

AIMSA Doctor Newsline

A helpful resource for the practice business



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Early retirement

What every GP needs to know

A graphic of four black footprints of varying sizes, arranged in a path that leads from the bottom right towards the top right, partially overlapping the word 'retirement' in the main title.

The possibility of early retirement is a major attraction to many GPs. **Barry Rigby*** spells out some key issues to consider

Over the past few years we have been asked by an increasing number of our GP clients about their options for early retirement within or outside the NHS Pension Scheme. This appears to stem from three main causes:

1 The increase in workload in general practice, combined with pressures on funding, which are causing many GPs to consider retirement before the normal retirement age.

The vast majority of GPs who are now in their 50s will be members of the 1995 section of the NHS Pension Scheme, where the normal retirement age is 60.

2 Increasing contributions, making the scheme more and more expensive for members. For many years until the new GP contract was introduced in 2004, GPs paid 6% employee contributions to the NHS Pension Scheme, in addition to any added years being bought.

At that time, the new contract theoretically introduced funding for the 14% employer contributions, which GPs were then required to pay, so that contributions effectively rose to 20%.

Since then, tiered employee contributions have been introduced and the top rate is now 10.9% for higher earners, with proposals that this will increase



still further. The abolition of the earnings cap also increased contributions for higher earning GPs.

3 Their potential liability to the new Annual Allowance and Life Time Allowance tax charges. Under recent changes, a tax charge arises where the 'deemed input' to a pension scheme exceeds £50,000 per year or where the deemed value of the fund on retirement exceeds £1.5m.

Note that in his Autumn statement last month (December), The Chancellor announced that from 2014-15, the Life Time Allowance will be cut from £1.5m to £1.25m and at the same time the annual allowance will drop from £50,000 to £40,000.

The method of calculating GP benefits, and therefore deemed inputs and fund values, is fairly complicated but generally it means that those with higher earnings and longer service could be subject to either or both of the new tax charges.

Your options

For GPs under 60, there are basically three options available:

1 To take '24 hour retirement' and draw their benefits from the NHS Pension Scheme. The benefits will be subject to actuarial reduction, and a table setting out these reductions is available.

For example, for somebody taking voluntary retirement at age 55, the pension accrued to that point will normally be reduced to 78.7% while the accrued lump sum is reduced to 85.4%.

We have some clients who have been able to afford to do this and are enjoying complete retirement, although this will of course depend on each person's overall financial situation and planning.

Where a GP draws their benefits and carries on

working, there will unfortunately and inevitably be a significant increase in their tax liability, as their NHS pension is taxable income and they will no longer be paying pension contributions on which tax relief is claimed.

2 To cease making contributions to the NHS Pension Scheme but to defer drawing benefits until normal retirement age.

Benefits will continue to accrue and there will be no actuarial reduction when they are drawn at age 60. This option may be attractive to those wishing to carry on working, as it avoids drawing their NHS Pension which would be taxed at their marginal tax rate, which is likely to be 40% and in some cases may even be 50% (45% for the next financial year).

3 To change nothing, and continue contributing to age 60, then draw benefits. Despite recent and proposed increases in member contributions, the NHS Pension Scheme is still generally considered to be an excellent pension scheme, and continuing contributions to age 60 will therefore still be the best option in most cases.

It is worth noting the general view that it is not normally worthwhile continuing contributions beyond the normal retirement age of 60, as the costs will normally outweigh projected additional benefits.

However, each member should take specialist advice about this which is tailored to their own circumstances.

The starting point for any consideration of the position must be to obtain accurate up-to-date information about benefits already accrued in the NHS Pension Scheme, and this information is available from NHS Pensions in Fleetwood.

The relevant information to be obtained would normally include the following:

- Details of pensionable service. This gives a useful opportunity to ensure that the record of service held by NHS Pensions is correct and complete, and the calculation of the uplift for pre-practitioner service can also be checked.
- Details of any added years being purchased. Again, this is an opportunity to ensure that the details are correctly recorded, and the calculation of the uplift in benefits can be checked.
- A copy of the dynamisation sheet, which summarises practitioner pensionable profits for each year of service, and the dynamisation of each of

these figures to current values. The total 'pot' of dynamised career earnings is then the starting point for the calculation of pension and lump sum benefits.

Many AISMA member firms have already started the process of obtaining information on behalf of their clients in connection with the new tax charges, and this information can also be used to prepare projections in respect of the options which are available.

Please note that this article gives only the most basic overview of options for NHS Pension Scheme members and you should take expert advice tailored to your own circumstances before taking or refraining from any action.

OPINION

2013: the squeeze is on but AISMA will help you run a tight ship

Chris Howe, committee member, AISMA

Another year has passed leading us to reflect on 2012 and look forward to what 2013 may bring. Issues surrounding yet another new contract loom increasingly large in everyone's minds.

On a broader timescale the Department of Health has been reflecting on some statistics from the past decade. It notes that the number of GPs has increased from some 28,800 in 2001 to 35,400 in 2011, although the GP provider count fell from 27,900 to 27,200 over the same period, owing to a ten-fold increase in salaried GPs and locums.

While provider numbers have remained reasonably steady, the Department reflects that their pay has increased in real terms over that period by over 20%. Recent entrants to the profession may not have noticed this however, since the major boost took place between 2004 and 2006 following the last new GMS contract.

Indeed more recently we have seen pressures from many angles on GP incomes. On the positive side, while incomes may be under pressure, they are at least steady, without the high risks that many of our non-medical client businesses are exposed to in this flat economic period.

On the negative side there are several factors which we are regularly highlighting as the reasons for reductions in take-home pay for some GP clients.

Firstly, the requirement to do more work within the same funding may force rises in expenses.

Secondly, tax rates have been quietly creeping up over recent years, with less income taxed at the basic rate, more National Insurance, and the penal rate of tax on the band of income over £100,000, to name a few.

Next, we have had large increases in superannuation contributions, with more to come. Many GPs we talk to have been surprised to learn that they are now contributing a quarter of their pay into the scheme.

Continuing the pension context, this month will see the first additional tax bills for those GPs affected by the new pension tax charge.

Finally, we are seeing some GP surgery owners noticing the negative cash-flow effects of paying down capital on their mortgage loans, and banks not being as willing as they were in the past to refinance.

Having reflected on these stresses, the good news is that we do still see well run practices, with hard working GPs, making progress or at least holding on to net incomes.

We look forward to the results of the 2013-14 new contract deliberations with keen interest and of course we will be on hand to help our clients – as far as possible – deal with the expected increased workload without significant reductions to their well-deserved rewards.

Financial questions GPs don't ask - until it's too late

Forewarned is forearmed. Former primary care support services boss **Paul Ham**** answers a puzzling array of dilemmas that often stump GP practices

After working in the NHS for over 20 years there is one thing that never ceases to amaze me and that is how little the majority of GPs really understand about how they are paid, how their pension is calculated, and what questions they should really be asking their accountant.

The role of the GP's accountant has evolved and gone beyond the fundamental tax and pension contribution calculations.

It now includes much broader financial planning and good advice which should eradicate a GP's need to ask any of these questions.

Below is a list of FATLQs. That's Frequently Asked Too Late Questions.

Pension contributions

Why does our contract payment include pension contributions for this GP who left two years ago?

The GP's end of year pension certificate was introduced in 2004 with the new contract and yet eight years on practices are still surprised to see pension contributions for a partner who left some time ago.

On some occasions practices are completely out of touch with the doctor and have no means of collecting the contribution. Practices often expect the PCT to refund the contribution and seek to retrieve the money directly from the doctor. However the Statement of Financial Entitlements (SFE) states that it must come from the practice.

This issue needs to be fully encompassed within the



partnership agreement and the departure deed. The agreement needs to include a clause to ensure that any GP or non-clinical partner leaving the practice will continue to be indefinitely liable for any pension contributions adjusted by the PCT/NHSCB in their name through the practice's contract payment. These adjustments should only represent adjusted profits and contributions relating to a period when they were working at the practice.

In almost every single instance of a profit sharing partner leaving there will be a pension adjustment processed approximately 10 to 22 months after they have left.

Seniority adjustment

Why has there been a seniority adjustment for a partner who left three years ago?

This issue is very much related to the one above concerning pension contributions. Seniority is initially calculated based on two known and two unknown pieces of information.

The known information is the GP's start date and reckonable service and the unknown is the GP's earnings and the national average earnings. In order for the PCT to be able to process a payment these unknown items are estimated.

The GP's accountant will estimate the GP's earnings primarily so that NHS pension contributions can be calculated and provisionally collected each month.

However this estimated earnings figure is also used for seniority calculation. The Government will estimate a national average pay figure purely for seniority purposes. This estimate is revised every year.

The earnings figures are used to establish a GP's entitlement to full, partial or zero payment of the seniority allowance. If estimated earnings are greater than 2/3rd of the estimated national average then the full allowance is payable, if between 1/3rd and 2/3rds then 60% of the full allowance is payable and if less than 1/3rd no allowance is payable.

This calculation was to replace the whole time equivalency adjustment from earlier seniority calculations as the new contract contained no requirement for practices to provide the PCT with this information.

These estimated pay figures are the reason why the final adjustments are delayed. A GP's actual earnings need to be established from the final pension certificate. Secondly (and the issue that really causes the delay) the Government needs to calculate the national average for the year.

There are a number of specific issues that have contributed to seniority recoveries:

- Practices question on-account seniority values and increase estimated profits to ensure that 100% is paid, then complain when a 40% recovery is made years later. If I had ever been aware of a practice increasing estimated profits specifically to increase seniority then I would insist that the practice acknowledged the possibility of a recovery in writing.

- Estimated profits occasionally included work pensioned elsewhere which does not count towards seniority. This would generally create a refund of contributions one year followed by a recovery of seniority the next.

- Overlap applied to the final pensionable profits calculation can significantly reduce final certified profits. The adjustment can even in some cases generate a

negative profit figure which often happens if a GP has reduced commitment leading up to retirement. This scenario often means that all seniority paid in the final period is recovered as certified profits fall below 1/3rd of the national average.

- The PCT is not notified of reduced commitment and reduced profits therefore seniority continues to be paid at the higher rate.

All of these scenarios should be identifiable in advance by a GP's accountant and therefore, even if it is unavoidable, provisions can be made thus avoiding what could be a rather nasty surprise.

Lifetime allowance

Why has the NHS Pensions Agency now told me that I've exceeded the lifetime allowance when I retired over two years ago?

The lifetime allowance represents a limit on your pension pot before it incurs some quite unfavourable tax charges. On 5 April 2012 the lifetime allowance was reduced to £1,500,000 from £1,800,000 (from 2014 it drops to £1,250,000).

To compare your pension pot against the lifetime allowance you simply multiply your annual pension by 20 and add the lump sum. Providing that the total is less than £1,500,000 then you will avoid the tax charges.

You can also work backwards. Therefore if you are a member of the 1995 section of the pension scheme then the maximum pension before hitting the allowance will be £65,217.39 (£1,500,000 / 23) or if a member of the 2008 scheme then it would be £75,000 (£1,500,000 / 20). The difference is due to the fact that there is no automatic lump sum in the 2008 section of the scheme.

When a GP suddenly finds that they have exceeded the lifetime allowance having been receiving a pension for over a year then it can only really be attributable to amended pensionable pay figures.

The pension would initially have been calculated using provisional profit figures which created a pension below the lifetime allowance but the final figures would have pushed it above the lifetime allowance.

This can occur due to the application of overlap on the final pension certificate where overlap was generated from the relatively low pensionable earnings pre the 2004 contract. This low overlap is then set against much higher final year earnings and the effect of this is to create an inflated income figure for the final period.

This would be much greater than the initial estimate used by the PCT when processing the retirement. The

GP would have had to have been very close to the lifetime allowance anyway. However that fact in itself could have been identified and therefore the consequence of the final certificate pre-warned.

This risk could have previously been mitigated by obtaining protection from the HMRC. However that option is no longer available and therefore the only solution is to try to forecast the issue before it arises.

Annual allowance

Why have I received this annual allowance letter from the NHS Pensions Agency?

The annual allowance is the amount your pension pot can increase by within a single year before incurring a tax charge. The limit is currently £50,000 (reduced from £255,000 in 2011-12). The calculation simply compares the increase in the total value of the pension at the beginning of the year to the value at the end of the year.

GPs would not yet have received a letter concerning this issue from the NHS Pensions Agency as the 2012 pension figures will not yet have been updated. The

Agency will be writing automatically to any scheme member who has exceeded the allowance by 6 October 2013. While none of these letters would have been issued yet experience tells me that this will become an FATLQ (Frequently Asked Too Late Question).

Tax due for the year 2012 is due in January 2013. However you will not be able to accurately forecast any liability or payment on account arising from exceeding the annual allowance until you receive the notification from the NHS Pensions Agency, although it can be estimated providing that you know the actual value at 1 April 2011.

An added complication is that any excess above the allowance can be set against carried forward unused allowances from the previous three years. The previous three years will however be assessed at the £50,000 rate and not at £255,000.

These are all issues that accountants could be guiding their GP clients through to avoid them becoming bombshells. They were not issues eight years ago and are a good indication of how primary care finance has become much more complicated. Bring back Items of Service payments and the Red Book - all is forgiven!

Support your manager in these stressful times

With a workload crisis causing unprecedented levels of sickness absence or resignations among practice managers, **Kathie Applebee** looks at what you can do to keep yours on board

Occupational stress among GPs has long been recognised as a risk factor for the profession, with the potential consequences of early retirement, ill health or premature death¹.

The causes of such stress are myriad but, in some cases, may be attributed to the ways practices are organised rather than to the demands of medicine.

General practices are complex organisations with their strange mixture of private enterprise and public service. Although practices are businesses, some are still run in ways which vary from fiefdoms to unofficial charities.

This makes them difficult to manage - but poor management will inevitably increase organisational stress for GPs and other team members.

At this time of increased pressure in general practice there have been recent reports from some LMCs that stress amongst practice managers is leading to unprecedented levels of sickness absence or resignations².

GP stress can only be exacerbated if the practice manager becomes dysfunctional, goes off sick or leaves, and so it becomes a business imperative to prevent this when problems are due to avoidable causes.

The PM role

The practice manager's role varies as much as practices do. But there are core elements which are likely to be universal:



- human resources (HR) and workforce planning
- patient services and customer satisfaction
- finance and profitability
- quality and data standards
- adherence to legislation
- resourcing and maintaining premises and equipment, and
- general administration.

The full job description runs to multiple pages and may make reference to the involvement of GPs, either in leading or supporting roles. For example, a GP may lead on the QOF clinical domain but provide support with HR issues.

Problems will arise when the practice is struggling in any of the above areas due to historical issues or inadequate resources. And this may be aggravated by a lack of management expertise among GPs which could enable them to understand and address such problems.

These situations may be compounded when the chain of command is unclear or the manager is perceived as ineffectual or inefficient. The result may be GPs starting to ‘dabble’, dipping in and out when and where they can (or choose), often resulting in increased confusion and inefficiency.

However, even efficient managers are struggling with the current workload and so the key issues are how to ensure retention of good managers or address the problem of failing ones.

Management stress strategies

Practice managers need the following in order to perform well:

- A clear role and chain of command
- Appropriate management skills and knowledge
- The abilities and resources to delegate, and
- Employer and peer support.

The above list is not exclusive but focuses on core requirements. If the chain of command is confused,

there may be duplication of effort, interference (as opposed to performance management) or confusion, and managers of all abilities will struggle.

Clarity of purpose and the supplementary roles of others in practice management should be reviewed and clarified as needed – treat discrepancies as significant events to give them their proper attention and prevent them recurring.

Management skills and knowledge are gained through a combination of education and experience. Do not wait for practice management courses because general management ones will be equally beneficial: for example, ACAS offers employment law training nationwide and is the benchmark for employment tribunals³.

If there are performance management concerns about the manager themselves, ACAS provides a free helpline, a wealth of supporting material which can be downloaded, and a consultancy service.

Delegation can be to external agencies as well as practice staff. Pension and payroll are the obvious starting points, along with bookkeeping – approach your accountant or Google ‘GP payroll’ for resources.

Remove as much clerical work as possible, leaving only the management elements (for example, pay rates and salary reviews, and managing sickness absence). If the manager regularly has to cover absent staff, review your staffing levels or investigate bank or temporary staff.

Just as GPs are not expected to do HCA work, so managers should not be doing clerical tasks. However, some may find it tempting to do these in preference to the harder and more nebulous work of true management, and this aversion needs to be addressed.

Finally, encourage involvement with other practice managers and with neighbouring practices, and going to local meetings and events.

View such time as an investment in renewal and sharing. Isolation is a problem for practice managers, who are generally one of a kind in a practice.

Within the team, consider a mentor who can be a sounding board for certain issues. The time spent on this will always be less than the time needed to cover an avoidable absence or loss.

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

1.<http://tinyurl.com/cgd7csb>

2.<http://tinyurl.com/biz7ap7>

3.<http://tinyurl.com/c2422b2>

More top **legal** issues GPs ask about

Lawyer **Alison Oliver** follows her article in the last issue by considering the remaining five of the top 10 most common legal questions raised by GPs

1 One of the partners is not pulling his weight/keeps making mistakes/has an alcohol problem/ is rude to the other partners: what can we do?

It is disappointing, but some of the most common questions I get asked relate to dealing with a partner whose conduct or performance is causing concern.

The ease with which problems can be resolved partly depends on whether the practice has a partnership agreement. A good agreement should provide a framework for dealing with performance and conduct issues.

If issues cannot be resolved, it may be necessary to expel the partner. Caution here is essential. If there is no partnership agreement in place, expulsion could constitute dissolution of the partnership which may result in the practice contract being terminated.

Even if the agreement contains expulsion provisions, they must be exercised fairly or there could be grounds for a claim against the partnership.

Practices should seek early advice to avoid inadvertently damaging their position and they should seek a negotiated solution wherever possible.

2 We've been in partnership for years and have always got on fine: do we really need a partnership agreement?

See no.1. It is extremely common for practices to either have no agreement or to have an agreement that is out of date or badly drafted.

Unfortunately, friends and colleagues can fall out – especially if their interests start to diverge, such as when one of the partners retires or when there are performance or conduct issues that need to be addressed.

A well-drafted partnership agreement will set out rules, entitlements, obligations and procedures which will help the practice run smoothly and minimise the risk of disputes arising.

If practices admit a new partner, their old agreement may be rendered ineffective unless the partners sign a deed of adherence by which the new partner becomes bound by the existing agreement.



3 Can we register overseas visitors as patients of the practice?

The Hospital Charging Regulations 2011 oblige hospitals to charge for certain services provided to overseas visitors, but these do not apply to general practice.

A practice must always provide immediately necessary treatment in accordance with the GMS/PMS Regulations. A practice with an open list has some discretion as to whether to register a person as a patient or temporary resident, but may only refuse if it has ‘reasonable grounds which do not relate to race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition’.

Reasonable grounds may include that the patient does not live in the practice area or that there is a reasonable suspicion of identity fraud.

Criteria for refusing admission should be applied consistently so as to avoid a claim of discrimination. The fact that a person is an overseas visitor is not, in itself, necessarily sufficient grounds to refuse to accept them.

Practices should make it clear (for example by displaying posters in their waiting rooms) that overseas visitors may have to pay for hospital treatment.

4 The partners have received a gift of a crate of wine from a patient. Should we refuse it?

It is fine to accept gifts but if a practice suspects that a patient is attempting to gain some advantage then the gift should be returned. Particular care should be taken with high value gifts and gifts of cash.

Whether the practice accepts a gift or not, a record should be kept of the gift and of the reasons why it was decided to keep it or to return it.

The GMS/PMS Regulations require the practice to keep a register of all gifts of more than £100 in value from or on behalf of patients to contract-hold-

ers, employees and locums (and to spouses, civil partners or ‘living partners’ of any of them).

It may be prudent to record all gifts connected with the provision of services at the practice regardless of value.

5 Because of falling profits, we have had to get rid of our long-term locum GP. He has threatened to bring a claim against us for unfair dismissal. Can he do this as he is not an employee?

The employment status of locum GPs frequently causes problems.

Employment status determines how an individual is taxed and whether they have certain rights.

Describing the locum as self-employed rather than an employee does not guarantee the locum will be treated as self-employed. Even if HMRC has determined that for tax purposes a person is self-employed, an Employment Tribunal may still treat the person as an employee for employment rights purposes.

Generally, the more ‘arm’s length’ the relationship, the more likely it is that the locum will be considered self-employed.

Long service may be one indicator that the locum was in fact an employee, although this will be looked at alongside a host of other factors.

A properly drafted contract will help demonstrate the employment status of a locum, but only if it correctly reflects the real nature of the relationship of the parties.

If the locum’s contract is terminated and they are held to have been employed by the practice, they could be entitled to a redundancy payment and/or compensation for unfair dismissal.

Alison Oliver, an associate in Ward Hadaway’s healthcare practices team, specialises in GP partnership and contractual matters

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