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Financial advice for a happy holiday 3



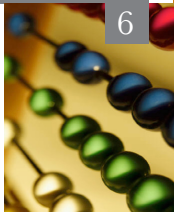
COST OF QUALITY

Why ongoing business development is a must 5



FINANCIAL DIARY

Topical jottings of a money-minded GP 6



Pension posers answered

GPs have more queries about NHS pensions than almost anything else. **Ross Mathieson** answers the most common questions about the NHS Pension Scheme for England and Wales

Q What changed in April 2004 in respect of a GP's NHS pensionable pay?

A From then, GP providers (partners and 'single-handers') and GP performers (salaried GPs) have been able to pension more of their 'fringe' NHS GP earnings.

'Fringe' earnings now include OOHs, NHS board and advisory work (i.e. PEC), section 12(2) work, blue badge work, care, fostering, and adoption work subject to the GP (or practice) being paid directly by a NHSPS Employing Authority. More information can be found on the NHS Pensions Division's website (www.pensions.nhsbsa.nhs.uk) in the Members' Library section.

Q What is the NHSPS SOLO form?

A The SOLO form is for those GP providers who prefer an individual pensions credit and do not wish to 'pool' (share) their fringe NHS earnings. The form is available from the Division's stationery store and can also be downloaded from the website.

The SOLO form is to be used when a GP is paid directly by a NHSPS employing authority (under a fee-based arrangement) for NHS work undertaken outside of their normal practice, for example PEC and OOHs NHS work. The SOLO form must be completed by the relevant fringe employing authority and the GP and sent to the GP's host PCT/LHB by the fringe employer (along with the employer and employee contributions) on a regular basis.

Salaried GPs should always use the SOLO form.

Q What pension rights do salaried GPs have?

A The regulations stipulate that salaried GPs are always afforded type 2 (assistant) practitioner scheme status and not officer or practice staff status. The 'employer' for pension purposes is always the PCT or LHB even if the GP is practice based.

Q What about locum GPs and their NHS pensions contributions?

A The GP locum's host PCT/LHB pays the employer contributions in respect of all pensionable NHS GP practice-based locum work. The GP locum webpage on the Pensions Division's website provides up to date information.

Q Are all Out Of Hours Providers (OOHPs) allowed to join the NHS Pension Scheme?

A No, they have to meet the legislative criteria as specified in the NHSPS regulations. Technical newsletters 15/2004 and 3/2005 provide more guidance. A list of those OOHPs that are NHSPS employing authorities can be seen on the NHS Pensions Division's website.

Q Are non-GP partners allowed access to the NHSPS?

A Yes. Non-GP partners in GMS, APMS, and SPMS are afforded NHSPS rights. Non-GP partners are classed as 'whole time officers' regardless of their working week. Their 'employer' for NHSPS purposes is the PCT/LHB and not the practice.

Q Can GPs opt out of pensioning some of their NHS GP work?

A No, the NHSPS regulations state that a GP must pension all of their NHS GP-type work or opt out of pensioning all their GP-type work. A GP can however opt out of salaried officer work (i.e. clinical assistant).

Q What legislative requirement is placed upon a PCT/LHB in respect of validating the annual certificate?

A The regulations state no specific legal requirement to validate all the figures declared on the certificate. Therefore the declaration that PCTs/LHBs are required to sign is worded in such a way that recognises that some of the income declared on the certificate will have come from other sources.

Q Does a provider have to complete more than one certificate if they hold more than one contract?

A Yes. Each GMS, PMS, APMS, SPMS contract that a provider hold must have its own 'ring fenced'



certificate.

Q Does a retired GP still have to complete the certificate?

A Yes, if it refers to a year when they were pensionable. Also, as the Statement of Financial Entitlements (SFE) requires for a certificate to be completed for seniority allowance purposes, a provider should complete a certificate even though they may not have been an 'active' scheme member - i.e. they have retired and returned to the NHS in a non-pensionable provider capacity.

Q Does this mean that a PCT/LHB may receive a certificate from a provider who is not an active scheme member?

A Yes. PCTs/LHBs should note that a small number of certificates will not require any pensions action. The certificate will have been completed mainly for the purposes of seniority.

Q What happens if a provider refuses to complete the certificate?

A It is a legal requirement that providers must complete the certificate. Those who do not are in breach of the statutory NHS Pension Scheme regulations and the statutory SFE. Not completing the certificate may have a detrimental effect on their NHS pension benefits and seniority allowance. Section 2 of the SFE also states that the monthly global sum payments may be withheld if a GMS provider fails to complete the certificate.

Q Should an SD86 still be sent to the GP?

A There is no legislative requirement upon a PCT/LHB to send out an SD86; some do some don't.

Q How are tiered contributions for a GP calculated?

A The tiered employee contributions rate in 2008-09 for a GP provider is based on the GP's aggregated GP pensionable pay (i.e. Practice + PEC + OOHs + Bed Fund) in year 2006-07. If the 2006-07 pay has not been finalised year 2005-06 should be used as the yardstick. More information can be found on the NHS Pensions Division's website.

For a salaried GP or a GP locum, tiered contributions for 2008-09 are based on their total 2006-07 GP pensionable income, or year 2005-06 if the 2006-07 pay data is unavailable. The tiered contributions are based on their actual, not their whole time equivalent, pensionable pay.

Q Is there still a pensionable earnings cap?

A From April 2008 NHS earnings are no longer capped. However members who were subject to the earnings cap prior to 1 April 2008 will still be subject to the earnings cap in respect of their Scheme added years contributions where the added years contract commenced before the 1st of April 2008.

More information can be found on the Pensions Division's website (www.pensions.nhsbsa.nhs.uk) in Technical Newsletter 17/2008.

Ross A Mathieson is senior technical and compliance manager, NHS Pensions

Scotland and Northern Ireland GPs should contact their AISMA accountants for specific advice.

£ave a £appy £oliday

Your money is under pressure at home – but even more so when you go on holiday abroad. **Robin Stride** has some sound seasonal financial advice



You've earned your summer break so make sure you make the most of your money this year and don't get ripped off.

1 Take travellers cheques

One in six holiday makers became a victim of theft abroad last year. So consider taking a percentage of

your cash in travellers cheques. They are like cash but insured. If they get lost or stolen you can easily get them cancelled, and a new set dispatched, by quoting the travellers cheque reference number on your receipt. This will take the sting out of losing a load of cash. Also consider splitting up your money, keeping some in the hotel safe and some in your pocket.



2 Email yourself

Use a web-based email account to email yourself any information you may need in case of an emergency - insurance details, help lines, travellers cheque numbers and emergency numbers for lost or stolen cards. American Express suggests you can access it all from abroad if you lose the hard copies.

3 Watch your plastic

If you pay the bill with a credit or debit card, keep your eye on your card and watch the transaction go through. Unauthorised use of your card will usually be insured against but knowing where your card is all the time will minimise the risks of your details being swiped.

4 Make sure you're insured

If you become the victim of crime whilst abroad, being insured will give you the peace of mind that your belongings can be replaced.

5 Beware card charges

Before using a debit or credit card abroad find out from the bank what charges are likely. Some cards charge as much as £1.50 for every overseas purchase, as well as additional foreign exchange fees ranging from 2.75% to 3%. They may also charge fees of 2.5% or a minimum charge of £2.50 every time cash is withdrawn from an ATM.

6 Watch out for sterling conversion

Don't get stung by Dynamic Currency Conversion - when retailers overseas convert plastic purchases into sterling instead of using the local currency and charge a fee of up to 4% on top. Always insist that the local currency is used, advises personal finance expert Simeon Linstead, at uSwitch.com.

7 Avoid machine double whammy

He also suggests travellers try to avoid withdrawing cash using their credit card - because they will be charged a cash withdrawal fee alongside a foreign exchange fee for using a cash machine abroad. You will also normally be charged interest from the day you take the money out even if you pay the bill in full as soon as you get it.

8 Know about ATMs

Research from the independent financial comparison website MoneyExpert.com shows that the cost of

withdrawing cash abroad can vary dramatically between providers. It urges holidaymakers to check their provider's charges before they travel.

The average cash withdrawal abroad is equivalent to £103, but it says the amount withdrawn that will show on a statement is likely to be around £107.

Debit card holders will pay on average an additional £4.12 in charges, and credit card holders £4.33. Although debit cards are a cheaper method

of withdrawing cash abroad than credit

cards, some current accounts still charge more than the cheapest credit cards.

MoneyExpert's Sean Gardner says: 'Withdrawing cash from an ATM or over the counter whilst abroad can be the most convenient way of getting hold of your money. It's also safe and simple.

'However, most people will have to pay for the privilege and some will pay considerably more than others. With the pound currently very weak against the Euro, unnecessary fees are the last thing holidaymakers need.' He adds: 'Even if you have a credit card offering zero per cent on cash withdrawals it's important to clear the balance as soon as possible on your return as the APRs charged on those transactions can be very high indeed.'

9 Don't leave it until the airport

So you're taking foreign currency? Then don't let busy surgeries stop you getting to the bank. Pre-paid currency card provider FairFX.com. warns that people are being fleeced when buying foreign cash from the airport.

Chief executive Stephen Heath said: 'Holidaymakers could be paying as much as 11 per cent more for foreign currency if they leave it until they get to the airport compared to organising beforehand'.

Using a pre-paid currency card like his, for example, would give you a claimed seven to 11 per cent more for your pound compared to the airport.

10 Check back home

When the holiday is a distant memory the statement you've been dreading will inevitably arrive. Always check it thoroughly to ensure you have not been a victim of fraud or spurious charges.

Opinion

Let the GP's voice be heard

David Clough, chairman, AISMA

It seems that our GP clients are in for a deluge of changes within the NHS.

Lord Darzi is not appealing to the average GP and the BMA must make it clear that doctors are becoming tired of continual changes to their contract.

2004 brought a new contract which within days was found to be flawed. We then had the belt and braces approach of the MPIG. It was ill-thought out, but in most cases gave practices sufficient funds to provide patient care based on their previous performances.

But this flawed approach has produced inequalities between practices with some receiving much larger correction factors than others. MPIG should end, there's no doubt about that, but what will replace the global sum and correction factor?

The Health Secretary must surely listen to those on the shop floor

and to specialists in medical finance such as AISMA members. As accountants we see how the regular changes in funding have become a very unreliable and inconsistent source of income for the GP.

Here today, gone tomorrow seems to be the normal method of providing funds by the Government. This stick and carrot approach is causing resentment among GPs who provide an excellent personal service through existing surgeries.

It makes you wonder whether Lord Darzi is deaf. Rather than introduce polyclinics staffed by salaried GPs, the general consensus of opinion is to retain the local surgery system, led by GP principals fully committed to the efficient running and development of their practices.

There is a tough job ahead for the BMA if the NHS is to retain the same type of system as it has previously provided.

The cost of quality

Continual business development will be key to improving practice income in the future, warns **Kathie Applebee**



The Department of Health publication NHS Next Stage Review: Our vision for primary and community care (3 July 2008) describes plans for developing 'a fairer funding system, giving better rewards for GPs who provide responsive, accessible and high-quality services'.

These plans include moving funding from the previously guaranteed MPIG to targets such as an enhanced Quality and Outcomes Framework and to responses to extended patient surveys.

This document is good news, in many ways, for high-achieving practices in that it enables them to replace the MPIG with targets to be met rather than simply losing it all.

In effect, their years of investment in developing their practices may now pay off.

Practices that are less well developed are likely to find this new regime difficult to master: this may be fair for those that consistently perform badly but will be hard on others that have been so focussed on clinical issues that they have neglected apparently peripheral areas such as data quality.

When advising practices on their profitability, the 'bottom line' is inevitably of great importance. However, this has tended to be viewed on an annual basis – the practice profits for this year are more important than those for future years.

This is especially likely where senior partners are approaching retirement and may be understandably reluctant to invest now for returns only derived after their departure.

Such failure to invest, either because of lack of interest and commitment or because of lack of predictive and proactive management, is an issue which could be raised by the practice's financial advisors.

In order to meet the proposed new targets (which are, as yet, only described in high-level terms), practices will be required to meet the following types of standards:

- Professional and robust management which can tackle difficult issues, such as workload discrepancies
- High-quality computerised data recording, and the ability to monitor data throughout the year

- Extended nursing services which enable appropriate delegation from doctors to nurses, and nurses to healthcare assistants and administrative staff

- Premises which, if not state of the art, are at least clean, pleasingly decorated and well furnished, and

- Patient-friendly services which encourage the controversial view of patients as customers.

For those practices that have relied on the global sum and MPIG, or have been half-hearted in tackling the QOF and enhanced services, investment in the above seems essential to ensure survival.

These practices may not be receptive to such messages but they are most at risk from competition (including from the commercial sector) and the new encouragement to patients to 'vote with their feet'.

It may help to discuss the proposed loss of the MPIG: cutting existing services will, of course, be the surest way of both saving money in the short term and guaranteeing the eventual demise of the practice, and should therefore be avoided.

Those practices that have taken some steps to address the need for improved standards should be encouraged to continue their progress and further their investment.

Meanwhile, those that have spent hard-won time and money on development should not rest on their laurels. General practice can only become increasingly competitive and target-driven as a result of the latest round of reforms, and even these will need to continue developing their businesses.

Kathie Applebee, organisational psychologist for primary care, and strategic management partner at the Callington & Gunnislake Group Practice
www.practiceservices.co.uk

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Financial Diary

Topical jottings of a money-minded GP

Rent review gains us £54k

One source of income not to overlook for partners that own their premises is notional rent. This is assessed every three years by the district valuer. It is important to make sure that a fair rent is awarded.

We recently had an assessment and were offered a 2% increase. But I knew rental rates were rising quite fast locally and thought being offered under inflation was unfair.

We engaged a chartered surveyor on a no win no fee basis. The fee would be 50% of any gain negotiated for the first year's rent. It has been a protracted affair with the district valuer asking us to take low offers because the health authority was pleading poverty and saying it could afford no more.

We rejected two better offers and accepted the third after 18 months. Our original rise in rent was £1,805. What we have accepted is an increase of £23,475 - a significant difference. It has cost us £10,835 in fees but by the end of the three year review period we will have gained an extra £54,175!

How we are going green

We have tried hard to contain consumable costs for the printers including paper and ink. By moving to a paper light system we have cut the need to print so many documents.

Changing work systems requires patience and ongoing training, but is worthwhile. We no longer complete referral forms for our practice nurse or district nurses. It is all done electronically, as are messages for doctors that used to be printed.

All hospital referrals are electronic and faxes are sent via NHS Net. Hand held computers are used for house calls to save lots of summaries being printed. Notes for meetings are circulated and stored electronically.

Provided generated paper has no confidential data, it is saved for scrap when no longer needed. Scrap paper replaces sticky pads. Being green saves money as well as the planet.

Top Tips

- Notional rent increases should be challenged to make sure a fair current market rent is being paid
- Going green can save on expense
- Effective time management is essential for the busy GP. Know what you do and how you do it
- Tidying disease registers is ongoing but essential for patient management and maximising QOF

Time saving techniques

Our new partner is hard working and enthusiastic but always stays late catching up on her admin. We chatted today about time management and I realised no one had ever spoken to her about it.

She needs to delegate. She takes on every task herself and never thinks to ask the staff for help. That day alone she had spent an hour trying to contact patients who needed repeat blood tests and prescriptions suggested in hospital letters.

She had also spent half an hour phoning the hospital, trying to get test results for patients who had been at hospital clinics. All this could be delegated.

I also suggested doing non urgent dictation from an afternoon clinic the next morning whilst logging in to the computer system, reading mail only once and actioning rather than procrastinating and dealing with it later. I said if someone needs to speak to you go to their room. It is easier to leave their room than get a long-winded colleague out of yours.

Tidying disease register pays off

I've just spent a profitable two hours tidying up our CKD register. Estimates say most practices have only identified half the patients who should be on it. It is also likely that patients have had their kidney function measured but not disease coded.

Our system can search for any patient who has had an eGFR less than 60 and not coded for CKD. I went through the list today only adding patients meeting the criteria of 2 eGFRs less than 60 three months apart. I picked up 47 patients to add to our list of 158.

An accurate register means patients can get treated appropriately and we do not miss QOF payments. And accuracy early on means no great catch up of work at the year's end.

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