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Issue 24 Winter 2014

The new contract 2014 examined



On 15 November 2013 the **BMA's General Practitioners Committee (GPC)** and **NHS Employers** (on behalf of NHS England) announced changes to GMS contractual arrangements applicable from April 2014.

An agreement had been reached a little further in advance of the implementation date than the 2013 -14 imposed contract changes. However the details to support the announcement, and the amendments to regulations through the Statement of Financial Entitlements (SFE), had yet to be published as we went to press.

Once again, forward planning within the business of general practice is proving to be extremely complex.

We asked **Debbie Wood** to give the known plans an 'accountant's eye' view. Here she assesses what the key changes might mean for a typical practice.

Seniority

Seniority payments will be removed over a six year period commencing from April 2014.

Anyone not already in receipt of seniority payments by 31 March 2014 will not become entitled to receive future seniority payments after 1 April 2014.

For practitioners currently in receipt of a seniority payment it is expected that payments will continue to be made in line with progression outlined in the SFE until 31 March 2020.

However there is also an expectation that the savings made from retiring GPs, and no new entrants to the scheme, will be at least 15% a year. If that is not the case then it is likely that the amount of seniority per band in the SFE will reduce to ensure a 15% reduction year-on-year is achieved.

This latter point is subject to further agreement between the negotiators and will not be evaluated until the 31 March 2015 data is available, probably not before September 2016.

Funding released from the seniority pot will be added into global sum payments. The details of this have not been confirmed but in general, where global sum funding increases, so too proportionately does the amount deducted for out-of-hours.

What might the impact be?

The incentive to stay longer in general practice or to keep superannuable earnings above the threshold by which seniority is paid in full may be diminished. This could well be an additional factor in the move for longer serving GPs to reduce their workload commitments or take early retirement. This reduces experience and capacity across primary care.

The redistribution of seniority payments to PMS/APMS practitioners should be redistributed fairly into those contracts on the same basis as the GMS global sum.

The reinvested funds should be approximately 15 pence per weighted patient a year.

Quality and Outcomes Framework

The major impact of the agreed changes has been in respect of the Quality and Outcomes Framework (QOF), currently worth a maximum of 900 points.

185 points of clinical indicators, 33 points of public health indicators, 33 points of patient experience indicators and 100 quality and productivity indicators will be retired.

10 points will be added to the clinical domain for hypertension.

Therefore 238 points worth of the released funding (£37,000 per average practice) will be added into the weighted capitation global sum payment but will not be subject to a 6% deduction for out of hours opt out and will be available to all practices including

those with a correction factor.

103 points (worth £16,000 per average practice) is transferred into enhanced services.

The total of available points will be 559 for 2014-15.

The threshold increases previously announced to take effect from April 2014 have been deferred for a further year.

Some of the time frames for reviews have also been increased.

What might the impact be?

The burden of bureaucracy, unnecessary patient testing and recall and box-ticking is removed or reduced. But clinicians will continue to use their professional judgement to carry out necessary treatments and so appropriate workload will not reduce but will be funded via the core contract.

Most of the imposed 2013-14 changes have been reversed.

QOF payments for 2014-15 will be at least 45% less than practices will have received in 2012-13 reducing the average from £21 per weighted patient to about £11.75.

However for the money taken out of QOF and reinvested in the global sum there will be an improvement to overall cash flow.

This is because more income will be received within the monthly global sum payment rather than only 70% via the monthly QOF aspiration payments and then waiting until May-June for a final 30% achievement payment.

Low QOF performers with high weighted capitation lists should do well from the reallocated funding compared to high QOF achievers with low weighted lists.

The likely increase to the global sum funding for the QOF reinvestment will be in the order of £5 per weighted patient.

Enhanced services

A new unplanned admissions enhanced service (ES) commences on 1 April 2014 for one year.

This will be funded by reinvesting 100 QOF points together with £42m from the 2013-14 risk profiling ES. A total of £160m is therefore available.

This will involve proactive case management of at-risk patients covering 2% of the over 18 patient population.

A personalised care plan will be created which identifies a named accountable GP.

The dementia ES is to be extended for another year, 50% funding on engagement and 50% on activity evidence.

Learning disabilities, alcohol and extended hours



ESs are all extended for another year.

The patient participation ES is retained but funding is reduced to £20m with the other £40m to be reinvested into core funding.

The remote care monitoring ES and patient online ES ceases at 31 March 2014 and the total £36m funding is to be reinvested into core funding.

The risk profiling ES also ceases at 31 March 2014 and the funding is reinvested into the new unplanned admissions ES.

What might the impact be?

No new money but for those who were not high earners from or involved in some of the previous ESs then the reinvestment in core funding should be of benefit, again particularly for those with high weighted lists.

There might also be an improvement in cash flow for reinvested money paid monthly rather than paid in arrears on achievement for ESs.

Money reallocated from QOF into ESs will be about £2.20 per weighted patient.

Money reallocated out of the patient participation ES into the global sum will be about 70 pence per weighted patient and from the remote care and patient online ESs will be about a further 65 pence.

GP pay and expenses

The Doctors and Dentists Review Body (DDRB) will make recommendations for the 2014-15 uplift in the usual way, for consideration by the Government. This should be announced in February 2014.

What might the impact be?

The DDRB should take into account the continuing inflationary pressures on running costs within general practice and the workload pressures on GPs and their staff to ensure a suitable pay award is recommended.

Minimum practice income guarantee

From April 2014 the correction factor payments used to meet the minimum practice income guarantee (MPIG) will be phased out over seven years. Funding will be recycled into the global sum. There is further discussion currently underway about possible transitional relief for special circumstances.

What might the impact be?

All practices in receipt of a correction factor payment will be affected and those with an above average weighted list should benefit. But there will be losers.

For a typical practice about 60 pence per weighted patient from the correction factor will be reinvested into the global sum.

Publication of earnings

Practices will have to publish GP NHS net earnings relating to the core contract only in 2015-16 using data for 2014-15. A working group is being established on what and how to publish the information.

The calculation will be on a like-for-like basis with other healthcare professionals.

What might the impact be?

Practices may need to collate their accounting information in a different way or pay their accountants to produce an additional analysis alongside the year end accounts required for tax purposes.

It will be vital to ensure clear guidelines are drawn up about how to disclose income streams and the expenditure relating to them. Consideration will need to be given to looking at this on a per patient basis (weighted or raw?).

There will also be discrepancies to consider where practices might choose to employ salaried GPs

compared to practices who share workload among more partners.

The main difficulty will be in how to make the comparisons fair alongside other healthcare professionals. That will entail thinking about full time equivalents, numbers of sessions and what is a full time working commitment.

All GPs who are members of the NHS Pension Scheme currently have to complete a certificate of their superannuable earnings annually. By definition this quantifies their NHS earnings from the core contract and other sources. It seems to me to be the most suitable template for tailoring into a practice wide model to calculate the figures that will be required.

PMS contracts

Appropriate changes should be reflected equitably in PMS contracts at a local level.

What might the impact be?

PMS practices will continue to undergo funding reviews and it may well be time to find out what reverting back to GMS will mean in terms of overall contract funding. If PMS practices have a high weighted list size their funding gap with GMS may not be as far apart as they think.

Other changes

Named GP for patients aged over 75 in relation to services provided under the contract only.

Practices opted out of out-of-hours will have to monitor the quality of service provided by the out-of-hours provider.

Practices will be contracted to take the Friends and Family Test from December 2014.

From October 2014 practices can register patients from outside their traditional boundary without obligation to provide home visits. NHS England will have the responsibility for in-hours urgent medical care at or near home for such patients. There has however been no mention of how this service requirement would be funded.

CQC inspection outcomes will have to be displayed in waiting rooms and on websites.

The weighting given to deprivation will be strengthened in the Carr-Hill formula from April 2015. The existing deprivation factors may also be updated from April 2014. Practices managing highly deprived populations should see the benefits in due course.

There are also various requirements regarding IT changes for patients and information that will be applied in 2014-15.

Around the regions

Northern Ireland

2014-15 contract changes in Northern Ireland are likely to be similar to England particularly with respect to QOF (245 points will move into core funding). However the quality and productivity (QP) targets will be retained.

Discussion is also taking place around federations, commissioning and more equitable funding.

There could be increased funding for out-of-hours.

MPIG will not be phased out from April but will be part of ongoing discussions to increase funding streams.

Scotland

In Scotland there will be no phasing out of MPIG and there will be minimal changes to the 2014-15 contract but some of the England reforms could be adopted.

Wales

The Welsh should have seen a contract deal shortly before we went to press and were expected to follow some of the QOF changes introduced in England; however they are retaining QP targets.

MPIG is not being phased out in Wales at this stage.

Practices may be paid to work in clusters.

Planning ahead

When the full details are published via the SFE, and in particular how the reinvestment into the global sum will be dealt with, all practices should be in a position to evaluate the likely changes to their income streams.

A profit projection and superannuable earnings projection for 2014-15 can then be produced so that cashflow and drawings expectations can be set from April 2014 at realistic levels.

There does not appear to have been anything negotiated around premises funding so practices will need to think separately about making the most of their premises within existing funding envelopes.

Do not forget that your local AISMA accountant is well placed to interpret the overall impact of the agreed changes on your particular practice.

Sources:

BMA News and FAQs

NHS England correspondence to area team directors

GP/Pulse publications news items

HSCIC statistical information for 2012-13

Debbie Wood, Vice-Chairman, AISMA

OPINION

Act to avoid a partnership fracture

Bob Senior, Chairman, AISMA

Changes to the GP contract from April 2014 are understandably causing a lot of concern to GPs.

The shake-up to the QOF and the Minimum Practice Income Guarantee (MPIG) are probably the most significant for many. However the changes to the seniority payments, in particular, are provoking a lot of comment.

But while it is of course right for practices to be planning for what is happening from April 2014 they should not forget that significant changes to the QOF were introduced in April 2013.

Increasing the upper thresholds for QOF, and reducing the time for achievement, is likely to have a material impact on practice results.

Back last Spring the GPC advised practices that it thought an average practice, with perhaps 6,800 patients, might lose £11,000 from those two changes. Although I cannot comment on the figure the general

trend of an increase in threshold and reduction in time leading to a reduction in payment makes sense to me.

At the moment many practices have yet to get a real idea of how these two changes might affect them. But they need to make a realistic assessment of that now.

Doing so will hopefully provide an impetus to the clinicians for the remaining part of the year, and indeed it may be that greater attention to exception reporting will be one of the results.

The key reason for trying to put a figure on any potential loss is to ensure that all partners are aware of the possible problem and its potential scale.

If a practice were to lose, say, £30,000 then that would obviously be a major problem.

But if some partners were completely oblivious to the scale of the risk then it could lead to a fracture of the partnership, which would be a disaster.

Deal with this year's QOF points first



Look to the future – but don't take your eyes off the last three months of the present contract, warns **Kathie Applebee**

The old contract is dead – long live the new contract!

It is perhaps premature to get too excited, as governments have a tendency to give with one hand and snatch with the other. However, those practices that have found the QOF a bureaucratic nightmare may find the new regime more palatable.

QOF has had its problems but it provided a clear framework for the exchange of services for income.

As it has reduced in value, the range and complexity of enhanced services have increased but without necessarily gaining the within-practice attention that the QOF has demanded.

There are two key similarities between these areas

of service provision and income generation:

- the service needs to be maximised to ensure that as many eligible patients as possible have access to it, and
- the data needs to be recorded accurately and comprehensively so that claims can be automated as far as possible.

One feature of enhanced services is the ability to tailor certain of them to local requirements, in the form of local enhanced services (LESs).

This adaptation may increase, and practices will need to be vigilant to ensure that their patient encounter and data recording systems adapt to such changes.

Practices that can adapt their own data entry screens to meet local variations, or in-house requirements, will find such expertise invaluable. Those without such expertise may wish to consider this as a learning imperative for 2014.

In previous years, the January-March quarter has included incorporating certain new QOF requirements ahead of time in order to hit the ground running on 1 April. This year is completely different.

A sense of, 'It won't matter after April' may have an adverse effect on this year's points, and it may be best to play down the QOF changes to the practice team in the run up to 1 April 2014.

<http://bma.org.uk/news-views-analysis/general-practice-contract/qof-changes-2014>

© Kathie Applebee 2014, organisation psychologist for primary care, and strategic management partner at Tamar Valley Health Group Practice

QOF point movements

QOF 2014-15 will be worth 559 points:

- Clinical domain: 185 points removed.
- Public Health domain: 33 points removed
- Patient experience: 33 points removed
- Quality and Productivity: 100 points removed

Total: 351 points removed from QOF

10 points added to HYP002

This leaves a balance of 341 points, the equivalent amounts of which will go to:

- enhanced services (103 points - QP 100 points and LD 3 points), and
- core funding (238 points). The latter will not have the standard 6% deducted where practices have opted out of out-of-hours work.

Big changes ahead

Significant changes to the clinical domain, with planned threshold increases deferred for a year:

- The hypothyroidism, child health surveillance, maternity, patient experience and QP areas are being removed, the latter to the Unplanned Admissions enhanced service.
- Cholesterol checks have been removed across a range of indicators.
- Practices can begin flu vaccinations from 1 August (supplies permitting).
- Cancer reviews following diagnosis now have a six-month timeframe instead of three.
- AF003 (patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1 (latest in the preceding 12 months)): the twelve-month requirement is being removed.
- The time frame for reviews of patients newly diagnosed with depression (DEP002) will be extended from 10-35 days to two to eight weeks and the requirement for a bio-psychosocial assessment will be removed.
- STIA002 (patients with strokes or TIA who have been referred) will be amended so that it only refers to the latest recorded stroke or first TIA within any QOF year rather than being cumulative.
- LD001 (learning disability register) will no longer have a lower age limit, and the record of blood TSH in certain Down's Syndrome patients is being moved to the LD enhanced service (3 points).
- The dementia annual reviews are due to be changed.
- The hypertension area is being reduced to a register and HYP002 only, the latter renamed HYP006 and now to be worth 20 points: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, with the threshold changing from 44-84% back to 45-80%.
- The lower age range for BP001 (BP checks within the last five years) rises from 40 to 45.
- RA will lose the two risk indicators (cardiovascular and fracture risk).
- Diabetes loses albumin creatinine, retinal screening, dietary reviews and erectile dysfunction.
- Mental health (MH) loses blood glucose, HbA1c and BMI measurements.
- Epilepsy is reduced to a single point for maintaining a register.
- CVD Primary Prevention will lose the lifestyle checks.
- 11 points will go with the removal of the need to ask all patients aged 15+ about their smoking status every two years.
- There will no longer be points for a system of advising women of smear results, nor a need to give LARC advice during routine contraception encounters (3 points remain for during emergency contraception consultations).

Protect your pension against the Lifetime Allowance

Previous articles in [AISMA Doctor Newsline](#) have warned of a number of issues affecting GPs in the NHS Pension Scheme, both currently and in the future. In our last issue **David Walker** * highlighted some potentially ruinous side effects of accepting a well-paid CCG position. Here he looks at something a little less heavy – the new forms of protection in relation to the reduction in the Lifetime Allowance (LTA) from April 2014

The LTA is the maximum amount of tax relieved pension savings one may make in a lifetime. If you go over the prescribed limit then the excess is taxed.

When looking at personal pensions, assessing the amount of the overall savings is easy enough. You merely look at the current value of the investments held. But for occupational pension schemes (sometimes called defined benefit arrangements), there is no pot of investments as such, so a different valuation method is required.

A capitalisation factor is used to achieve this. It is an attempt to work out what notional pot of money would need to be invested to provide similar benefits to those earned in the NHS Pension Scheme (NHSPS). A factor of 20 has been agreed, plus the lump sum if there is one. For instance:

Pension	£67,000
Lump sum	£201,000
Pension x 20	£1,340,000
Lump sum	£201,000
Total capital value	£1,541,000



The capital value as calculated above is measured against the LTA for the year. Any excess over the limit is taxable at 25%. The scheme will pay this on your behalf and will reduce the pension benefits to recoup the tax paid for you. This is a permanent reduction calculated by reference to a recovery over 20 years.

The capital value in this example is £41,000 above the current £1,500,000 limit. Tax due on the excess at 25% is £10,250, which the scheme will pay. Your pension will then be reduced by £512.50 a year gross (£10,250/20).

Probably being a 40% taxpayer in retirement, this equates to a net loss of £307.50 (£512.50 x 60%), or £25.62 per month.

LTA charges may, in some circumstances, be due at 55% and possibly 40%. Those occasions are fairly rare and not relevant here.

Changes from April 2014

From 6 April 2014, the LTA limit is due to fall from £1,500,000 to £1,250,000. Consequently, if you retired on 31 March 2014 with a capital value of your pension rights of £1,400,000, you would not suffer a charge.

But if you retired a week later at 7 April 2014, you would have an excess of £150,000 and a tax charge of £37,500. You are obviously badly disadvantaged if the above happens. People in this position are therefore to be given opportunities to take out protection to avoid paying the £37,500.

There are two new forms of protection to be offered: Fixed Protection 2014 and Individual Protection 2014.

Fixed Protection 2014 (FP14)

An application may be made before 6 April 2014 for FP14. The application form is available on HMRC's website, or you can apply on-line. Upon the granting of FP14 you retain the higher limit of £1,500,000. Should your pension benefits exceed this when they are drawn, the excess will be taxed as above.

However, FP14 will be lost under certain circumstances, which means your LTA limit will revert to the standard LTA of £1,250,000. These circumstances are:

1. A new arrangement is made (i.e. a new pension is commenced), or
2. Benefit accrual occurs.

It is fairly easy to tell whether benefit accrual occurs under a personal pension arrangement. If you make a contribution, then benefit accrual has occurred and you lose FP14. To retain the higher limit, therefore, you must cease making contributions to all private pension arrangements.

But in a defined benefit scheme such as the NHSPS, when does benefit accrual occur? The first thing to be said is that continuing to contribute to the scheme does not in itself mean you lose the protection.

There are also provisions within the legislation for growth at an annual rate specified within the scheme rules to be permitted. There is no such rate within the NHSPS. Benefits increase by a combination of increased service, pay, or dynamisation.

The protection is lost if the capital value of your benefits, at any time in the tax year, grows by more than a permitted percentage. The permitted percentage is the increase in the Consumer Price

Index (CPI) for the 12 months up to the September falling in the previous tax year.

So, for example, if you wish to judge the growth of your capital value in 2014-5, you measure it against the CPI growth for September 2013. The CPI for the year to September 2013 was 2.7%. If your capital value grows by more than that, then FP14 is lost and your limit reverts to the standard £1.25m.

For anyone in the NHSPS, particularly GPs, it is ridiculously easy to exceed growth of 2.7%. A GP with a dynamised pot of career earnings of, say, £1,500,000 with 18 years practitioner service and 22 years of total service would only need a dynamisation rate of 1.5% (the minimum it can be) and pensionable pay in the following year of £35,000 to exceed 2.7% growth in the capital value.

In my experience, such values together in one year would be rare. For it to happen over a number of years consecutively to retirement probably stretches the imagination.

FP14 can be lost at any time in the tax year. Once HMRC grants the protection, there is an obligation upon you to advise them of its loss within 90 days of that happening. Penalties may apply if you do not.

This means, therefore, that you must, at least every three months, value your benefits to see if benefit accrual has occurred. That could be both time consuming and costly.

Individual Protection 2014 (IP14)

This is a form of protection that was argued for before 2012, when the LTA reduced from its limit before then of £1,800,000 to the current level of £1,500,000. No such protection was provided at that time, so it is a welcome advancement, and almost unique, that the Treasury has actually listened to the critics and provided something which is remotely of any use.

IP14 can be applied for by anyone with benefits with a value of more than £1,250,000 at 5 April 2014. Should that be the case, you may continue to accrue benefits within your scheme, but you will have a personalised LTA limit set at the value of your benefits at 5 April 2014, subject to a maximum of £1,500,000.

To reach a capital value of benefits of £1,250,000 in, say, the 1995 side of the NHSPS, you will need a pension of £54,348, so we are mainly looking at older members who have been in the scheme for some time. The protection should be effective for such members and it means that you can carry on building your benefits after 5 April 2014.

If we follow the above example of a member with a 1995 pension of £67,000, with IP14 there

would be tax payable on an excess over £1.5m of £10,250. Without the protection, there would be tax due on an excess over £1.25m of £72,750. Yes, another £62,500 of tax payable!

It is disappointing that the protection is restricted to only those with values above £1.25m. Opening it up to everyone in the scheme before the change would have been even better. The Government is, however, attempting to reduce a deficit, so someone has to pay the taxman.

To obtain IP14 you will need to have a valuation of your benefits performed at 5 April 2014 to ascertain whether they are over £1.25m. It will not be possible to value benefits at 5 April 2014 until after that date.

Unlike FP14, which must be applied for before 6 April 2014, applications for IP14 can only be made after that date. HMRC is proposing a window of three years in which you can apply.

Legislation upon the application of IP14 has not yet been passed, so final details are still unknown. As the figures above show, though, the tax saving with IP14 can be considerable and, as it is not very often that HMRC gives you something for nothing, it may well be advisable to take up the offer.

Other considerations

There are possible implications if you have an existing form of protection in place. You may not take out either FP14 or IP14 if you have Primary or Enhanced Protection in place. You can, however, apply for FP14 if you have FP12 in place, which preserved your limit at £1.8m, although why you would do that is a mystery.

You are able to have both FP14 and IP14 in place at the same time and can also have IP14 if you already have FP12. It is therefore quite flexible.

When should an Independent Financial Adviser (IFA) be involved? As we have seen, for FP14 to remain valid you must effectively cease contributing to your pensions. That obviously has a direct affect

upon what you will live on in retirement and, as such, is a decision that should be taken with the appropriate IFA advice.

IP14, however, is a safeguard. It provides a best case scenario in the absence of other valid protections. If it works, you benefit. If it doesn't, you are no worse off than if you hadn't had it.

Whether you make an application does not, therefore, require any IFA input. A valuation of your benefits at 5 April 2014 will, however, need to be performed, so there may be additional costs if your accountant does this for you or prepares the application form.

The devil will no doubt be in the detail when it comes out. But the initial impression is favourable and applications should be encouraged.

The new 2015 NHS Pension Scheme

With a new NHSPS coming into being from April 2015, many GPs in existing 1995 and 2008 sides of the current arrangement are querying what impact the new scheme will have on them.

Those within 10 years of their normal retirement age as at 1 April 2012 are fully protected. That means that they will remain in their existing scheme until retirement and the 2015 scheme will have no bearing.

For those over 10 years from their normal retirement age, the 10 year full protection period is restricted by two months for every month they are over 10 years from their normal retirement age at 1 April 2012.

Don't miss our next AISMA Doctor Newslines explaining how this works, and what the new scheme will look like.

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