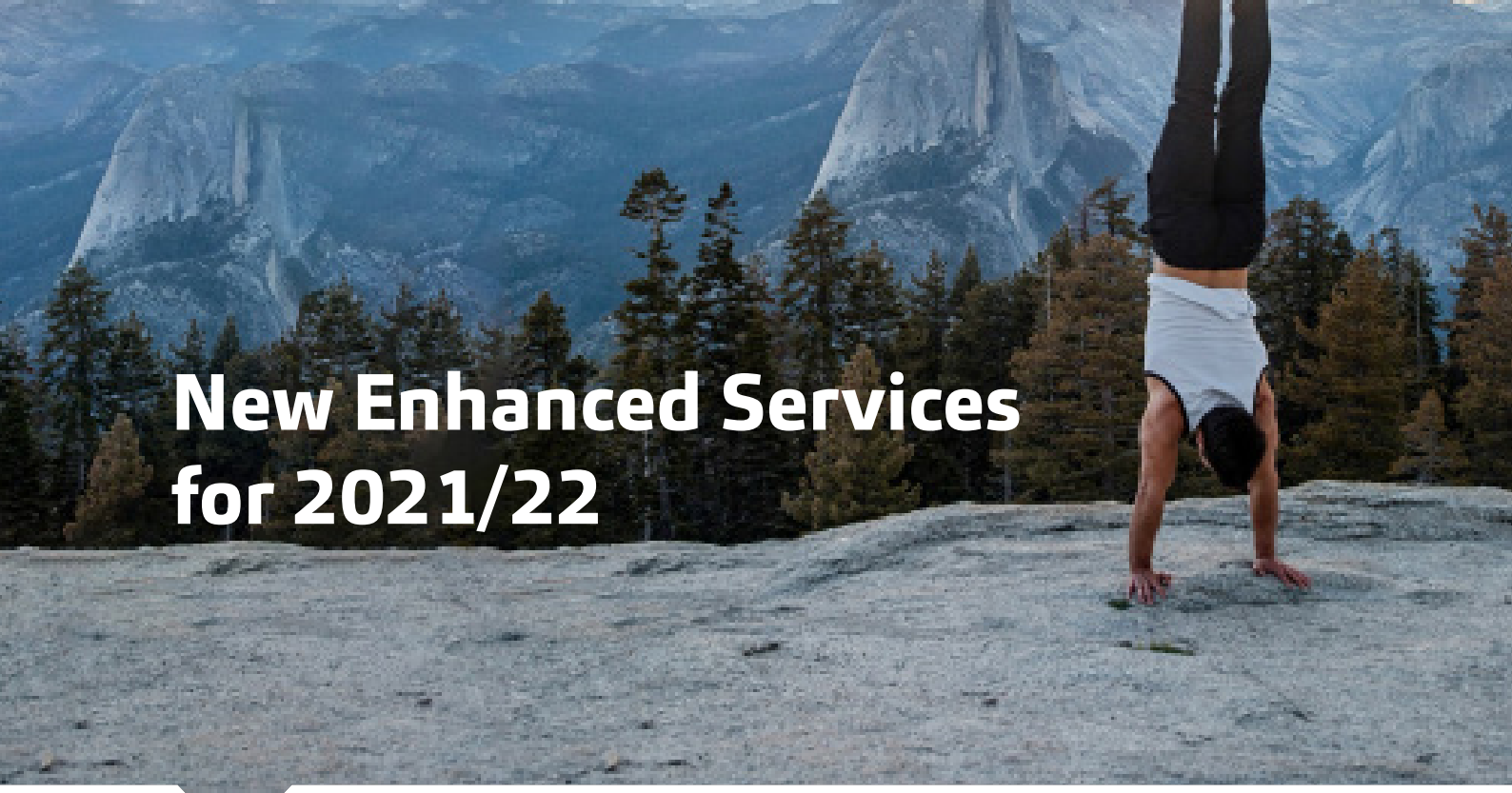
> The success of the vaccination campaign and the resulting relaxation of restrictions has enabled many to enjoy a summer with greater social freedom.

As General Practice now moves into the autumn with a combined Flu and Covid vaccination campaign the workload on GPs is as high as ever. However, amid the rush it's important not to miss important changes and updates that affect general practice or to plan for forthcoming changes.

With this in mind this quarters newsletter will look at the in year changes to the 2021/22 GMS contract and provide a quick update on the response to the McCloud Judgement and Final Pay Controls. We then look forward to the impact of changes that are being proposed regarding the taxation of practices with year ends other than 31 March or 5 April. These are being brought in to simplify the introduction of Making Tax Digital, but may have a significant impact on the tax liability of partners in practices where the accounting year doesn't currently align with the tax year.

This is followed by a quick round up of topical points to consider when reviewing or updating your partnership agreement. Finally we are please to include an article by Oliver Pool of VWV relating to the valuation of surgery premises on partnership changes.

MHA Healthcare team



New Enhanced Services for 2021/22

Our last Newsletter looked at the changes to the 2021/22 contract. However, since then NHS England have announced two new enhanced services for 2021/22 together with additional funding for PCNs. The new enhanced services for weight management and Long COVID will run from 1 July 2021.

Weight management enhanced service

The aims of this service are:

- To support practices to develop and implement a proactive approach to the identification of patients living with obesity. For the purpose of this enhanced service obesity is defined as a BMI ≥ 30 or ≥ 27.5 for those of Black, Asian and other minority ethnic groups.
- To incentivise practices to engage with individual patients living with obesity on weight management and to support patients who are ready to make behavioural changes to do so through referral to appropriate weight management programmes.

The practice should develop and implement a protocol for the identification and support of patients living with obesity which seeks to:

- normalise conversations about weight and weight management in all consultations;
- recognise that these conversations need to be handled sensitively, using shared decision making principles, to understand if a patient would want to be referred;
- ensure that all opportunities for the identification of people living with obesity are maximized;
- empower patients to provide the practice with information on their weight, BMI and other self-reportable health information;
- ensure that, where a patient has a BMI recorded in their record that indicates they are living with obesity, an updated BMI is recorded annually;
- utilise healthy weight coaches to identify and support patients as appropriate

Patients on the QOF obesity register as of 31 March 2021 and those identified as living with obesity during the service period the practice should have an individual assessment of their readiness to engage with weight management services and the outcome of this assessment should be recorded in their records.

All patients identified as being ready and able to engage with weight management services should be referred to the most clinically appropriate service. Acceptable referrals would include;

- NHS Digital Weight Management services for those with hypertension and/or diabetes.
- Local Authority funded tier 2 weight management services.
- NHS Diabetes Prevention Programme for those with non-diabetic hyperglycaemia
- Tier 3 and Tier 4 services

Payment

Practices will be paid £11.50 for each referral to a weight management service. Practice earnings will be capped and this will be calculated as their share of the £20m national funding using the practice obesity register as at 31 March 2020.

Long COVID enhanced service

The enhanced service recognizes that General Practice will play a key role in supporting patients, both adults and children, with long term symptoms of COVID-19. This includes assessing, diagnosing, referring where necessary and longer term holistic support of patients. It also recognizes that this is a new and complex condition and will require professional education, consistent coding of patients, planning of practice clinical pathways to assess and support patients as appropriate.

The enhanced service requires:

Professional education

Practice staff are required to have the knowledge, as appropriate to their role, to identify, assess, refer and support patients with Long COVID. This would include:

- Ongoing education tailored to the needs of different professionals in the team and the sharing of learning with other healthcare partners and through national online platforms.
- Knowledge of local clinical partways.

Coding

Practices are required to ensure accurate coding within the clinical records including diagnosis codes, signposting and referral codes, and resolution codes.

Measures to reduce inequity of access

Practices are required to consider how to reduce potential inequity of access to Long COVID services. This could include working with the Patient Participation Group or other partners to identify and understand potential barriers to support.

Payment

Up to £30m will be available nationally for this service. Practices will receive 75% of the funding by monthly payments with the remaining 25% being payable when the commissioners have confirmed the requirements of the service have been met by 31 March 2022. This will represent 49.5p per registered patient in total.

Additional funding for PCNs

NHSE has agreed to continue the funding for additional Clinical Director support from July 2021 to September 2021.

The letter issued by NHSEI on 17 June 2021 concludes with the statement that "further arrangements for 2021/22 will be developed and communicated in due course, providing as much notice to practices as possible."

Public Sector Pensions – what the McCloud judgement means for you

The Issue

All Public Sector Pensions administrators were obliged to introduce new versions of their pension schemes from 1 April 2015 that were sustainable and fair. Some older members received full protection from the changes and could stay in their previous scheme. Those a little younger were moved across to the new scheme on a sliding scale dependent upon age and younger members went straight into the new scheme from 1 April 2015. This affects members of schemes such as the NHS, Civil Service, Teachers, Judicial, Police, Armed Forces etc

The Judgement

The above treatment was found to be discriminatory against younger members on age grounds and restitution was required to treat all members the same.

The Outcome

The majority of pension scheme members will be given the option as to which scheme they wish to be part of in the period from 1 April 2015 to 31 March 2022. This has become known as the 'Remedy Period'. From 1 April 2022, all members will accrue benefits in the new 2015 schemes. Members can elect for all benefits in the Remedy Period to be in their original legacy scheme or they can all be in the new 2015 schemes, but not some combination of both.

Mechanism

In April 2022 as well as beginning to accrue benefits in the 2015 scheme, there will be a default position where everybody will have their benefits in the Remedy Period converted to their old scheme if they had moved into the 2015 scheme. This may have several knock-on effects.

Effects

Changes to schemes in the Remedy Period may affect the level of contributions due, the tax relief available, the pension tax charge due to the Annual Allowance and adjustments to tax returns and/or Scheme Pays elections may be necessary, for up to seven years. The level of pension entitlement will also, of course, change.

The Decision

The decision will need to be made at the point the benefits are about to be drawn. For many, that decision will be several years in the future. By this time, scheme administrators will be required to have systems in place that provide annual comparative figures so an informed choice can be made.

Retiring in the next few years?

Administrators are required to have these information systems and comparative figures in place by October 2023. If you are retiring before then, what decision will you reach if there are no figures available? How can you be sure that all the years in the Remedy Period and the final pension benefits are correct and the best for you?

Action

We have many years specialist experience in examining the tax and pension affairs of public sector workers. We have expertise in the calculation of benefits, pension tax charges, tapered annual allowance, scheme pays election completion and tax return declarations. We work in parallel with scheme administrators and Specialist Independent Financial Advisers (IFA) to ensure our clients are fully aware of the detail and can make a reasoned choice. If you are retiring in the near future, you may wish to talk to us.

Final Pay Control Reclaims

Has your practice received a Final Pay Control charge since 1 April 2018?

In our experience this has most often occurred when a practice manager or nurse partner has retired, and pensionable profits have risen in excess of the stated limits in the last few years before retirement. This can also happen for senior nurse grade or practice manager employees. The charges on the practice can be significant.

A change of rule has been implemented with effect from 1 July 2021 that affords exemptions to the charge in certain circumstances where the increases for non-GP partners were caused solely by normal commercial fluctuations in profits. Crucially, these exemptions have been backdated to 1 April 2018.

Consequently, if the practice has received a charge since 1 April 2018, it may be possible to appeal against it should the new exemptions apply. The charge could potentially be removed entirely. Should this be the case for your practice, please contact us to discuss whether an appeal can be made.

Deadline!!

Should an appeal of the above nature be required, a deadline for previous years has been set at 31 December 2021. There is therefore limited time to prepare and submit the appeal. Action sooner rather than later is therefore required.

Proposed change to tax basis periods affecting non-March year end practices

The government has announced a proposed change to the way profits are taxed for unincorporated businesses that do not use a 31 March or 5 April accounting year end. In 2022/23 those businesses, which includes GP partnerships, will be taxed on the profits for an extended period, less any overlap profits brought forward. The move is designed to simplify the tax system but also to make the transition to Making Tax Digital, a long-held government aim, more easily achievable.

There is no requirement to change the accounting year-end of the practice, just the way profits are taxed. That, however, would just seem to confuse matters, so we envisage that accounting year ends will change to 31 March.

We anticipate that the change will be effected through the Finance Bill in due course.

Impact

A worked example may best demonstrate how this works. Imagine a practice has a normal accounting year end of 30 September. In 2021/22 that practices' partners will be taxed upon the profits for the year ended 30 September 2021, for all partners who have been continuously in the practice during the 2021/22 tax year.

In the following year under the new rules those partners will be taxed on the profits for the year ended 30 September 2022 plus for the period 1 October 2022 to 31 March 2023. The overlap profits brought forward from when a partner first joined the practice, or when self-assessment was introduced for older partners, are then deducted as follows:

2022/23

Year ended 30 September 2022	**100,000**
Period 1 October 2022 to 31 March 2023	**50,000**
Total	**150,000**
Less overlap profit brought forward	**(20,000)**
Taxable profit	**£130,000**

As you can see, there may be quite an impact on cash flow if you are normally being taxed on profit of £100,000 and now you are being taxed on £130,000. This is because there is no inflationary increase applied to the overlap profits which may have arisen many years previously from lower profits. No allowance is given for that in the calculation. What the government has announced, however, is that the additional profits that become taxable as a result of this change, £30,000 in this case, will be taxed at £6,000 per year over the 5 years 2022/23 to 2026/27, which eases cash flow issues.

It may be that overlap profits are considerably higher than stated above. If a partner only joined the practice in, say, 2019/20, their overlap profits will be based upon much more current earnings. They might even be greater than the extra earnings being taxed for the extended period. If that is the case, there is a provision that allows the 5 years spreading of taxation to be disapplied.

Pensions

Since the introduction of the new GP contract in 2004, there has been a direct link between taxable NHS profits and NHS pensionable profits. A corresponding change to the pensioning of profits would therefore seem probable. It is not known at this stage, however, whether spreading provisions would be acceptable to NHS Pensions. It may be prudent to include somewhat higher figures in the Estimate of Pensionable Profits to cater for some of the increase, but more will follow on this in due course as things develop.

Hot topics to consider when updating your partnership agreement

We have had more new partner meetings in the last two to three months than we have had in the previous two to three years, and a new partner should always be a trigger point for reviewing and updating a partnership agreement.

Updating a partnership agreement should not just be the adding or removing of a name, it is an opportunity to make sure that the content of a partnership agreement is still fit for purpose and that it incorporates any changes that have happened with how the practice operates as well as other NHS developments.

In this article we will cover the main newer 'hot topics' that should be considered for inclusion in the partnership agreement, if relevant, giving a brief explanation of what the subject is and why it should be included:

1 New to partnership payment scheme

Key features:

- For new eligible clinical partners from 1 April 2020 (not having been a partner previously in England).
- They have to work at least 2 clinical sessions per week with a 5 year commitment.
- The new partner MUST sign a partnership deed.
- The monies are paid to the practice who have to pay it over to the new partner within 28 days of receipt.
- There is a pro rata clawback from the practice if the partner leaves within 5 years, although it can be ported across to another partnership.

It is the last point that needs to be covered off in the partnership agreement to confirm that this is a personal liability of the partner concerned and that they will be required to reimburse the practice for any clawback monies that aren't covered by existing funds that they have in the practice (e.g. partner current and/or capital account balance).

2 Final pay controls

Key features:

- Relates to non-GP Partners who are in the 1995 section of the NHS Pension scheme.
- If their NHS profits increase above the allowable amount in the three years prior to retirement (currently 4.5% + inflation) then the practice will be invoiced a final pay control charge. This is effectively paying a contribution towards the additional pension that the person will receive.
- This was brought in to prevent practices awarding large pay increases for certain employees prior to retirement so that the employee would then benefit from a higher pension. However, this also captures non-GP partners' whose income can increase significantly purely from a better profit performance of the practice in a relevant year.
- The practice will have to pay this and so the practice needs to decide if it will be a pooled practice expense or chargeable to the partner concerned's profit share so that they bear the cost.

Again, it is the last point that is the key consideration for the partnership agreement where the practice decision on the agreed treatment needs to be documented to confirm whose liability it is. If it is the partner, then it needs to be made clear that they will have to reimburse the practice for any shortfall not covered by existing funds in the practice.

3 Primary Care Networks

Specific provisions should be included in the partnership agreement to reference/cover:

- Compliance with the PCN Network Agreement.
- General treatment of surplus or deficits from the PCN accounts within the partnership accounts.
- Inclusion of the PCN member current account balance and/or PCN company shares as assets of the partnership.
- Confirm flow down of PCN monies into each partners' current account balance.

4 24 hour retirements

With an increasing number of partners wanting to reduce their hours leading up to full retirement, and come out of the NHS Pension scheme at the same time for various reasons, then we have seen more 24 hour retirements in recent years.

Key features:

- 24 hour retirement is the mechanism for a GP to draw their NHS pension and then return to work.
- All GPs cannot work for the first 24 hours after their retirement and if they are in the 1995 section they cannot work for more than 16 hours a week in the first month.
- The GP effectively resigns their NHS contract for 24 hours and so needs consent from the other partners to be able to return unless it is automatically allowed in the partnership agreement. Consent will also need to be obtained if the returning partner wishes to change their hours.

The partners should specifically document in the partnership agreement whether there is an automatic entitlement to take a 24 hour retirement or if a partner has to seek permission at the time with a required notice period.

Please note that there are specific difficulties with a 24 hour retirement relating to sole practitioners that are not covered by this article as for them there will not be a partnership agreement.

5 New partner clauses

Although this is not a 'new' topic we still class it as a current 'hot' topic due to the number of new partners that we have been seeing recently.

Although most partnership agreements will have some clauses relating to new partners they may be out of date and not reflect current practice or they may not contain sufficient detail to be clear on what is required and expected.

A new partner joining is therefore a good time to review this with the key financial considerations and decisions being:

- The length of the mutual assessment period if not covered by a salaried period before becoming a partner.
- Confirmation of profit-sharing basis, progression to parity and any standard prior share of profit items (for example net rent if property owner).
- Capital buy in requirements if applicable (including timing, valuation basis, buy in amount calculation).
- Lease obligations, possibly including responsibilities for historic service charge arrears.
- Current account buy in (including timing – lump sum, specific instalments or flexible over a period of time?, and basis for calculation – set amount per session or other).

The new partner offer letter must be consistent with the relevant partnership agreement clauses.

The partnership agreement has always been an important document but can often be ignored by practices and easily become out of date or obsolete.

The risks in letting this happen can be significant and so it should be reviewed on a regular basis and updated to reflect changes in how the practice operates along with new NHS initiatives and funding. We always advise that a medical specialist solicitor is used for this.

GP surgery valuation

We are seeing more and more disputes about valuations of GP surgery premises. Many of these arise out of differing approaches to valuation taken by specialist valuers. In this article we set out our views on why these issues are arising and how they can be avoided.

Two key approaches to valuation

When a surveyor is asked to value a GP surgery, his or her first question should be "On what basis should this valuation be produced?" The partners may well have agreed between themselves certain stipulations about the valuation, and the valuer will need to know about these. Indeed para 5.7 of the RICS guidance says that "The actual wording of the partnership deed should be scrutinised in case it affects the appropriate basis of value to be determined." It is certainly not uncommon for partners to agree certain provisions in their partnership deed that will have an impact on the valuation. So if a valuer does not ask to see the partnership deed, the partners should be asking why not.

> The RICS guidance goes on to say at para 5.8 that
>
> In the absence of any specific instruction, agreement between the parties or reference in the partnership deed as to the basis of value, it will usually be appropriate for the valuer to recommend the basis of Market Value in accordance with the GPC recommendations."

The GPC recommendation (which is also set out in the RICS guidance) reads as follows:

"The freehold/leasehold assets of the practice shall be valued […] having regard to the (open) market value as defined by the RICS of the premises having regard to both the existing use of the premises and the benefits of any income or rent reimbursement (whether real or notional) paid in respect of the premises but disregarding any element of personal goodwill which may attach to them as a result of the occupation of them by the partners."

The same guidance says at para 5.3 (and also at 6.2) that "In respect of owner occupied premises, it is recommended that vacant possession should be assumed for those areas under GPs' occupation." This fits with the case law, which we have written about separately.

To summarise then, the RICS guidance on valuing owners-occupied premises says that unless instructed otherwise by the partners, valuers can take account of the fact that the premises attracts notional rent, but should otherwise assume vacant possession (i.e. assume no lease, but assume that another GP practice would take over occupation). In our experience this has been the approach taken by the majority of specialist valuers of GP premises for many years.

Assuming the existence of a lease

However a minority of specialist valuers are starting to move away from this approach, and instead they assume that a lease is already in place, even if it isn't. A point not often appreciated by GPs who "just want a valuation" is that setting up a premises as an investment increases the value.

When a practice sells its building to an investor such as Assura or PHP, the investor isn't just interested in owning the bricks and mortar - the investor is particularly interested in the income stream, i.e. the lease rent which is paid to them every month, and which is backed by rental reimbursement. For this reason, an investor will generally only buy a GP building if the practice enters into a lease, thereby promising to pay rent for a set number of years. Entry into the lease is what adds value for the investor. Having a lease in place makes the building a more "liquid asset" which can be bought and sold much more easily between investors. And (in the large majority of cases) the longer the lease, the more the investor will pay for the building.

The illustration one often uses is to think about purchasing a "buy to let" as an investment. Would you rather buy an empty house, for which you then have to go and find a tenant - who may leave in due course? Or would you prefer to own a building with a tenant who has promised to stay for at least 15 years? Clearly the latter is slightly more valuable.

So it's important to remember that the length of the lease directly affects the value of an investment property - generally: the longer the lease, the greater the value.

How the problem arises

As we say above, there's nothing wrong with taking account of a lease when it is used to value investments, i.e. where a lease has in fact been, or is being, set up. However problems arise when this same approach is used for premises that are not in fact set up as investments. Naturally, if one values a building on the assumption that a proper lease is in place, one generally comes up with a higher valuation. But if no lease is in fact in place, then that is not an appropriate assumption to make. If one were to value the building on the assumption that it occupied a waterside location and was made of solid gold, but it was in fact landlocked and made of straw, then the valuation would be inappropriate - and much the same is true if you assume a lease is in place when it isn't.

Furthermore, assuming a lease is in place when in fact it isn't (or comparing the building to others where leases are in place, without applying an appropriate discount to the non-leased premises) is inconsistent with paras 5.3 and 6.3 of the RICS guidance. You can't both assume vacant possession and assume a lease is in place.

So how do (some) valuers justify assuming a lease is in place when there is no such lease? Is it appropriate to compare an owner-occupied buildings with investment properties on an equal footing? The argument most often made refers to the Premises (Costs Directions) 2013 (The Directions). Valuers who take this approach point out that when determining the notional rent, the District Valuer should assume that a 15 year lease is in place. Therefore, they say, they are justified in assuming a lease is in place when carrying out a valuation.

But the Directions only tell a District Valuer how to calculate the notional rent. They don't say anything about how a surveyor should determine the capital value. So in our view that argument is somewhat flawed, and is liable to warp the value.

The goodwill rules and public policy

This is more than just a technical argument - although of course it is that as well. Criminal liability rests on this. The goodwill rules provide that it is a criminal offence to buy or sell goodwill in GP surgery premises. It is a criminal offence if a GP surgery is sold for "substantially" more than it would have been "if the premises had not previously been used for the purposes of a medical practice" (NHS Act 2006 Schedule 21 para 2(1). Arguably even taking account of notional rent would breach this rule - but we know that it doesn't because there is case law (such as Blackmore v Timberlake) which backs up the RICS guidance, to show that taking account of future payments of notional rent does not produce a valuation which breaches the goodwill rules. However we are aware of no case law which permits a valuer to assume a lease when there is none. In our view, adopting an assumption that is known not to be true, and which drives up the value of a GP premises (to the benefit of an outgoing partner), is precisely the sort of thing that the draftsmen of the goodwill rules would have had in mind as giving rise to a criminal offence. If a prosecution were brought, and a conviction obtained, a fine or even imprisonment could be imposed.

As a matter of public policy, and given current conditions, it cannot be appropriate to uphold valuation practises which artificially increase the value of GP surgery premises. It is already very difficult for many younger GPs to buy into the surgery premises. Forcing the value of the premises up further makes this all the more difficult. If new partners cannot raise the funds to buy in, usually the freehold has to be sold to an investor, and a lease taken out instead. Whilst this relieves GPs of the need to take out a loan to finance the surgery premises, it swaps one problem for another: instead of taking risk under a loan the GP partner instead takes risk under the lease. And contrast the two positions: if you are taking risk under the loan, you at least have the reward that goes with ownership of the asset, potential increases in value, and yields a notional rent profit in the meantime; whereas if you are taking risk under a lease you have no valuable asset to back it. Thus assuming leases are in place when they aren't tends, albeit indirectly, to undermine the independent contractor model and makes partnership slightly less attractive and remunerative for GPs in the longer term. The "winners" from this are both a) those retiring partners who have sold out at the higher valuation, and b) the investors who stand to purchase more and more of the primary care estate as a result of it becoming less and less affordable to partners. It seems to us that if anyone were to litigate that this approach to valuation is a breach of the goodwill rules, a court may well take this public policy into account, and would be unlikely to excuse the breach of the wording of Schedule 21 para 2(1).

How to avoid these sorts of disputes in the first place

Disputes as to value are usually unpleasant. A retired partner who has received a higher valuation which assumes a lease is in place tends to take that valuation to heart and quite naturally, loss aversion comes into play. In his/her view, it is the only valuation that can possibly be correct. He/she tends to feel that anyone wanting to pay him/her less than that number must be acting in bad faith, trying to do him/her out of his/her retirement pay off. Understandably the retiring partner does not appreciate that the nuances set out above are the reason for the very different valuations.

The most common situation in which a dispute as to value arises is where there is no partnership deed, or the partnership deed has "fallen away" and become unenforceable for some reason. After all, the existence of the partnership deed is usually the key to this. If a retired partner goes off and gets an "investment" valuation, then the other partners should have the right under the partnership deed to say either a) "that isn't agreed, let's get an independent valuation appointed by the RICS if necessary" or b) "that valuation doesn't comply with the terms of our agreement so it's meaningless, let's start again." So if the partnership deed is in place, and says what it ought to about i) the approach to valuation and ii) how to resolve disputes about valuations, then the issue should not arise.

Situations to watch out for, where the deed can become invalid are:

1. where a new partner has joined, without signing a new deed or a deed of adherence. In this scenario, what the old deed says can become invalid, and can end up binding nobody - so when a partner retires, the valuation provisions don't work any more.

2. where the deed contains an "option" to buy out the retired partner, but that option isn't exercised in the applicable time limit. Many deeds do contain provisions like that (particularly where there is a "last man standing" clause), and it is not at all uncommon for the partners not to recognise the need to serve the notice, or to forget to do so. In some cases (particularly in some deeds drafted by BMA Law the option has to be exercised before the partner even retires - so the moment he leaves, the others have lost their right to buy him out.

In such a situation, the retired partner cannot be forced to sell and so the arguments above about the correct approach to valuation become academic - unless you can agree a price with him or her, the retired partner can just refuse to sell. The issue can't be settled by the continuing partners agreeing to pay a bit more - because that is likely to be a breach of the goodwill rules.

And even if they did agree to pay a higher sum, they may well be unable to borrow that money from the bank, whose valuer will (correctly) be telling the bank that the building isn't worth what the partners want to borrow - which will feel to partners very much like they are in negative equity. These sorts of disputes particularly acute, and long running - which of course makes them all the more expensive.

So it is important that practices keep their partnership deeds up to date as partners join; and we at VWV are always happy to review the selling out provisions and valuation provisions (without charge) to ensure that they work properly, and aren't going to give rise to the issues described above. If you are experiencing these sorts of issues at your practice, it might be worth taking advice on whether differences in valuation approach may be at the root of it. We would of course be delighted to help.

The writer Oliver Pool Oliver Pool is a partner in VWV's specialist primary care team. He deals with partnership agreements, GP mergers, and disputes. VWV (which merged with Lockharts in 2017) has been advising the primary healthcare sector for over 30 years and the team has acted for over 2000 GP practices.

Oliver can be contacted directly at **opool@vwv.co.uk**

MHA Healthcare Contacts

South East

Andrew Leal
Partner and Head of Primary Care
E: Andrew.leal@mhllp.co.uk

North West

Deborah Wood
Partner
E: deborah.wood@mooreandsmalley.co.uk

North East

Chris Potter
Partner
E: chris.potter@taitwalker.co.uk

East Midlands (North)

Nick Stevenson
Partner
E: nick.stevenson@mooreandsmalley.co.uk

South West

Laura Green
Partner
E: laura.green@monahans.co.uk

East Midlands (South) & London

Steve Cosford
Director
E: steve.cosford@mhllp.co.uk

Disclaimer

MHA Hub offers clients and contacts a diverse programme of professional events, training, and publications that has been created to offer the latest in best practice, good governance, and regulatory updates and insights.

To find out more about the services
MHA can offer, please contact

T: 0207 429 4147

mha-uk.co.uk

Now, for tomorrow