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How to cope with swine flu

Kathie Applebee presents the really useful GP management guide

Wintertime is bad enough in general practice without the threat of a swine flu pandemic - and the urging to plan for it may seem pointless when many practices feel stretched under normal circumstances.

However, we cannot prevent seasonal outbreaks and their sinister pandemic relations from troubling us, so a degree of planning is prudent. A good starting point is to accept that you will have limited resources and that these must be used wisely.

Vaccinations

Now that pay agreements have been reached for vaccinations, practices will need to plan for the storage of additional vaccines and where to hold clinics. Because of the volume, production-line systems will be needed. This means reception staff marshalling patients into queues and helping with clothing removal and other administrative staff updating patients' medical records while nurses and HCAs administer vaccines.

For clinics held off site where practices lack remote computer facilities, paper lists are needed for checking patients in. These ideally would be bulk entered on return to the practice, either by creating a patient group and thence updating their records or by using macros (such as Keyboard Express) to automate data entry for individual patients.

Infection control precautions

Because flu viruses can survive for more than 24 hours on hard non-porous surfaces and for up to two hours on soft materials, additional cleaning services will be needed. Non-essential soft furnishings, toys and paper literature should be removed from surgeries during a pandemic.

Kitchen and bathroom hygiene must be scrupulously maintained, especially with regard to crockery and cutlery - a dish washer and extra supplies of mugs and spoons are helpful. Stock up on supplies well in advance, and nominate duty staff to check on paper towels, soap and alcohol hand rub at set intervals.

Receptionists may feel uncomfortable wearing gloves at the desk but one benefit is that these may remind them not to touch their faces with their hands. Provide a supply of pens on strings for all team members and ban the sharing of these. Any pens used by patients should be thrown away or disinfected.

Prioritisation of work

All team members will need to help as necessary with additional workload or covering absences, even if this



means working in different roles or at alternative locations. This requires everyone to learn to make, change or cancel appointments and home visits.

Practices should announce changes in regulations/rules once a pandemic is declared or is deemed to be adversely affecting the practice, for example:

- Sick self-certification will be extended from seven to 14 days.
- All repeat prescriptions due for review will be reissued automatically, without GP involvement, until such time as the practice declares itself to be back on a normal footing (which might not be the same date as the pandemic is officially declared to be over).
- Non-urgent services, such as for the QOF and routine enhanced services (eg minor surgery, coil fitting), will be suspended.
- In the event of delays to the payroll, staff will be paid the same amount as for the previous month and adjustments made when normal service resumes.

Communication

The practice needs to be able to communicate with patients and amongst the team. Twitter and the practice website, as well as local media, can be used to advise patients of different arrangements, such as pandemic flu immunisation clinics.

Within the practice team, all those unable to work should text several key individuals as soon as they realise that they will not be able to work. All team members should provide updates of their home and mobile numbers, and details of family/friend/neighbour contacts.

Planning for the worst

Photographic ID of doctors and staff may be required (for example, to access fuel supplies). Each practice should

develop an electronic library of staff photographs (with identities and job roles) as part of a staff contact database so that no time is wasted should these be needed by the PCT producing photo IDs in a pandemic.

Emergency boxes should be located in reception in each practice. The contents should include:

- Torch and spare batteries.
- Standard phone for use without electricity to the phone system.
- Spare blanket.
- Up-to-date copy of the practice pandemic plan.
- Signs advising of the failure of electricity, water, etc.
- Photocopied patient encounter forms (in case computers are down).
- Ream of A4 paper and pens.
- Details of the location of prescription pads.

Because personnel may need to swap between practices, or external staff brought in, a number of additional generic computer log-ins will be needed, along with a simple guide to logging on and using the practice computers. Use of such generic log-ins must be noted for subsequent identification, e.g. Martin Green / Locum1 / 24.12.2009.

Finally, remember that much of the stress of over-work comes from internal expectations. Support team members by assuring them that exceptional times need exceptional responses and they will need to cut corners. And don't forget to include planning for the post-pandemic party.

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

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Should you stay or should you go?

Dr Andrew Dearden warns be ready for your imminent NHS pension choice

GPs and their staff are about to start the NHS pension review choice exercise. This is a one-off opportunity for active members of the NHS Pensions Scheme's 1995 section, also called the old or current scheme, to move into the 2008 section, known as the new NHS pension scheme.

This process starts in January 2010 and is expected to run for three years in England and Wales, for three months in Scotland and from 1 October 2009 - 31 January 2010 in Northern Ireland.

Each member will receive a choice pack to explain their options. It will contain personal details of their pension benefits and details of what could happen to them if they

stay in the old section or transfer to the new one. You won't need to request this pack as it is being sent to all in the pension scheme. But due to the large number of people involved, 1.3 million alone in the England and Wales scheme, this will take three years.

There will be several tranches, starting with the over 50s, those nearing retirement and other specific groups like those applying for ill health retirement. Different SHA areas are covered at a time in England and each devolved nation will be treated as a single entity.

The NHS Pensions Agency (NHSPA) will send the pack to all GPs and their staff in the first tranche of each SHA/devolved country area. This keeps numbers manageable.

Don't worry about when you get your pack. If you opt to move into the scheme's 2008 section your benefits will be backdated to April 2008, so those who chose last feel no loss. The key dates in England and Wales are:

EVENT	TARGET DATE
New pension arrangements effective	1 April 2008
Effective date for choice	1 October 2009
Choice for retirees	1 July 2009
Choice for early adopters	1 July 2009
National rollout begins	22 January 2010
Exercise complete	31 March 2012

Choice statements will be issued by the NHSPA to GP employers who must distribute them to their staff. I strongly advise you not to give pensions or financial advice to your staff regarding choice; leave that to an Independent Financial Advisor. If you give out the wrong advice you could be held personally responsible for any resulting financial loss.

In Scotland these packs will go to members' home addresses. They then have four months from issuing of statements to register their choice. Anyone with doubts about their statement or any of the numbers/figures in it must immediately register their query. The 'clock' then stops for them until their query is settled.

To move all your pension benefits, as it is an all or nothing transfer, you must fill in the form, and return it saying 'yes'. If you say 'no' or fail to respond you will stay in the 1995 section, the one with the retirement age of 60 for example.

It is an important choice. Don't rush it and think hard. And take good independent financial advice. It is a

one time, irreversible choice. If you transfer you take all previous pension benefits with you, and if your circumstances change in future you cannot return. But if you decide to stay in the 1995 section you would not be able to transfer into the 2008 section at any time in the future either.

So when you get your pack, read and consider it, get good financial advice and make an informed choice. It will affect your retirement no matter how close or far away that is.

Dr Dearden chairs the BMA superannuation committee

Summary

- All scheme members get a choice to transfer all service (including added years) to the new NHS pension scheme.
- The over 50s, and specific groups including GPs and their staff, get their packs first in an orderly manner by area.
- In considering whether to transfer, be aware of differences in the normal pension age and accrual rates.
- Retirement before age 65 will normally result in actuarial reduction to benefits.
- All members will receive a comparative benefit statement – benefits as at 1 April 2008 are transferred.
- If in doubt about choice seek independent financial advice. BMA members can get help with technical aspects at pensions@bma.org.uk.

Opinion

So are salaried GPs good for the profession?

David Clough, Chairman, AISMA

The GP's status has changed since the new contract in 2004. There were previously incentives to appoint a new partner but that has changed radically and practices are increasingly employing salaried GPs rather than an equity partner.

There are several reasons for this change. For some it was a financial decision as a salaried doctor was cheaper. For others it was due to general practice's uncertainty. But for whatever the reason, salaried doctors and locums now account for approximately 40% of the doctor workforce in surgeries.

Is this trend good for the profession? There has to be a limit to the employed work force. Equity partners are required to manage the practice, take responsibility and fund it. Without the entrepreneurial doctor, medical

practices face the possibility of being taken over by private companies or PCTs – which will affect their status as an independent contractor, undermine the current self-employed status, and transfer control away from the doctor.

Maybe this is what the Government wants so primary care becomes a salaried service. But do doctors want this? I am sure some do but a salaried doctor will not easily have the opportunity to earn more, will have a restricted pension, will lose tax benefits arising from expense claims and will not have the flexibility in working hours that many GPs now enjoy.

By all means have salaried doctors. But in my opinion the profession should not give up its current benefits.

Beware the traps of salaried GP superannuation

A superannuation minefield is hitting employers of salaried GPs, warns **Andrew Goddard***

The superannuation of salaried GPs in England and Wales has become a minefield since tiered contribution rates were introduced.

For superannuation purposes, it is first necessary to establish if the salaried GP is a NHS Pension Scheme member. If so, the procedure is as follows:

1 When the practice pays the salaried GP, the employee's superannuation (plus any added years or additional voluntary contribution) should be deducted. The rate of employee's contribution should be determined by reference to the actual earnings for the current year. This is different to the system used for other practice employees, where their contribution rate is determined by reference to the prior year's earnings and to the whole-time equivalent annual earnings.

2 The salaried GP's superannuation should not be included in the cheque that the practice sends to the NHS Pensions Agency each month in respect of staff superannuation.

3 The PCO should be informed when the salaried GP is employed. It will require an estimate of the GP's annual salary and will deduct superannuation at the appropriate rate (employee's, employer's and, if necessary, added years or additional voluntary contribution) from the practice each month. Should the salaried GP's remuneration vary during the year, the PCO will continue deducting contributions based on the original estimate unless a revised estimate is submitted.

4 Following the end of the tax year, the practice should inform the PCO of the actual pensionable pay of the salaried GP in that year. The PCO should then calculate the contributions due in respect of that year, compare with the contributions already taken and either deduct or refund the difference.

5 During a period of maternity or sickness, the employee contribution tier is determined by the normal level of remuneration but the contribution is calculated by applying that rate to the actual remuneration paid. Added years contributions, by contrast, are calculated by applying the added year's rate to the normal level of remuneration.

We have encountered the following types of error in the operation of these procedures for 2008-09:

A Treating the salaried GP as a normal employee and including the superannuation in the cheque sent monthly to the NHSPA. This results in the practice paying over the superannuation twice.

B Failing to deduct employee's contributions from the salaried GP. This results in the practice over-paying the GP. This is difficult to regularise in arrears, as it would involve asking the GP to make a repayment to the practice.

C Deducting employee's contributions using the wrong contribution rate. This may be due to referring to the prior year's earnings in error or to a simple failure to understand the contribution tiers.

D Using a manual calculation of the employee's contribution in the first month and then setting the payroll software to automatically deduct the same amount each month. This will result in errors if the gross earnings change but the employee's contribution is not amended.

E Basing the employee's contribution tier during a period of maternity or sickness on the actual remuneration paid.

F Calculating the employee's contribution during a period of maternity or sickness by applying the normal rate to the normal level of remuneration.

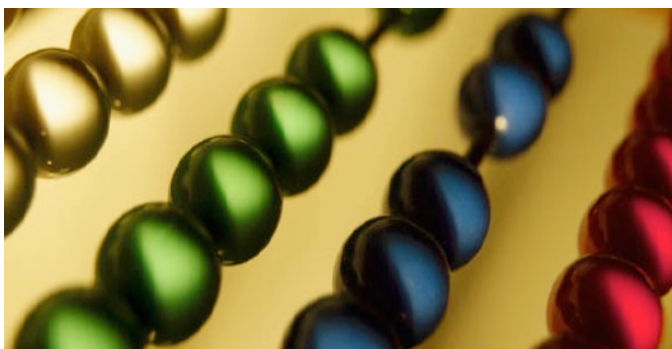
G Failing to provide the PCO with details of the actual pensionable pay in a timely fashion after the end of the tax year (or after the employee has left the practice). This results in delays in achieving the necessary adjustment and can even result in the adjustment being overlooked.

H Providing the PCO with incorrect details of the actual pensionable pay after the end of the tax year. This will lead to an incorrect adjustment – the PCO is unlikely to realise that the information provided is not correct.

Due to a combination of the above factors, we are seeing an increase in the number of clients for whom our work has had to include sorting out the problems with the salaried GPs' superannuation - one more reason why practices need the services of specialist accountants.

Financial Diary

Topical jottings of a money-minded GP



100% grants are still out there

Rising utility bills meant we shopped around between companies and saved a bit. We encouraged the staff to be green and switch off lights and turn down radiators rather than open windows if rooms got too hot.

But we have two old fashioned boilers which are expensive to run on gas. They are sited at a fire exit and we made a case for an improvement grant to get a new boiler re-sited on safety grounds. We were pleasantly surprised to get 100% of the costs due to the safety issue.

This should save us £200-300 a year in gas bills. We were advised that any building work to help it comply with the Disability Discrimination Act would also get 100% grants. We are looking at installing automatic doors at the entrance.

Insurance review reaps savings

Another area of property costs we have reviewed is buildings and contents insurance. For years we have used a local broker as it was easy. But my executive partner decided to use an internet comparison website and found we could save £150 a year on buildings insurance.

We also reviewed our contents insurance and discovered we still paid for cover for computers when in fact we do not own the computers any more. We checked with the health authority and it does not insure computers at all as it feels the replacement costs are so little.

Also our insurance included protection for lost data which we no longer need as we are on a central server and all data is backed up by the health authority. The upshot was a saving of £165 on our contents insurance annually.

GPs get bonus from rental income

Buildings can be used to earn money although one must be careful not to breach notional rent or cost rent arrangements which usually allow up to 10% private work. A colleague rents two rooms to a dental practice

Top Tips

- Check out 100% improvement grants for property work needed for safety or disability access.
- Review buildings and contents insurance to get the best current deals.
- Spare building capacity such as car parks can generate income.
- Don't always say yes to extra work if the remuneration does not reflect the work involved.

and gets back more than his notional rent so does not claim for these rooms.

I know of two practices making money from their car park. One is near a football ground and on match days charges out spaces. After paying a parking attendant they clear £200 for each match. Another practice is city centre-based and lets out its car park to a farmers' market once a month. They clear about £300 every month for this.

Another local practice has two fantastic conference rooms equipped with PowerPoint projectors, flat screen TVs and a music system. It rents these rooms in the evening to local clubs. It keeps charges low but earns £500-£700 a year in rent.

Contraceptive fees tempt us back

A few years ago our practice decided not to offer a fitting service for IUDs or contraceptive implants as long acting contraceptives because the fee offered was so small for the time and effort.

However the PCO now offers a new contract with a £135 fee for IUCD insertion, £82.58 for implant insertion and £82.50 for removal. The service can now be offered by appropriately trained nurses and does not need to be done by a GP. It is an ideal role for our nurse practitioners. This good earner also means we will offer a service to patients that we did not do before. A win win situation.

OOH – no it's too taxing

I used to do out of hours work to help pay for school fees and skiing trips. I stopped two years ago and enjoy my time off. Now our out of hours service wants me to work for it again so it can gear up for anticipated extra work with the H1N1 flu crisis.

The rates were reasonably attractive but after consideration I turned them down. I don't want to give up my spare time and I reckon most of my earnings would be swallowed up in tax thanks to the Chancellor's Budget changes. I will only consider outside work that pays a reasonable rate once the tax is deducted.

A new way to access money

GPs can now get a boost from the Enterprise Finance Guarantee Scheme.

Ian Crompton shows how

Finance is perhaps easier to obtain in the healthcare sector than some others because the banks view it, with good reason, as lower risk. Income and debt serviceability tend to be good but there are occasions when lack of security makes a proposition unacceptable as the overall risk is considered just too great.

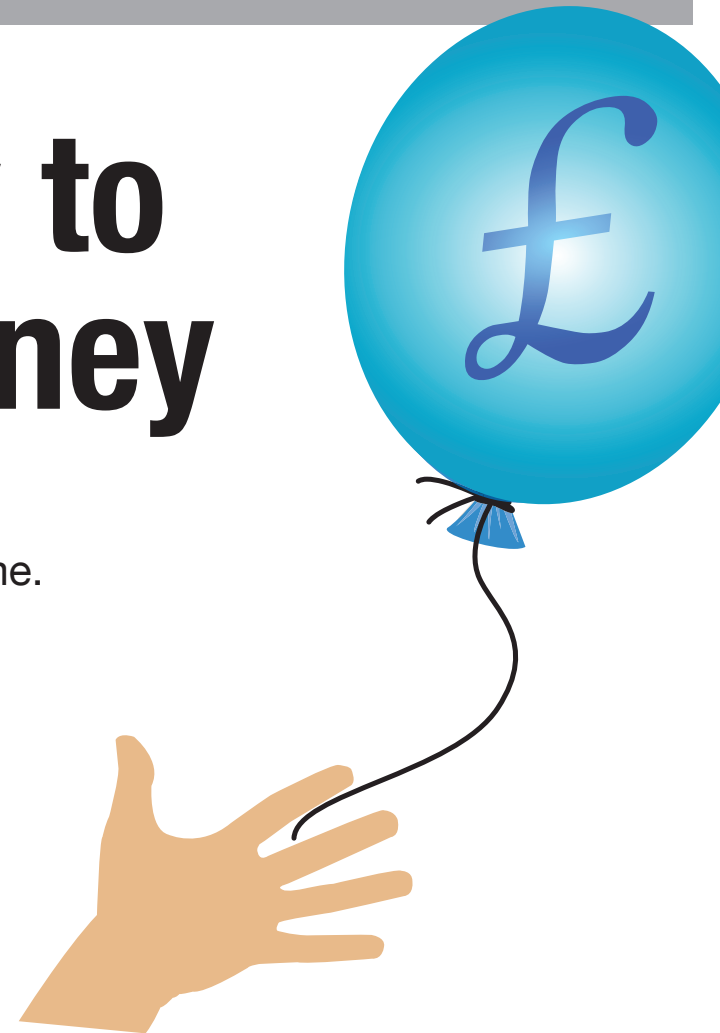
In the past and for other sectors, the Small Firms Loan Guarantee Scheme (SFLG) would have been considered if a case looked good but the lack of security meant a bank would not lend. The scheme however, specifically excluded 'medical services' and as such was not used by healthcare professionals.

But the Government's recent launch of the Enterprise Finance Guarantee Scheme (EFG) aims to help support business and is effectively an enhanced SFLG scheme. It offers much greater levels of support and was recently changed to allow health sector businesses to use it.

The scheme is available if a business' turnover is £25m or less and allows businesses of all ages to raise finance, through participating banks, with 75% of the loan's value guaranteed by the Department for Business, Enterprise and Regulatory Reform (BERR).

The main features are:

- Flexible lump sums are available: from £1,000 to £1,000,000.
- Repayments can be spread over one to 10 years.
- Variable or fixed rate interest terms are available depending on your circumstances.
- An early repayment charge is payable if you choose to repay part or all of a fixed rate loan early.
- A capital repayment holiday up to a maximum of two



years may be available.

- Flexible draw down arrangements (where total loan is over £25,000).

As well as the interest, a user will pay an arrangement fee, plus a Government premium of 2% a year (1.5% for 2009) on the outstanding balance.

The EFG is not a means of avoiding the need to provide security - and banks must ensure that any proposal fulfills their normal credit assessment criteria. If a bank would normally take a personal guarantee to tie a borrower into the commitment, this will still be the case with an EFG loan. A bank will not use the scheme if it is happy to lend without the EFG but equally the scheme does not make a bad proposition into a good one.

We have used the scheme where insufficient security was available to healthcare professionals. It has made it possible to lend where once it would not have been.

Ian Crompton is head of healthcare banking services at Lloyds TSB Bank, Bristol

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