AISMA Doctor Newsline

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Issue 16 Winter 2012

Take time to beat new QOF

You just get used to QOF - and then they change it. **Kathie Applebee** advises on what's new for 2012-13 – and how to keep on top of this valuable income source

The race is already underway

Widespread QOF alterations from 1 April 2012 could catch out practices who, until now, have done well under previous versions.

There are two new clinical areas - PAD (peripheral arterial disease) and osteoporosis – and 12 new indicators, as well as changes to existing ones in the form of retirements, replacements, wording alterations, and revisions to the numbers of points and/or thresholds needed to achieve top marks.

Where indicators have been changed (other than the value of points or thresholds), they are renumbered. This leaves gaps in the documentation where the redundant indicators used to be.

Due to the breadth of the changes, practices may miss certain crucial ones and so the detailed guidance documents should be studied carefully[1].

All changes should be assessed for the value of the points, the amount of work needed to meet them and the changes potentially required to be made to practice systems and procedures.

Accurate record keeping is essential and, as many indicators are scored on the 15-month period between 1 January 2012 and 31 March 2013, certain changes should be introduced as soon as possible. The clock is ticking!

The indicator threshold changes include:
- 90% upper threshold - all lower thresholds raised from 40% to 50%
- 70-85% upper threshold – all lower thresholds raised to 45%

13 other indicators have had individual threshold increases.

QP indicators

The six QP (quality and productivity) indicators which were introduced last year, covering outpatient referrals and emergency admissions, remain for now but the prescribing ones (QP1-5[2]) are being retired (28 points). Instead, there are three new QP indicators for A&E attendances (QP12-14), worth 31 points.

These A&E indicators require internal data reviews by 31 July, with A&E attendance patterns being used to assess whether practice access is appropriate. Peer group review then needs to be done by 30 September and an action plan, aimed at reducing avoidable A&E attendances, submitted to the PCO by 31 March 2013.

Apart from the prescribing QP indicators, further retirements include CHD13 (7 points) and AF4 (10), bringing the total value of the retired points to 45. In addition, five other indicators (BP4 & 5; DM2 & 22; and CKD2) have lost a total of 16 points. These points have all been allocated elsewhere, leaving the overall QOF total at 1,000.

New clinical indicators

Apart from the QP indicators, which are included in the Organisational Domain, the Clinical Domain has nine new indicators: four in the new PAD area; three in the new osteoarthritis area (the enhanced service for this disease ends on 31 March 2012); and one each for AF (atrial fibrilation) and smoking.

Smoking has had several changes (see box) and, due to the large numbers of patients involved, may need special attention.

Achieving high scores

Practices fail to do well in the QOF for a range of reasons which include lack of monitoring and recall procedures, poor record keeping, and a reluctance to actually do some of the work. These problems could be tackled by quantifying the value of the points and then measuring these against the work needed in a series of very simple cost-benefit calculations.

If the value of the points exceeds the cost of additional staff time, for example, they are worth pursuing for financial reasons, leaving aside the wider clinical implications.

It is worth noting that some points have a cumulative value. For example, recording smoking status and cessation advice in the 27 months prior to 31 March 2013 will help achieve the smoking requirements linked to clinical areas which total 50 points for indicators Smoking 5 and 6, with a combined total of 73 points.

Practices also need to be confident in the use of exception reporting[3]. This enables patients who are either non-compliant or unsuitable for treatment to be ignored when threshold achievements are calculated.

Although getting to grips with changes to the regulations and new record-keeping requirements may seem the most difficult part of QOF changes, the real problem often stems from resentment at having such changes imposed.

While it may be acceptable to rant about this as individuals, any decision by principals or staff to ignore the new requirements will adversely affect income and thus may need treating as a formal business matter rather than merely as individual choice.

Smoking changes

• Smoking 5 & 6 (25 points each) replace Smoking 3 & 4 (30 each) and now include patients with PAD (50% - 90% threshold)

• Smoking 7 (11 points) - previously Records 23 - the percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months (50% - 90% threshold)

• Smoking 8 (12 points) is new: The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months (40% - 90% threshold)

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1 The BMA website is a good source: http://tinyurl.com/6j3433p
2 However, practices which are budget outliers will be expected to participate in peer reviews during the QOF year.
3 Guidance on exception reporting can be found at http://tinyurl.com/dzeu3d

OPINION

Use your AISMA accountant to help beat profit pain

Debbie Wood, Vice Chairman, AISMA

One always tries to be optimistic of better things to come when looking ahead at a New Year's beginning. However when considering the perspective for our clients in general practice that could be difficult.

Running general practice is not going to get any easier in the coming year. So it will be essential to understand where your practice is now and what changes may need to be made to maintain profitability.

Making plans about the future is extremely difficult

in the current economic climate where uncertainty abounds at a global, European and national level.

For practices specifically there remains a lack of clarity about the impact of the Health and Social Care Bill becoming law, on potential contract changes, and on wider changes to public sector pension arrangements.

So what do we know for 2012-13? Broadly speaking there is another pay freeze in place, with the GMS global sum increasing only from £64.59 to £64.67 per weighted patient. For those 65% of practices still with a correction factor even this small increase will be eroded by a reduction in the correction factor as part of the overall withering away of the Minimum Practice Income Guarantee (MPIG).

Income from the QOF is increasing by about 2.5%, or £3, per point. However it will be more difficult to reach the 1,000 point maximum as some target thresholds are lifted.

It is clear that such small enhancements to income will not keep pace with the likely rises in expenditure, particular if the cost of living index continues to run at around 5% a year. Employed staff may be looking to their GP employers for reasonable pay awards to combat additional superannuation tiered rate contributions and general cost of living rises.

The GPs themselves may be finding their own contributions increasing with higher personal tax obligations at a time when available drawings from the practice profits are reducing.

My advice to our GP and practice manager clients, bearing in mind the above, is to stay close to your practice finances and seek assistance from your AISMA accountant to budget and monitor cash flow requirements.

Your easy A-Z of GP tax planning

Chris Howe* gives tax planning tips and advice for GPs

With only three months of the tax year to run, it is time to review your situation and see if there is anything that can be done to reduce your tax bill either now or in the future.

The following A to Z has been compiled to assist you in your thoughts.

A **Annual Allowance,** of which there are several. For Capital Gains Tax, if you have a share portfolio outside ISAs, it's time to review whether any gains have been made in the year. Consider selling to utilise your annual tax free allowance of £10,600, and double that if your spouse is in a similar situation.

B **Benefits in Kind**. Christmas gifts such as vouchers to practice staff are taxable. £100 given as a gift could cost you a further £100 in tax.

C **'Capital Allowance'** permits a tax deduction for large items such as cars, computers and furnishings. If you need to replace any such items and they are used for business purposes, then up to £100,000 is claimable against this year's income if you purchase by 5 April 2012. Cars must be low emission to qualify.

D **Defer income**. If you are suffering the 50% tax rate, consider whether any income can be deferred to later years in the hope that this rate will be abolished.

E **Entrepreneurs Relief**. If you are selling part, or all, of your surgery share, ER allows you to pay only 10% tax on any gain in value rather than 28%. While most GPs should qualify, there are strict conditions to be met.

F **Film Schemes.** For those who dislike paying tax and who are prepared to take a risk, there have been schemes aimed at funding new films, which effectively swapped a tax bill for an investment in a film production. However these are now under the taxman's scrutiny and certain reliefs are being denied.

G **Gift Aid**. While most GPs are aware that donations by taxpayers to charities qualify for income tax relief, I have found that many do not realise that they can receive higher rate tax relief on these. The charity gets basic rate tax relief, but you must claim for the higher rate relief. If you give £80 to a charity, it claims back £20, but you can also claim a further £20 by a cut in your tax bill. £100 for the charity costs you £60.

H **Highest Rate**. Your 'personal allowance' of £7,475 will be taken away as your taxable income creeps over £100k. Do you really want to do that extra piece of work if it's now taxed at 62%?

I **Individual Savings Account (ISA)**. Each individual over 18 can invest up to £10,680 into an ISA. Future income and capital gains from shares and the like are tax free. These have now been around for 24 years, and their cumulative effect is worth pondering. If a couple invested every year from say age 30 to age 60, they would have a joint pot of £640,000 without growth above inflation. This could be producing tax free income of £30k pa now, saving tax of £12k a year in retirement.

J **Junior ISAs.** These have just been introduced for over 16s and are worth considering.

K **Kids.** If you have children over 18, and are minded to gift money to them, they can start their ISA now with your help.

L **Limited Company.** For most GPs in standard NHS contracts, it seems either impossible or impractical to operate as a company. But for those that can there can be tax advantages, including for GPs with significant private income, particularly if family members invest in the company too.

M **Mortgage.** Remember that only the interest part of monthly mortgage repayments is tax deductable. Hence as the years pass and the loan is paid off, less interest is claimable. This means higher tax bills and also lower drawings as funds are left in the practice to pay off the loan. Consider remortgaging, if the bank will support you at a sensible rate.

N **National Insurance.** If you have income from an officer post as well as the practice, then make sure any overpaid NI is claimed back.

O **Overseas investments.** If you have any forgotten or undisclosed overseas investments, then disclose them to the taxman now, before they approach you, as this should reduce any penalties.

P **Pension Tax.** This is a hot topic at the moment. GPs should obtain a pension forecast and initially make a rough assessment of whether they will be taxed for exceeding the 'annual allowance' or 'lifetime allowance'. If so, then detailed financial advice should be sought to assess what options are available to reduce such taxes.

Q **Query.** If there is something in your tax bill that you do not understand then query it. AISMA accountants will be delighted to receive a query from a client and will be pleased to explain any anomalies.

R **Reduced Profit.** If like many GPs your profits are falling, work with your accountant to estimate your 2011-12 profit share and ask him or her to reduce your January 2012 tax bill accordingly.

S **Save for Tax.** A typical GP will need to save about a third of their profit share for tax, so make sure this is put away, out of temptation's reach.

T **Trusts.** If you are concerned about inheritance tax, then consider using a trust to make gifts to children, tax free, in good time.

U **Use of Home.** Most professionals do some work from home, even if just keeping up to date by reading journals or the web. Tax saved by a claim for using your home as an office could cover the cost of a few meals out.

V **VAT.** If you have to deal with VAT in your accounts, ensure that your monthly calculations are checked regularly by your accountant. The VAT man can go back four years and simple mistakes can be very costly.

W **Wear and Tear.** If you have a buy to let property that is furnished, then claim this allowance of 10% of net rents against your profit.

X **Xenagogue**. Make sure you have a specialist accountant to guide you through the strange land of GP tax. They need to be a lot sharper than Steve Brody in Life's Too Short.

Y **Why pay more tax than you need?** Always consider how you could reduce the tax you pay.

Z **be Zetetic.** Make sure that your tax affairs are in order, just in case the taxman picks you for an investigation. The new rules impose harsher penalties for errors. Motor expense claims are a favourite.

Why fixing a partner's retirement age is risky

Partners beware! Andrew Lockhart-Mirams sounds the alert about age discrimination and fixed retirement ages in partnerships

GP partners are sometimes surprised to hear that some aspects of employment law apply to their partnership arrangements too.

The law says discrimination amongst partners on any 'protected characteristic' is as illegal as if it was by an employer against an employee.

These characteristics, listed in the Equality Act 2010, are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Prior to the nGMS contracts and permanent PMS agreements, GPs were obliged to retire at 70. But this is no longer a part of their terms of service and there is no limit on the age they can continue working to.

Many partnerships instruct lawyers to include an agreed fixed retirement age in their partnership agreements, whether at 70 or earlier. But agreements before the 1 October 2006 discrimination provisions came into force often set out a fixed age without much consideration.

Since the law change it has been unlawful to discriminate on age grounds. There is now no fixed retirement age for employees but the law does not provide for a legitimate retirement age for partners.

You can expect that challenges to forced retirement on the grounds of age discrimination will be a growing area of dispute, especially where the reasons for a selected age are unjustified.

Under partnership law alone, partners were free to agree any terms they wished amongst themselves about retirement age, or other grounds of retirement. But this freedom to contract must now be read alongside the right not to be discriminated against on the grounds of age (a 'protected characteristic' under the Equality Act). This leads to the apparently paradoxical situation where you are free to include a fixed retirement age as long as this does not discriminate on the grounds of age.

Perhaps unsurprisingly, this been the subject of legal challenge. The leading case here is Seldon v Clarkson Wright Jakes, concerning a fixed retirement age for partners in a solicitor's firm.

Mr Seldon was forced to retire at the end of the year after his 65th birthday. Unhappy at this he brought Employment Tribunal proceedings on the basis that the provision in his Deed was discriminatory on the grounds of age.

This went to an Employment Appeal Tribunal, the Court of Appeal and is set to be heard in the Supreme Court this month (January). Hopefully it will provide some clarity.

The Court of Appeal held that the firm was permitted to have a fixed retirement age as it could justify this by reference to the fact that it provided for its associates to progress to partnership on retirement of existing partners, so providing a clear career path.

It was felt this facilitated the partnership's planning and gave the workforce long-term expectations on when vacancies would arise. And it limited the need for partners to be expelled via performance management - contributing to the firm's congenial and supportive culture.

So as the law stands now, it is possible to have a fixed retirement age in a partnership deed, provided this is 'justified'.

From our experience of advising GP practices, the most relevant factors from the Court of Appeal case were the facilitation of the planning of the practice's future and avoiding the need to 'performance manage' partners beyond age 70.

The second of these is the more controversial element of the appeal court's decision. It presently appears possible to justify 65 as a retirement age to allow the remaining partners to plan for replacements in good time certain in the knowledge when retirement will occur, if necessary by enforcing the agreement.

But until the case is decided, and even possibly thereafter, there will be risks associated with electing to have a fixed retirement age pre-determined in an agreement.

Of course, every partnership differs. Each should take advice before relying on such a clause especially as its lawfulness and the circumstances when it may be relied on are up for a legal challenge in the land's highest court.

Andrew Lockhart-Mirams is senior partner at Lockharts Solicitors

Tips to ease the CQC registration burden

The CQC registration process in general practice has begun to gather speed. **Martha Walker** gives an update

Registrations start in the late summer of 2012 and aim to have all NHS general practices covered by April 2013.

Much remains for clarification but in October the CQC published *An Introduction to Registration with CQC* for providers and you should remember two things:

1 As a practice already providing clinical governance information and operating monitoring systems measuring performance, results and patient satisfaction to external bodies you should have much of the evidence already. Use this data to demonstrate compliance with the CQC essential outcomes. You should have little to create from new.

2 The essential standards focus on the outcomes experienced by patients, not the policies and procedures your practice has.

Get the building blocks in place

Your registration preparation should now be underway.

You and/or your practice manager should be registered with the CQC online community and be part of the Provider Reference Group. This gives your practice a chance to be involved in developing the registration process. (cqc.org.uk/prg)

From the CQC website your practice manager should have downloaded:

1 the *Essential standards of quality and safety* March 2010 and have started considering registration and compliance requirements

2 the Provider Compliance Assessment (PCA) tool for each of the 16 essential outcomes

3 *for providers of NHS General Practice - An Introduction to Registration with CQC*.

A designated GP partner needs to work with the manager to understand how the process will unfold, what it entails and to share this with the partners.

Within the practice your manager should be:

• introducing the nursing team to the *Essential standards of quality and safety* and thinking together about the best ways to gather clinical evidence to demonstrate compliance.

• starting to discuss the CQC registration with staff at team meetings. There is much negative and often inaccurate information surrounding the CQC including practice closures if they fail to demonstrate compliance. Bring staff on board at the start and get them to understand that CQC registration is an opportunity to publically show what an effective and caring practice they belong to.

• reviewing current processes and creating a year plan if there isn't already one to plot when various reviews, surveys and audits will take place.

Outside the practice your manager should be talking to other managers in your area to see what collaborative work can be done, including:

• arranging training workshops. The CQC maintains you don't need extra staff or training to complete the registration forms. But experience in the independent medical and dental sectors shows collaboration, training or support can help the practice in understanding the interpretation of the outcome requirements and how to manage achieving compliance where it isn't currently happening

• sharing policies

• discussing joint activities and ideas like audits and staff training (such as child protection and resuscitation).

Not everything is decided yet

As the CQC has not yet decided everything it is very important to participate in the consultation processes to influence the way forward.

• A key issue yet to be determined is fees. There will be consultation on this and I imagine the fee structure will be one of the last decisions taken before April 2013.

• Changes to the CRB checks are now taking place. It is proposed that if the provider or registered manager is a member of the GMC at time of registration they will not be required to have the CQC countersign the CRB application. CQC are about to go out to consultation with general practice providers on this subject through the Provider Reference Group.

• The exact time scale for registration application to commence is still to be determined – if it is the same

or a similar system to that for dentists then you will only have a short window of time to submit your registration. That is another valid reason to start gathering your evidence to demonstrate compliance now.

• Take advantage of the road shows and exhibitions as well as online web chats the CQC is offering in the next 18 months as it firms things up.

By ensuring you have the building blocks in place your practice will be ready to move forward confident in the knowledge that you know at every step of the way what the CQC is expecting from you and the services you provide.

Martha Walker advises practices and runs CQC compliance workshops. info@cqcconsultancy.co.uk 07974 756 189, cqcconsultancy.co.uk

Act now to protect your pension

There's been much ado about pensions – and there's still much to do. David Walker** brings some timely advice

Public sector pensions are much in the news. This of course includes the NHS Pension Scheme and therefore affects all AISMA members' clients.

But over and above most other public sector schemes there are a number of key areas where action needs to be taken sooner rather than later, or where decisions need to be made.

AISMA recently conducted a pensions training day in Birmingham for its members.The following are the essentials for GPs to be aware of:

Pensions choice exercise

From April 2008 a new version of the NHS Pension Scheme was introduced. Generally speaking, the potential benefits available at the new scheme's normal retirement age are higher than those available before, even though there is no automatic right to a tax free lump sum.

The trouble is that the normal retirement age is 65 rather than the old scheme's 60. Members have the right to transfer their existing benefits into the new scheme and GPs are having to decide now.

Should you transfer? Every case, of course, must be considered individually on its own merits in conjunction with appropriate advice from a specialist medical IFA. But in all the cases I've seen so far, unless you are under 60 and know for certain that you're going to be working until the age of 65, transfer to the 2008 scheme is not beneficial.

Annual allowance charges

From April 2011 the maximum 'pension input' one can have in a tax year has been capped at £50,000.

In terms of the NHS scheme, the pension input is measured by reference to a capitalisation of the growth in the pension amount from the start of the year to the end, although you can revalue the starting year figure to allow for growth in the CPI.

Any growth in excess of the £50,000 is taxed at your top marginal rate.

There are a number of issues to consider here:

• How do you know what the growth in your pension benefits is?

Well, you can ask the NHS Pensions Agency, but it is not obliged to let you have figures for 2011-12 until October 2013. This is some nine months after the deadline date for submission of your 2011-12 tax return.

So, what do you put on your return? Unless you can accurately estimate the figure you leave yourself open to large penalties if your figure is under the actual figure.

• Unused allowances from previous years can be brought forward to offset any future excess, but are you in a position to calculate them? What else can be done to mitigate the charges?

• Where the charge arising is in excess of £2,000, you can elect for the scheme to pay the tax on your behalf. Your benefits at retirement are then reduced to collect the tax paid for you. Preliminary calculations that we have seen seem to indicate that the recovery is out of all proportion to the tax paid. This area has not been finalised, however, and is being followed closely.

• You should by now be in dialogue with your accountant about how you are going to approach this highly complex area. It is possible that your AISMA member accountant could calculate the estimated

impact of the annual allowance charge for you.

Lifetime Allowance

The Lifetime Allowance is reducing from April 2012 from £1.8m to £1.5m. The Lifetime Allowance is the level of tax advantaged pension savings one can accrue over a lifetime again before potentially severe tax charges are payable.

GPs have needed a pension of over £78,261 to breach the £1.8m limit but from April 2012 that figure will be £65,217. This exposes many more GPs (and consultants) to a potential charge.

There are ways to mitigate the potential charge, but the starting point will be an attempt to put a quantum on the figure. That will lead to discussion concerning planning and mitigation and may cover some or all of:

Continuing in the scheme and paying the charges: The NHS Pension Scheme benefits compare favourably with any scheme around and it may be that you are still better off staying in the scheme paying full contributions to enjoy a higher benefit at retirement.

Ceasing added years: This may be an option to stay in the scheme but reduce your exposure to tax charges while continuing to accrue main scheme benefits.

Ceasing membership and deferring benefits: Ceasing membership for GPs has certain cash advantages as you pay your own employer superannuation contributions. Ceasing membership means you get to keep these payments as well as your employee contribution. Although they are subject to tax, this can build up quite a cushion by the time you actually take your benefits.

24 hour retirement: Again this is an option. You must fully retire for 24 hours and cannot work more than 16 hours a week in the following month. If you are under the age of 60, though, you should be aware that the pension benefits are reduced because they are in payment for longer.

Pension commutation: This is where you give up some pension for additional tax-free lump sum and it has the effect of reducing your capital value for Lifetime Allowance purposes. It is quite effective for when you are on the margins of the limit.

Fixed protection: It is envisaged that there will be very limited uses for this protection when membership by GPs is continuing, but there may be instances where it may be effective for someone retiring in 2012-13 or where used in conjunction with deferred membership.

An application for fixed protection can be made prior to 5 April 2012, so action is required sooner rather than later. You should not apply for this protection if you have enhanced protection in place.

Enhanced protection: For GPs this is a very beneficial cover. Although the deadline for making an application for enhanced protection was 5 April 2009, the legislation allows late applications in certain specific circumstances.

This may apply to you, but you will need to get in touch pretty quickly or the opportunity may be lost.

So you can see that there are a number of key areas where planning is required. I like to try to give my GP clients as much warning as possible for tax liabilities, but some of the numbers I am seeing in respect to these charges are significant, so burying your head in the sand should not be an option.

The advice you need is not just isolated to the number crunching to establish the tax effect. Once you have that information then work closely with specialist medical IFA advice to take the right decision about mitigating those costs while maximising retirement benefits.

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