

Healthcare Matters

For General Practitioners



Consortia – the future

Following publication of the 2011/2012 NHS Operating Framework and the Government's response to the White Paper consultation, we now know a bit more about how GP consortia will work.

Size and structure

GP consortia will be free to merge, expand or change location. Not all practices in a consortium have to be physically located in the same area. Two towns could be covered by one consortium.

There will be no minimum or maximum size, but the NHS Commissioning Board must be satisfied a consortium's population is appropriate. There will be no legislative requirement for lay members of consortia boards, but neither does the Accountable Officer (the equivalent to a Primary Care Trust Chief Executive) have to be a clinician. Many small consortia are expected to federate into larger networks to increase their buying power and share back-office functions.

Joining a consortium

Legislation will ensure GP practices cannot operate if they do not join a consortium. Practices that have not done so by 2012 will be placed into one by the NHS Commissioning Board.

Each GP practice will nominate a clinician to represent it on the consortium board. Lawyers are currently working on model contracts to bind practices into consortia but the BMA has warned against moving into legal arrangements until legislation is finalised.



Transition

From now on, PCTs must involve emerging GP consortia in NHS contracting, with a view to transferring functions fully by April 2013. PCTs are presently merging into clusters to cut costs and consolidate falling staff numbers and functions.

So far, 141 consortia have been granted pathfinder status – these sites are effectively piloting GP commissioning and will report to the DH on their success. Come 2013, between 250-300 consortia will have been established across England and Wales.

The DH admits a 'small minority' of consortia will not be ready by 2013. The NHS Commissioning Board will commission services in areas where GPs are not ready when PCTs are abolished.

Funding and PCT debt

GP consortia will be responsible for those debts that PCTs accrue in their final two years – 2011/12 and 2012/13, even though Health Minister Simon Burns at a recent Kingston Smith seminar unequivocally denied this would be the case. Consortia and PCTs are expected to work closely in this period to reduce the risk of deficit as PCTs are abolished, but will not be directly responsible for deficits accrued in 2010/11 or earlier.

Beyond 2013, consortia will be paid a 'quality premium' for quality outcomes and financial stability, likely to be top-sliced from existing GP income. From April this year, consortia will receive £2 per head to fund GP involvement, on top of existing practice-based commissioning funds. By 2014/15, consortia will receive £25 to £35 per patient to cover running costs. The DH has not confirmed how much they will receive in 2013/14, the first

year in which they are fully operational. The GPC says consortia may be short of cash once infrastructure costs are deducted.

Work on a formula to allocate consortia budgets based on member practices' lists may take until 2013 to complete.

Accountability

Authorised GP consortia will become statutory bodies in 2013. What this means in practice we don't yet know. Our view is that a Company Limited by Guarantee (non-profit making) could be the most appropriate vehicle – ensuring limited liability protection for its members.

The NHS Commissioning Board, based in Leeds, will hold them to account on using a Commissioning Outcomes Framework, based on NICE advice. The board will intervene if 'there is evidence that consortia are failing or are likely to fail to fulfil their functions'. It will also issue guidance on financial risk management.

Consortia will have powers to performance manage member practices but the NHS Commissioning Board will hold GP contracts and decide if practices should be ejected from consortia.

The Bill indicates that the NHS Commissioning Board will be able to change a consortium's constitution, without the consortium's agreement, which could, for example, affect their election, voting and governance arrangements.



Will GP consortia be responsible for PCT debt between 2011-2013?

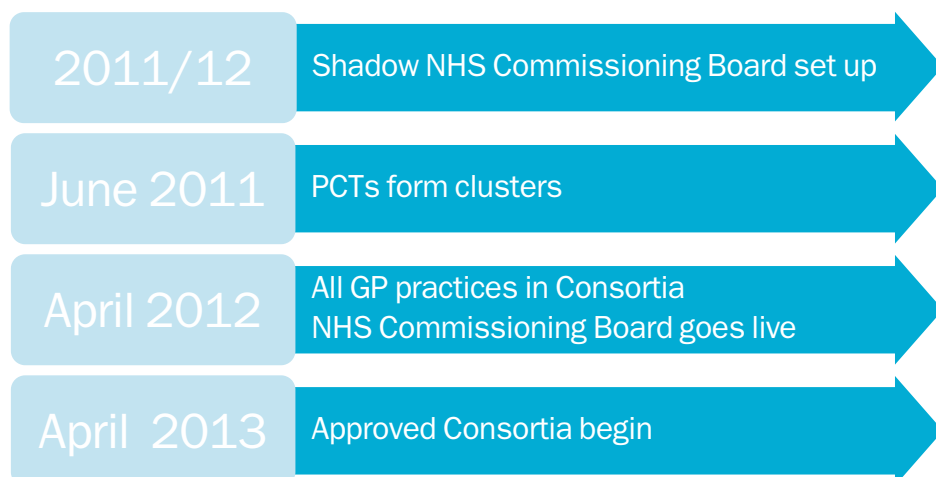
The Bill gives few details about how the NHS Commissioning Board will measure if a consortium is failing, but grants it draconian powers to dismiss and replace the consortium's Accountable Officer. It makes it clear that the replacement could not come from within the consortium, seeming to undermine the importance of local determination of the process.

The NHS Commissioning Board will be able to dissolve consortia and change consortia areas following consultation. However, the consortium and the public it serves will want to know more detail before dissolution takes place.

With so much changing in the NHS, now is the time to ensure that GPs and Practice Managers are fully prepared for the move to consortia. Our healthcare team at Kingston Smith has a wide range of experience in the healthcare sector, from advising GPs and hospitals, through to NHS Trusts and consultants, on a variety of business issues.

From April, we are running free financial clinics for Practice Managers and GPs. The clinics will address any concerns you might have, whether it be cashflow management, understanding accounts through to partnership taxation or VAT issues.

To find out more about these clinics, contact Paul Samrah, lead healthcare partner on 01737 779000, psamrah@kingston-smith.co.uk





GP pensions choices

GPs have a three month window in which to decide whether to remain in the 1995 pension scheme or transfer to the 2008 scheme.

Whilst at first sight the benefits provided by the two schemes are broadly similar, there are some important differences and making the wrong decision can have a significant impact on GPs' retirement plans.

The 1995 scheme provides a pension of 1.4% of pensionable earnings for each year, with an additional tax free lump sum, whereas the 2008 scheme provides a pension of 1.87% for each year, with the tax-free lump sum paid for by exchange of pension. The following example demonstrates the difference between the two schemes:

A GP with final revalued pensionable earnings of £100,000 and 40 years' service would receive a pension from the 1995 scheme of:

$$£100,000 \times 40 \times 1.4\% = £56,000 \text{ pa}$$

The additional tax free lump sum is three times the pension, amounting to £168,000. The same GP in the 2008 scheme would receive a pension of:

$$£100,000 \times 40 \times 1.87\% = £74,800 \text{ pa}$$

Assuming the same lump sum is taken, the pension is reduced by $£168,000 / 12 = £14,000$, leaving a pension of £60,800, some £4,800 pa more than under the 1995 scheme.

The 2008 scheme potentially provides a higher pension than the 1995 scheme but it won't start until your 65th birthday, whereas retirement is at 60 under the 1995 scheme. It is important not to overlook the benefit of receiving the NHS pension five years earlier under the 1995 scheme.

There are other factors to take into account. If you wish to take voluntary early retirement, you can do so from age 55 under both schemes, but your pension will be reduced as a result. The reduction is higher under the 2008 scheme. For example, under the 1995 scheme a GP retiring at 55 would face a 24% reduction against a 44% reduction under the 2008 scheme. Those planning to retire early should probably remain in the 1995 scheme, although the 2008 scheme does offer more flexibility and choice around partial retirement

or switching to part time. In deciding when to retire the potential impact of the Lifetime Allowance must be taken into account.

The Lifetime Allowance (LA) is the maximum amount that any individual is allowed to hold in pension arrangements without incurring a tax penalty. It is currently £1.8m and will reduce to £1.5m from 6 April 2012. Any excess pension funds above the LA will be subject to a tax charge of 55%.

To value NHS pension benefits against the LA it is necessary to multiply the value of the NHS pension by a factor of 20. For the 1995 scheme, also add on the tax-free lump sum. Any other pension assets must also be taken into account, including Additional Voluntary Contributions, added years, and personal pension funds.

Possible solutions could include: -

- Consider ceasing any contributions to AVCs or added years.
- Stop funding any personal pension arrangements.
- In extreme cases, it might be necessary to consider whether there could be any benefit gained from leaving the NHS pension scheme and becoming a deferred member or even taking the pension early.

Other news

Specialist advice

Pensions have become ever-more complicated in recent years and specialist advice is essential to avoid being caught by the various tax traps built into the system. This particularly applies to GPs where the impact of the Lifetime Allowance and interaction between the NHS pension scheme, added years, AVCs and personal pensions must all be taken into account.

Kingston Smith Financial Advisers have highly experienced financial planners who have obtained specialist qualifications. We work closely with accountants, solicitors and other professional advisers, to ensure that our clients receive comprehensive and integrated advice as part of an ongoing long-term relationship.

This article has been prepared with all possible care to ensure its accuracy. It is based upon our understanding of current HMRC practice. A full review of your circumstances and objectives should be undertaken before any action is taken.

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Practice Manager and GP financial clinics 2011

Kingston Smith will be running free financial clinics for Practice Managers and GPs on either a one-to-one or on a group basis at practices from April onwards. These sessions will address any areas of concern that you might have. Topics may include:

- Cashflow management
- Understanding practice accounts
- HR matters
- Partnership taxation
- Financial advice
- Bookkeeping and management accounts
- Tax and legal consultancy
- VAT advice

To find out more about these clinics please contact lead healthcare partner, Paul Samrah on 01737 779000 psamrah@kingstonsmith.co.uk

Contact us

More information about Kingston Smith LLP and our services can be found at www.kingstonsmith.co.uk

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