AISMA Doctor Newsline

A helpful resource for the practice business

aisma
association of independent specialist medical accountants

Issue 18 Summer 2012

NHS Pension Scheme: should you count yourself in or out?

GPs are now asking AISMA member firms more questions about the NHS Pension Scheme than anything else. **David Walker** and **Gareth Rose* answer** the big concerns

Q The NHS Pension Scheme – is it still worth it?

A This suggests there is a simple 'yes' or 'no' answer. But consider the bigger picture. Is it still worth it to the member and is it sustainable?

Firstly, sustainability. The Scheme is often described as 'pay-as-you-go' - where contributions being made now are used to pay the pensions in payment now, with no fund of invested assets. But this does not really tell the full story. The funding objectives are that the pension contributions you pay now are sufficient to pay for future pensions. That may seem a small difference, but it has huge financial implications.

The contributions currently being paid in exceed the pensions going out by around £1.8 billion a year[1] . That sounds positive but further explanation is needed. As we said above, the funding objectives require you to be able to fund future pensions (think of it as funding your own pension), not that of those who retired 15 years ago. And you are likely to live a lot longer than them.

If provision for increasing longevity and inflation was not built in then the contribution rates of future NHS workers might have to rise even further to pay for your pension. Either that or the burden would fall back on the taxpayer through an increased Treasury contribution. Officially, employer contributions should not increase as they have been capped at the current level.

Even assuming a current £1.8 billion surplus, that will not last forever. The increasing cost of NHS pensions means that, without the contribution rate changes from April 2012, this situation was expected to reverse from 2016. Contributions being paid in would then be less than the pensions being paid out. So the 'powers that be', from the Hutton report onwards have determined that there needs to be a

rise in contributions and changes to benefit entitlement.

And let us be clear - that £1.8 billion 'surplus' includes the taxpayer-funded employer contribution, the extra bit over and above the employee and added years contribution.

For public sector pensions as a whole, not just the NHS, pensions paid out in 2011 were £26 billion and the employee contributions coming in were £5.2 billion. The shortfall of £20.8 billion was funded by £1 billion of sundry other income with the other £19.8 billion coming from the taxpayer through £15.2 billion of employer pension contributions and £4.6 billion directly from the Treasury[2].

The employer/taxpayer should of course play a full part in funding arrangements as pensions play a vital role in recruiting and retaining the best staff. It is also important to note that public sector pension scheme members are contracted out of the second state pension's earnings-related part. They will consequently only ever receive the basic state pension, for which the solid public sector benefits are a bit of a trade off, although they do pay a bit less national insurance to reflect this.

So, in asking if the NHS Pension Scheme is sustainable from the national position, the powers that be obviously think not. Changes to scheme membership, contributions and benefits aim to cut future obligations on the national purse.

From an individual point of view as a worker in the NHS, whether the scheme is still worth it is most definitely a question for a medical specialist Independent Financial Adviser (IFA). It depends on your own circumstances.

The answer will revolve around family responsibilities, cost, potential Annual Allowance and Lifetime Allowance charges and the possible reduction in resulting benefits, available alternatives, external pension provision, cashflow and retirement requirements. Two members with identical benefits may therefore receive different advice. So one size does not fit all.

As generic advice, however, our calculations show that, for the 1995 and 2008 schemes, to provide similar benefits - including the guarantees, CPI increases and widow's benefit - on the open market by private provision would cost a huge amount more than you would pay into the NHS Pension Scheme.

But the NHS Scheme does not really give you contribution flexibility. It is mainly all or nothing. In the private sector you can set your contributions at a level you can afford. In the NHS you must pay contributions on all your pensionable pay if you wish to stay in the scheme, no matter what you can afford.

Will the 2015 scheme be worth it? Time will tell as full details emerge, but the BMA is working extremely hard to negotiate the best deal possible for those who will be in transition from either the 1995 or the 2008 schemes to the 2015 and for those who will be joining straight into the new one.

Q Should I stay in the Scheme or should I opt out?

A This is not quite the same question as above, as it is absolutely down to individual choice. Only decide after taking an IFA's advice. But, generically speaking, we have seen few instances where opting out is favourable.

After opting out early, a curtain comes down on your membership and while you still may be entitled to cost of living increases before you draw your pension, your final benefits are likely to be lower than otherwise. This is because you will not get the benefit of increased service, higher pay, more dynamisation and extra pay for practitioners.

Yes, you will save the costs of the membership for your deferred period, subject to tax, but do those cash savings outweigh the reduction to pension benefits? In our experience, not often.

But be aware there are many influencing factors again, including exposure to the Annual Allowance and Lifetime Allowance charges, that may - if the scheme pays them for you - cut your final benefit figures. If there are lower retirement benefits from staying in the scheme because of these charges, then the gap between the cash advantages from deferral and higher benefits from staying in closes.

Calculations can be done to approximate how long you would have to survive after retirement, assuming you stayed in the scheme and received a higher pension, to recover the immediate cash advantages you obtain from deferring. Our experience typically shows this would be around seven or eight years. But every member's situation is different and specialist IFA advice must be taken, with the benefit of fully modelled calculations, before deciding.

Q Should I cease my Added Years contract?

A Possibly. We have seen doctors where the extra annual increase in benefits derived from an Added Years contract is nullified by the potential decrease in pension resulting from the accumulated Annual Allowance charges paid by the Scheme. We have also seen instances where this is not the case.

And we have seen times where a higher benefit would have arisen with the Added Years contract, but doctors decided to cease because the main-scheme benefits

projected at retirement provided sufficient income. They benefitted at a time when they needed an improved cashflow. But we stress that each case is different and must be reviewed by a suitably qualified IFA.

Q How do our partners cut superannuation costs?

A Generally speaking, do less pensionable work! This has the effect of making less pay susceptible to contributions and possibly reducing the tier rate at which you pay. But the lack of flexibility mentioned in answer to the first question above does restrict one's ability to do this easily while maintaining income levels.

Opportunities may arise if a new GP core contract materialises. And there is always the option of forming a limited company that performs, say, your pensionable out of hours work. That renders it non-pensionable while retaining the income. But there are tax considerations on top of all the usual pension calculations. Sorry, but you will need to see your tax adviser as well as your IFA in this case.

1 & 2 Office for Budget Responsibility – Economic and Fiscal Outlook March 2011

OPINION

Financial issues to dominate summer

Deborah Wood, Vice-chairman, AISMA

Conversations with our GP clients currently revolve around tax, cashflow, pensions and clinical commissioning groups (CCGs).

With regard to tax, GPs will be asking their accountants if they can reduce their July 2012 payment on account of their 2011-12 tax liabilities.

This might be possible where it is clear that taxable earnings in 2011-12 are less than they were in 2011-12 but will you know this before 31 July? You should do if you have a non-March year end but it may not be the case if your practice has a 31 March year end.

Even if practice profits are lower, the interaction with tax relief for superannuation contributions, higher rates of national insurance contribution, outside earnings and changes to tax thresholds might result in an increased liability.

For those GPs affected by the annual allowance tax charge on pension growth this liability arises for the first time in 2011-12 and could very well increase the overall 2011-12 tax liability above that due for 2010-11 on which the July payment on account is based.

Do not be too hasty in reducing the July payment to then find you have more to pay at 31 January 2013 together with interest on the July underpayment.

On pensions, David Walker and Gareth Rose have provided some useful advice in their article starting on page one.

Cashflow is affected by tax liabilities, pension contributions and practice profitability. The effect of CCGs will directly impact on all of these.

Practice managers are key to how this is managed and if practices have started to see the impact of downward changes to enhanced services and commissioning income without the ability to also reduce core costs then GPs may be feeling the pinch in their drawings.

Will this continue to be the case for some time or are there opportunities to improve the situation?

The answer might depend on where you stand on opportunities arising from CCGs.

CCGs should create opportunities and advantages for practices as they become authorised to commission the majority of health services not already delivered via the core contract.

Where they identify changes to service delivery to improve quality, generate patient choice or save money those services will be recommissioned through new local enhanced service arrangements or other service level agreements.

It is at this point that practices need to consider if they can provide those services as they currently stand or whether they need to do so through a different vehicle.

You therefore need to be getting involved with your CCG, to find out what its priorities are and where your practice could fit in and could offer services.

Money follows patients and they have a widening choice available to them. Practices need patients to choose them to ensure they generate income.

If you decide to offer new services it may be beneficial to consider offering them through a separate Limited Company rather than as an additional general practice service. This can be beneficial for a number of reasons including risk management, tax mitigation, cash flow and pension planning.

But seek specialist advice early to get the right structure in place and make the most of the opportunities.

Swot before YOU chop

Cutting practice staff costs can be costly if you don't do your homework, warns Michael Rourke

With budgets frozen or cut across the NHS, many practices have to make savings where they can – and the employee salary bill is often a target.

Partners are increasingly considering staff dismissals, either due to financial considerations, problems with employee behaviour, or inability to adapt to new working practices.

But protection against 'unfair dismissal' is one of the most significant protections for employees. Once employees have worked for the relevant qualifying period, they can only be dismissed by employers for one of the 'potentially fair reasons' (see below).

For staff hired before 6 April 2012, the qualifying period is one year of continuous employment. For those employed since, two years of continuous employment is required to bring a claim for unfair dismissal.

There are no 'qualifying periods' for discrimination claims. And be aware it is even possible for claims to be made by prospective employees who have not been hired - on the basis of a protected characteristic such as race, age, or disability.

Here I will deal with what is usually referred to as ordinarily unfair dismissal, not any of the possible discrimination claims, or automatically unfair dismissal claims.

The five potentially fair reasons for dismissal are conduct, capability, redundancy, breach of a statutory restriction, and 'some other substantial reason'. Conduct or capability issues are the most common.

A major difficulty for bosses, especially small employers like GPs, is that there is often an unwillingness to discuss problems with employees at an early stage. Then you reach breaking point.

Lawyers too frequently have to advise clients with longstanding 'problem' employees who have been unwilling to confront and formally tackle the issues.

Where an employee has ongoing issues to do with capability or conduct, as opposed to a single instance of gross misconduct, it is far easier to justify a dismissal on these grounds if there is a history of disciplinary action with written and oral warnings recorded formally.

When an employer is considering action against an employee it is important that they consider carefully their duties to avoid, even in the case of a potentially fair dismissal, procedural errors which can render this dismissal unfair.

The ACAS Code of Practice on Discipline and Grievance Procedures applies to disciplinary situations which explicitly include misconduct and poor performance dismissals.

All employers should be aware of their duties under the ACAS Code as, if the employer unreasonably fails to follow it then an Employment Tribunal may increase an employee's compensation by up to 25% if an unfair dismissal claim succeeds.

Where an employee has, for instance, committed an act of misconduct which could potentially justify dismissal, and the employer has carried out a fair procedure investigating and considering this, the boss may still only make a decision in the 'reasonable band of responses'.

This means that dismissing a long serving employee for a single instance of misconduct could potentially be found to be unfair.

So practices considering reductions to the wage bill should consider taking legal advice before acting. But it may well be too late if the first advice they take about an employment matter is after a dismissed employee makes a claim.

Costs of making a mistake can be high. For dismissals since 1 February 2012 the maximum potential award that can be awarded for an ordinary unfair dismissal is £85,200.

Michael Rourke is an associate at Lockharts Solicitors, specialising in employment matters.

Tips to defuse complaints

Dealing with a patient complaint is the single most common reason doctors contact defence body MDDUS for help. **Dr Barry Parker** gives advice on key areas of concern

It can certainly be distressing for GPs who get complaints about the care they provide. But an open and constructive approach is desirable to try to resolve issues at the earliest possible stage.

Most patients are not interested in pursuing long drawn-out formal complaint procedures. A complaint can often be dealt with on the spot with an honest and direct explanation and, where appropriate, apology.

Often just listening and understanding a patient's concern can be enough to defuse the situation.

1 Healthcare or treatment provided

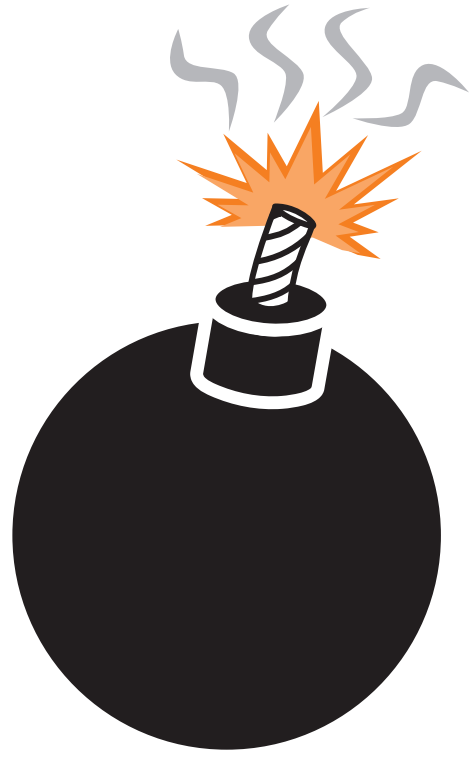
Patients have a right to expect the very best healthcare from their GP and sometimes they are unhappy with their treatment.

Where doctors can identify any failings in their care of the patient then it is reasonable to apologise and learn from these.

But sometimes the complaint arises from a mismatch between the patient's expectations and the doctor's view of best treatment. For example, patients now have access to a great deal of information, albeit of variable quality, on the internet. They may have already self-diagnosed and have clear expectations of how things will be treated.

They may want specific medication, investigation or referral, and may be disappointed if this is not offered. It is important for doctors to try to recognise the patient's agenda and discuss this so misunderstandings can be addressed.

GMC guidance *Good Medical Practice: Doctor patient partnership* states that doctors should encourage patients who have knowledge about their condition to use this when they are making decisions about their care.



2 Competence of doctor being questioned

GPs may feel very threatened or undermined by having their clinical competence called into question by a patient. Doctors have, of course, an obligation to always act within their own limitations in terms of knowledge and skills, and to seek assistance where it is needed.

Unfortunately, some patients may question their doctor's actions even where good medical practice has been followed and actions were competent. Good record keeping in these situations is essential as this can support a doctor's actions in addressing a complaint, whether locally or to the Ombudsman or GMC.

3 Communication problems

Many complaints are a result of a breakdown in communication between doctor and patient rather than any specific clinical issue.

Sometimes patients may feel the doctor has not given clear instructions or communicated properly, leaving them confused about their care. This could result in patients not following prescription instructions or healthcare advice properly.

Sharing information in a way that patients can understand, with treatment options available to them explained in clear terms - including risks and benefits – is vital. Doctors should respond to patient questions and keep them informed about the progress of their care.

4 System failures

Complaints about clinical care are often found to be the result of systemic rather than individual failings. Repeat prescription errors, delayed referrals and problems with result handling following investigations may all indicate problems with systems in place for dealing with these issues.

Although never welcome, a complaint of this type may be particularly useful if approached as an opportunity to learn and develop. Improvements in systems can be effected as a result of discussing the underlying causes of what went wrong. And that may benefit patients and avoid similar complaints in the future.

5 Complaints about conduct

Occasionally, patients complain about a doctor's conduct rather than their clinical care and treatment. This may range from complaints about attitude or lack of bedside manner to more severe accusations of inappropriate conduct during physical examinations.

Of course, intimate examinations are a necessary part of medical care for some patients and doctors must take steps to ensure patients are put at ease and the process is dealt with in the correct manner.

GMC guidance *Maintaining boundaries – guidance for doctors* explains the measures doctors should take. One key element is to offer a chaperone wherever possible during intimate examinations, even when doctors and patients are of the same gender.

When we consider the complexity of the work that doctors undertake, and the number of daily contacts they have with patients, overall rates of complaint remain low and the vast majority of patients appear satisfied with the care they receive.

But when this is not the case, proper handling of a complaint from the outset is vital.

Dr Barry Parker is a MDDUS medical adviser

Why surgery underfunding may be your fault

Too many GPs are losing important income due to filling in their PREM1 forms inaccurately, warns **Chris Johnson**

Increasingly we are seeing GP practices across the UK lose out on notional rent reimbursement because they make errors on their PREM1 forms received from the PCT.

PREM1 forms are received by GP practices every three years as the first stage in the rent review process. Practices are asked to write down all the available space for which they plan to claim rent reimbursement.

But we estimate that 70-80% of surgeries are underfunded because their rent reimbursement is too low, approximately 20% of which is due to failure to include all of their useable space on their form.

This may be down to doctors and practice managers going through a very busy time and rushing to complete their forms. Or they are simply unaware of what they can or cannot include.

With the growing financial pressures on practices it is all the more important to receive the correct rent reimbursement. So I would urge all practices to allocate appropriate time and resources to getting their PREM1 forms right.

The main spaces that we are finding practices leave out are areas like lofts, basements and outbuildings they may use for storage. Using these spaces for storage frees up more space for recep-

tion areas, treatment rooms or circulation space. Therefore it is vital to include them on the PREM1 form to ensure it is all taken into account when the notional rent reimbursement is calculated.

We are also seeing more cases where the PCT's representative uses the details on the PREM1 form to limit what is included in their valuation, causing lost income and long delays in rectifying mistakes.

I would advise, instead of trying to note down all the individual spaces available within the premises and running the risk of leaving something out, practices simply write: 'The whole of the property known as [insert name of GP practice] is used for GMS/PMS purposes'.

At GP Surveyors we have worked with over 2,000 GP surgeries nationwide and have negotiated notional rent increases of up to 80% - amounting to five figure sums.

Savings made have been put towards new IT systems, refurbishments and equipment. Investments like these may be vital in the future where improvements are needed to ensure a surgery's CQC compliance.

I urge all GPs and practice managers who are unsure to seek advice on filling out their PREM1 forms. This should be a priority as it has such a huge effect on their income if they get it wrong.

And any practice who believes it should be due a rent review but has not received a PREM1 form should contact the PCT as soon as possible.

We are seeing some practices holding back on starting their next rent review due to concerns that their notional rent reimbursement will be decreased as a result of the poor state of the UK economy. They are worried about the media hype around the reduction in the value of house prices and the increased cost of borrowing.

But with an aging population and an increasing demand for primary care, the need for doctors' surgeries is on the up. As a result, primary care is one of the few sectors where property prices have generally not deteriorated.

Installing complimentary services such as pharmacies, dentists and opticians, into premises can significantly increase revenue, raise the surgery's capital value and enhance patient experience - vital for CQC compliance.

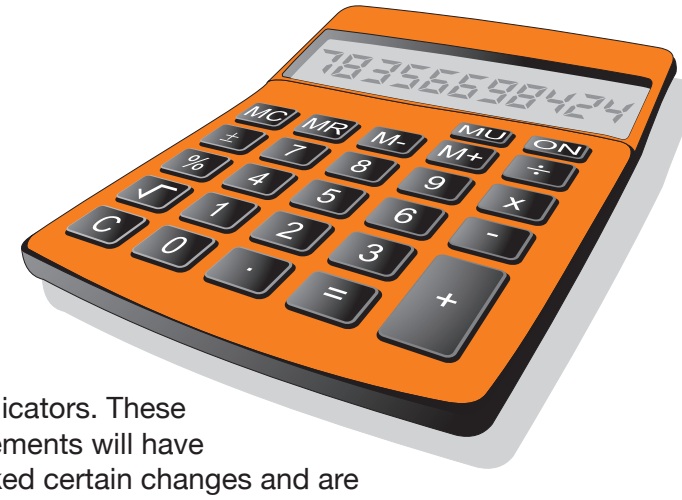
Surgeries already accommodating complimentary services on their premises must ensure they are receiving the correct rent from them. But we find many settling for rents much lower than average.

For those surgeries who are still on a Cost Rent scheme, it can be a financial boost for them to move onto a Notional Rent scheme before the Cost Rent scheme comes to an end. A specialist surveyor can calculate the best solution for them.

Chris Johnson is a co-founder and director of GP Surveyors

Figure out your costs

There are some useful profit and loss calculations you can now do in the run-up to commissioning. **Kathie Applebee** explains



Clinical Commissioning Groups (CCGs) are having an intensive year during which form may well be taking precedence over function.

Groups have to be established and fully functional by next April - and in some areas this may have resulted in a lull at practice level when it comes to local commissioning changes.

There is, however, a universal need to meet the QIPP targets and, for practices specifically, the QOF QP indicators. These requirements will have provoked certain changes and are a useful testing ground for fully fledged CCG commissioning when it comes to assessing the impact on practices.

The QP indicators provide a simple example. Each practice stands to earn up to 99.5 points for these. The value of the points varies nationally –

currently £133.76 for England, £133.69 for Wales and £129.88 for Northern Ireland, with Scotland's figure still, according to the guidance document, to be recalculated from £130.38 for 2011-12.

These figures are linked to practices' patient populations - see *Focus on QOF Payments*, *April 2012* for the national formulae[1]. Each country's points' values are linked to a different number of patients, with England the largest at 5,881 patients per point.

The QP indicators provide some guidance to the potential impact of commissioning activities within practices, with the potential income providing a benchmark against which corresponding work can be done.

For example, if you held a half day meeting attended by 10 GPs, with each one backfilled by a locum, the locums fees would need to be set against the eventual earnings.

Although employing this many locums would rarely happen, the work that would have been done during the meeting time will have to be done at another time and this is an actual cost to all those involved.

If the costs exceed the likely rewards, the work should cease or be changed to become more cost effective. But this gets complicated when the practice becomes exposed to PCT and CCG pressures to make changes to meet QIPP and other efficiency drivers.

Every patient treated in general practice who would previously have been treated elsewhere becomes an additional cost. If this is met by new funding streams (for example, a LES for phlebotomy), and the funding truly meets the costs, the practice does not lose from this arrangement.

However, unless a practice calculates the full and true costs, it may not know whether or not it is in the black as opposed to a red deficit.

Such costs can be complicated by events in year. For example, if a phlebotomist becomes ill and is away on extended sickness leave, the staff costs immediately double due to payments to locum staff.

Of course it is up to practices how they choose to respond to and measure such initiatives. From a management perspective, it would seem wise to begin calculating how much each department, group or service costs to provide. A simple explanation of cost centres can be found in *The Times 100 Business Case Studies*[2], with useful links to further information.

I am not suggesting that practices should refuse to participate in commissioning activities, nor even that every service should be profitable.

Some may have indirect benefits which are deemed compensatory: for example, an initiative involving medication reviews of patients in community care settings would also meet the practice's other requirements to do such reviews annually.

Practices may choose to take on initiatives for a multitude of reasons, not all of which need involve profit and loss.

But given that the deficit is unlikely to ease anytime soon, and we may be in for a long haul, such decisions are better being fully informed ones when it comes to costs.

1 http://bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Contracts/gpfocusonqofpaymentsapril2012.pdf
2 http://businesscasestudies.co.uk/business-theory/finance cost-and-profit-centres.html

Kathie Applebee is strategic management partner at Tamar Valley Health Group Practice

AISMA Doctor Newsline is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK. www.aisma.org.uk

AISMA Doctor Newsline is edited by Robin Stride, a medical journalist and former finance editor of Doctor magazine. robin@robinstride.co.uk

*David Walker, senior tax consultant, and Gareth Rose, financial planning consultant, Moore and Smalley LLP (Moore and Smalley are regulated by the Financial Services Authority)