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AISMA Doctor Newsline

At the heart of medical finance...

'McCloud' on the horizon

10 key things you need to know

Important changes being implemented in April 2022 will affect the NHS Pension Scheme, following a court ruling about age discrimination across wider public sector pensions. **Laura Bowler** takes a detailed look at the 'McCloud Remedy'

1 What is the current structure of the NHS Pension Scheme?

It is made up of three separate sections: 1995, 2008 and 2015. The section/s an individual belongs to will be based on the date they joined the scheme.

The 2015 section was introduced on 1 April 2015 and for certain people it was mandatory to move into it at that time.

It was the period of time until normal pension age, as at 1 April 2012, that determined whether someone moved into the 2015 section.

If someone joined the pension scheme for the first time after 1 April 2012, they are unlikely to be affected by the issues discussed here.

2 How was the 2015 section introduced?

If a member had more than 13.5 years to their normal pension age as at 1 April 2012, they would have automatically been moved into the 2015 section on 1 April 2015 for all new pension benefits built up after this date.

If they had under 10 years to their normal pension age they would have remained in their original - also known as legacy - section.

If the member had less than 13.5 years but over 10 years to their normal pension age, they will have been moved into the 2015 section but possibly at a date after 1 April 2015. The precise date would have been based on individual age.

3 Was it just the NHS Pension Scheme?

No. The changes applied in 2015 were replicated across most public sector pension schemes as part of wider reform. The objective was to establish a more equitable basis for public sector pension provision.

4 What was the court case?

As set out in point 2, the way the 2015 section was introduced was influenced by the individual's age. Two separate legal challenges were raised - by a member of the Judicial Pension Scheme (Judge McCloud) and a member of the Firefighters' Pension Scheme (Mr Sargeant).

Both these cases raised the same point - that the way the reforms were being implemented was unlawful due to age discrimination.

The courts agreed with this position and a remedy had to be put in place to remove the age discrimination aspect. The government has confirmed this remedy will apply to all public sector pension schemes affected, including the NHS Pension Scheme.

5 Why is it called McCloud?

The remedy and indeed the overall ruling has been nicknamed The McCloud Case/Remedy on account of the initial ruling being in favour of the Judge McCloud legal challenge.

The Treasury is responsible for designing and implementing the remedy which will apply across all the affected public sector pension schemes.

In 2020 it ran a consultation seeking views on two possible approaches and in February 2021 it confirmed its response to the consultation process and feedback.

6 So what is the remedy?

The remedy will take effect from 1 April 2022 and some of it will look backwards and some of it will look forwards.

If an individual was a member of the pension scheme as at 31 March 2021, this remedy will affect them, even if they did not initially move into the 2015 section.

The main features are:

a Anyone who was moved into the 2015 section will effectively be treated as if they had remained in their original section up until 31 March 2022.

b From 1 April 2022 everyone, regardless of age or proximity to normal pension age, will become a 2015 section member for all new pension benefits.

c Benefits accrued in the 1995 or 2008 sections will remain where they are and the same normal pension age and link to current pay will be retained.

At retirement members will be provided with a choice about their pension benefits. They can then assess which of the two options provides them with the better outcome:

- Option one will assume the member joined the 2015 section on 1 April 2022.
- Option two will assume the member joined the 2015 section on 1 April 2015.

7 Do members need to do anything?

Not right now. The pension scheme will communicate with members as the changes come into effect. The final legislation, which provides all the specific details the pension scheme needs to put into practical effect, is not yet known.

Pension schemes will therefore have until 1 October 2023 to get all these changes into place. GPs thinking of retiring in the next 12–18 months should review their retirement planning.

It is important to understand that it is very unlikely members will be worse off because of this change. A higher pension will be provided in some cases.

8 Previous pensions tax (annual allowance) charges – how will these be affected?

There is a limit on tax free pension saving, known as the annual allowance. Members who breach this allowance in a tax year will have a pensions tax charge to pay.

For pension schemes such as the NHS, it is the growth in annual pension accrual which determines if the allowance has been exceeded.

Members who had previously moved into the 2015 section will have their pension calculated differently than if they had remained in their original scheme.

Moving back into the original scheme for the period to 31 March 2022 will therefore change the pension calculation and any pensions tax charge. There is no action to take at this stage, and more information will follow.

9 Is there anything individuals can do if they have made a decision based on the pension scheme benefits at the time they made that decision?

There is going to be a process which will enable contingent decisions to be raised and reviewed.

A contingent decision is one which was made based on the pension scheme basis at that time, but this has since changed retrospectively. We do not yet know how this process will work and more communication will be forthcoming.

10 How do individuals find out how this affects them personally?

This will not be possible at the moment.

The pension schemes are not in a position to provide specific information pertaining to individual circumstances. Legislation is still to be finalised and then NHS Pensions will be able to communicate a plan for implementation.

It is possible that specific pension figures in respect of this change will not be made available until October 2023. Individuals are advised not to contact the pension scheme as it will be unable to help them currently.

FACTS

The pension scheme normal pension ages are

- 60 for 1995 section (unless special class status applies)
- 65 for 2008 section
- State pension age for 2015 section
- On moving to the 2015 section the final salary link to the previous benefits will remain in place.
- Making a decision about which retirement option is best at retirement is known as a deferred choice.

Laura Bowler is director of pension engagement consultants Pen-gage Ltd

Time for reflection but action too

OPINION

Sue Beaton
AISMA board member

Many practices have now had sight of their 2021 accounts, or at least have an idea of how they performed in the last financial year.

At the beginning of the 2020-21 year, coinciding with the start of the first lockdown and amid great nervousness and uncertainty, the financial results for the forthcoming year were regarded as unpredictable. Many were anxious about how results would fare.

GP practices are well used to rising to challenges, but this past year has been a challenge like no other!

Some non-NHS income sources, such as room rentals, insurance reports, medicals and travel clinics, inevitably decreased or in some cases ceased altogether.

From a review of the results so far, it is evident that many practices have worked incredibly hard to continue to meet demand.

In England practices have received income protection, for at least some of the 2020-21 year, Covid-19 support in the shape of resilience funding, expansion and capacity funding, funds advanced for the vaccine delivery programmes, as well as PCN investment, impact funding and care home premiums.

Scotland, Wales and Northern Ireland have provided similar support to practices to help them with the demands and pressures of the last year.

Practices also appear to have worked 'smarter' overall, with careful control of locum use, utilities and administration costs.

The next challenge for some practices might be a potentially sizeable future cashflow tax drain if they do not currently have a 31 March/5 April year end, given the government tax proposals which are currently being considered (see ***Ask AISMA!*** on page 8).

Why? Because HMRC is proposing changes to bring forward the timing of tax payments for such businesses, moving taxation of their profits from 'current year basis' to 'tax year basis'.

This is part of the government's wider income tax reforms. Until a few weeks ago this tax acceleration was to take effect from 2022-23, also coinciding with the then timetable for mandatory commencement of Making Tax Digital (MTD) and quarterly reporting for all.

During the recent tax reform consultation period regarding these proposals, AISMA sent a detailed submission highlighting several areas of concern which required further research and consideration by the government.

Following this and other responses it was announced these deadlines have now been put back a year.

But a delay does not mean it won't happen. So now might be the right time to consider the implications of changing your accounting year end to align with the tax and NHS year if you have anything other than a 31 March/5 April year end.

What does it mean? Currently businesses (individuals and partnerships) with a non-March year end are taxed on the profits for the 12 months ending with the accounting date which falls in the tax year.

For example, the year ended 30 June 2020 falls in 2020-21 so profits from that year will be taxed in the 2020-21 tax year. But under the proposals, assuming the general emphasis will continue to be to align tax and accounting year ends, a business will be taxed on profits arising in the tax year (irrespective of the accounting end date.)

This means there will be some catching up and acceleration of tax payments.

Taking a 30 June 2023 year end, profits from this period will be taxed in 2023-24 as well as profits for the period 1 July 2023 to 5 April 2024. This is to bring all profits to 5 April 2024 into the calculations, although historic overlap profits may be available for deduction in 2023-24, the year of change.

Although there are likely to be some transitional provisions it may now be a sensible time to consider the impact of changing your practice year end to 31 March/5 April, if this is not already the case, and to allow time to plan and save for the catch-up in tax, rather than having change forced upon you with little or no time to budget in a few years' time.

There is more time to plan than had previously been announced, following the Government's delay in implementation, but the additional time available creates an opportunity to assess and budget for such changes.

Tax liabilities, as well as superannuation which follows tax basis periods, continue to be an important area to plan for.

This is not only in connection with recent profit levels, but also going forward amid the government's planned income tax basis period reforms.

Planning ahead and seeking advice will, as always, help you to better manage the cashflows.

Digest a risk management lesson from a slice of Swiss cheese

Do holes in your system mean it is designed to get the results it gets? Fiona Dalziel recommends a timely review to aid patient safety

Every GP practice in the country has tackled a vast array of challenges and change since March last year with the usual amount of energy, commitment and urgency.

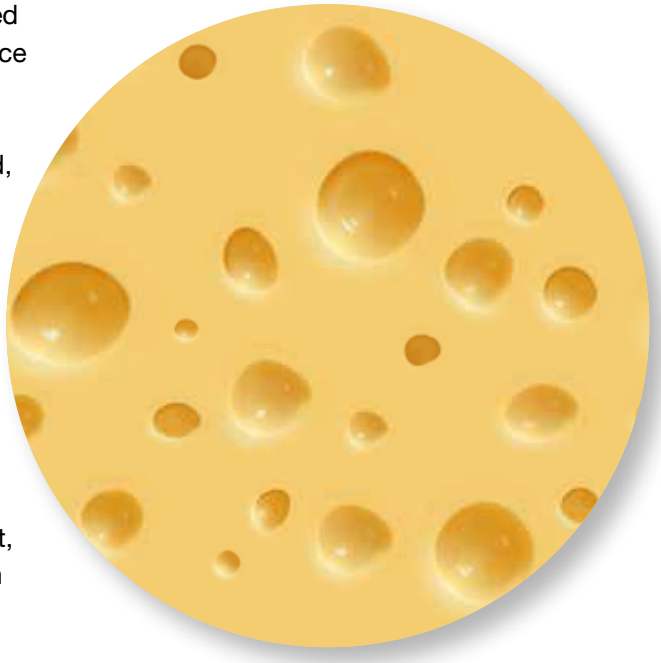
Despite allegations of practices being closed, GPs and their teams are battling to provide routine services and keep both patients and staff safe, as well as delivering millions of Covid vaccines.

Oh, and flu immunisations and now boosters, all with a workforce which has shrunk since 2015.[1]

Routine care delivery has its own risks and these change when service delivery methods change. This involves clinical risk management, something GPs understand well and work with every day.

But we also all need to understand risk management in terms of systems development and delivery.

Those with a management role in the practice can provide strong support to the clinical team by developing a good working knowledge of organisational risk management and now is a good time to give this some thought.



'Every system is designed to get the results it gets'

Although attribution of this quotation is disputed (W. Edwards Deming? Donald Berwick? Stephen Covey?), its basic truth is not, and the thought is sobering.

'Active failures'

Although people do make mistakes within systems by committing unsafe acts, nobody comes to work thinking 'I'm going to do a bad job today'.

Unsafe acts often occur because people are tired, under pressure or overloaded and take short cuts in a cumbersome system. These acts may or may not result in harm; in the case of general practice, to a patient.

Around two decades ago, organisational accidents were often blamed on an erring frontline individual. However, blame culture has become less common as risk management theory has shown us that harm may occur because of 'latent conditions.'

'Latent conditions'

Active failures or unsafe acts are now regarded as a consequence of the original system design. The original system may have been designed in a hurry in a crisis. It may have omissions or gaps which are not noticed right away.

One day, a latent condition, designed into the system, comes into contact with an active failure. The defences of the system are breached and harm is the outcome. Sometimes, we are just lucky and the defences are not breached (that we know of).

The Swiss Cheese Model

Writing in the *BMJ* in March 2000[2], and in his book '*Managing the Risks of Organizational Accidents*'[3], professor of psychology James Reason uses the image of a slice of Swiss cheese to illustrate how harm or 'losses' occur in a system.

The lines of defence built into a system are represented by the slices of cheese, but holes are built into the system. These are latent conditions. When all the holes in the system's

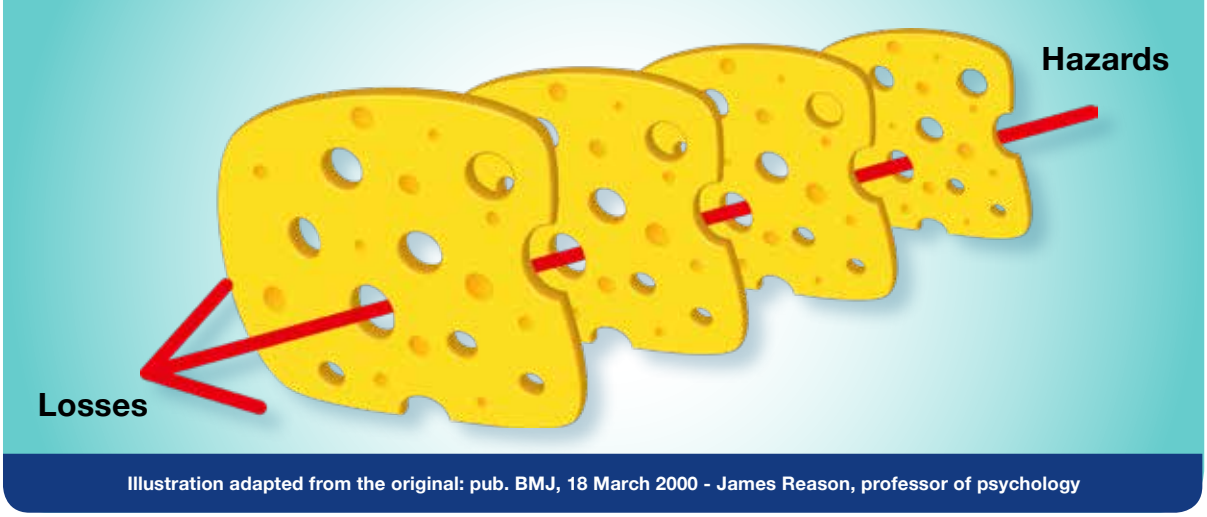


Illustration adapted from the original: pub. BMJ, 18 March 2000 - James Reason, professor of psychology

defences line up, hazards are able to breach the system's defences and harm occurs.

Results systems tend to be a high-risk area in practice and we are all familiar with the types of things that can go wrong (see box below).

We all know of the things that can go wrong

- The practice knows a sample was sent, but not that a result came back
- Patients are asked to come for a test, do not come, and nobody is aware
- Action to be taken is not clearly recorded
- Action recorded to be taken is not taken
- The result is filed in the wrong patient's records
- Confidentiality is breached when the result is given out

These are only examples for illustration; your own practice's systems may not allow any of these to happen.

Of course you can in fact try to make all systems, especially high-risk ones, as detailed as possible to identify every possible hazard and defend against it happening. We can try to design out as many as possible 'latent conditions' and minimise the holes in the cheese.

But running a system like this can take up an enormous amount of costly time. And the system may become very cumbersome to use. People take shortcuts and active failures are generated. A balance must be found between risk of harm and a workable system.

Looking for hazards and building defences

After such a challenging 19 months and now moving into what might be a precarious winter for health services throughout the UK, it might be worth reviewing any systems that have undergone radical change during the pandemic and which your practice feels might be high on the scale of systems that may cause patient harm.

For each stage in a high-risk system, consider:

- What could go wrong at this stage in the system? Do not assume everyone will notice if something is a potential hazard
- How likely is this to happen?
- If it did happen, whom could it affect?
- How potentially serious would that be?
- What should we do to stop that occurring?

When reviewing a system, make sure you involve as many team members as possible in discussing the risk analysis as above.

Bear in mind that defences need to be proportionate to the risk to patients and that the incorporation of defences into a system will have a cost in time and effort. The cost of the defences needs to be balanced against the cost of something going wrong.

Remember to re-train everyone if you amend the system and raise everyone's awareness of their contribution to patient safety. You won't stop accidents from happening. But at least you will know your system is designed to get the results it gets!

Reference material

[1] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice

[2] BMJ 2000; 320 doi: https://www.bmj.com/content/320/7237/768

[3] Reason, James 1997 *Managing the risks of organizational accidents* Ashgate Publishing Limited, Aldershot, Hants

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ASK AISMA!

Getting a new partner does not always go to plan. Some topical questions from GPs are answered here by Abi Newbury*

You can ask a question by contacting your local AISMA accountant or messaging us through Twitter @AISMANewsline

MORE WORK, BUT LITTLE EXTRA TO DRAW

Q **We have worked additional sessions and the earnings from these will increase our income compared to the previous year, but there doesn't seem to be much money available to draw. Why not?**

A This is a question we have heard from many GPs this year. The last year has brought a huge amount of extra work for most practices, from which additional income has flowed – but the amounts immediately ending up in the doctors' hands are disappointingly low.

Tax

Often the income will be taxed at 40% - but this extra money may fall into the band between £100k and £125k where there is an effective 60% tax rate as personal allowances are withdrawn.

National insurance

It is likely that there will be a 2% charge on the additional income.

Annual allowance charge

Sometimes this extra income will push a doctor's 'pension inputs' over the permitted limits so that there is a tax charge on the excess.

Pension contributions

Most of the additional income will be pensionable, so the doctors will be bearing both the employer contribution at 14.38% and the employee contribution at up to 14.5%.

"The advantage of this new system would be that it gets rid of the 'tax time-bomb' currently hitting partners on leaving a partnership with a non-March year end"

But the tax relief on this extra contribution will not be available until the contributions are actually paid. That is likely to be after the year end if profits were not known about early enough to make an additional payment on account.

So, in a worst-case scenario, you could be looking at net cash in hand of around £12 - £15 for every £100 earned. And that's before any annual allowance charge that arises, or student loan deductions if applicable.

But bear in mind there will be extra tax relief in the next tax year, when the contributions are paid over, and the extra pensionable pay will mean additional pension income at retirement. So it is not quite as bad as it looks at first sight.

CHANGING THE PRACTICE YEAR END

Q **I've read about simplifying tax by having to have a 31 March year end – what does that mean?**

A HMRC is moving towards Making Tax Digital (MTD) for all businesses. This means that partnerships and sole traders will need to make quarterly returns online and do a 'tidy up' at the end of the year rather than just relying on the annual tax return as they do now.

Where profits are calculated to a year end date other than 31 March or 5 April this currently means that the tax is not directly in line with the tax year and it was felt this would cause confusion with MTD.

The proposal suggests that all tax will be based on the year to 31 March (or 5 April) in the future.

For businesses who currently have non-March year ends, this will mean that over 12 months of profit could be taxed in one go, less an appropriate amount of overlap relief, to get the figures to a March year end. This in turn is likely to cause an acceleration of the payment of tax for many GP partners.

Following an announcement last month (September) the Treasury confirmed the change will not come into effect before April 2024, with a transition year no earlier than 2023.

This wording indicates that there is some doubt as to what is actually going to happen – the government will respond to the consultation on reforming basis periods 'in due course'.

Where the tax liability is materially increased under this change, the proposal is that you will be able to spread those additional profits over a period up to five years. Whether that is beneficial will depend on what you think tax rates might do over that time. It could increase the liability.

The advantage of this new system would be that it gets rid of the 'tax time-bomb' currently hitting partners on leaving a partnership with a non-March year end. It is just detonating it earlier!

Note that these changes will not give rise to tax on more profits over the whole life of the business. It will just change the timing of tax payments.

These changes do not mean the accounts year has to change. But it will make tax returns more complicated if each year has to be time-apportioned.

In many cases it will mean provisional returns will have to be submitted and amendments done when the actual figures are available. So many practices will decide it is easier to amend their year-end to match the NHS and pensions year ends.

"There is a very tight window for requesting the review. It must be submitted by 31 December 2021"

IMPACT OF FINAL PAY CONTROLS RULES

Q **We had a large charge under the final pay controls rules a couple of years ago – will recent changes affect me?**

A Employers are charged under the final pay controls (FPC) regulations if they give an 'excessive' increase in pensionable pay at or in the three years before retirement, to any officer (ie non-GP pension scheme member) of the 1995 scheme, including 1995/2015 transition members.

The recent changes to FPC calculations allow for a greater permitted uplift of 7% + CPI, up from 4.5% + CPI, before a charge arises.

They also permit some further reliefs for very strictly defined genuine internal promotions and a relaxation for non-GP partners who do not change their profit share/sessions.

Internal promotions to be accepted must rely on fair and open competition. So the job must have been advertised outside the practice, and a full job description provided. You are unlikely to succeed in avoiding FPCs without such evidence.

For non-GP partners, increases in pensionable pay caused by a rise in practice profits where the profit-sharing ratio is static will be exempt, as will rises due to a fellow partner leaving or a fellow partner dropping sessions.

However, an increase in share for other reasons will still be caught. Be careful with prior shares of profits which can inadvertently change a non-GP partner's share.

The new rules came in force from 1 July 2021 and are being back dated to April 2018. So anyone who has suffered a charge between those dates can now ask for it to be reviewed.

There is a very tight window for requesting the review. It must be submitted by 31 December 2021. So practices previously caught by this should look at the calculations under the new rules or work with their accountant to do so and submit a claim where it might be beneficial.

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Opportunity knocks for GP provider organisations

The new Health and Care Bill published in the summer sets out how the government plans to reform health services and achieve better integration between health and care in England. Ross Clark and Alison Oliver explore some of its key elements and its implications for general practice

Background to the Health and Care Bill

This is the first major piece of legislation affecting England's health and care services since the Health and Social Care Act of 2012, which - amongst other things - reinforced competition as a means of driving up health services' quality.

It also created the NHS Commissioning Board (known as NHS England) and clinical commissioning groups (CCGs) to commission services at local level, now including primary medical services.

Since then the narrative has been focused much more on the importance of integration of health and care services. Some key developments in the intervening period have included:

- *The Five Year Forward View* (published in 2014) proposed various new models of providing health and care. These models were aimed at

"Under the Bill, CCGs will be abolished, and every area of England will be covered by an integrated care board (ICB) and an integrated care partnership (ICP), which will together make up the ICS"

achieving better integration of health and care services for patient populations.

They included Primary and Acute Care Systems (PACs) and Multispecialty Community Providers (MCPs). For general practice, MCPs offered two models: a fully integrated model (where primary care contracts would be suspended and the funding included with the MCP funding) and partially integrated (where primary care contracts remained outside of, but operated in tandem with, the MCP contract).

- *The GP Forward View* (2016) promised additional funding for practices to reduce workload, expand workforce and invest in technology and estates, as well as to redesign services to extend GP access for patients.
- *NHS Long Term Plan* (2019) formally introduced integrated care systems (ICSs) and primary care networks (PCNs). Crucially for general practice, PCNs do not form separate legal entities and so additional services are commissioned as directed enhanced services, forming part of each practice's primary care contract.
- *Investment and Evolution - Five Year Framework for GP Contract Reform* (2019) outlined how the GP contract would be reformed to enable implementation of the NHS Long Term Plan. It outlined plans for the introduction of a new PCN contract as a building block of every ICS.

Before 2019, the developments can be seen as efforts to shift the NHS towards more integrated service delivery, with single block contracts covering whole populations.

However, the use of directed enhanced services for PCNs under the NHS Long Term Plan saw a return to individual contracting with GPs, albeit with a requirement for the services to be delivered collectively by practices within a PCN.

Overview of the new Bill - system, place and neighbourhood

The new Bill reinforces this direction of travel. In summary, health and social care delivery is organised around:

- *Systems* – covering a whole ICS with a population of between 1 and 3m and with responsibility for strategy and system-wide planning;
- *Places* – covering a population of between 250,000 and 500,000. Bringing together health, social care and voluntary sectors to redesign local services in cities and towns, likely to be co-terminus with local authority boundaries; and
- *Neighbourhoods* – covering PCN areas with a typical population of between 30,000 and 50,000, with general practice working with other providers as part of multi-disciplinary teams.

Under the Bill, CCGs will be abolished, and every area of England will be covered by an integrated care board (ICB) and an integrated care partnership (ICP), which will together make up the ICS.

- *Integrated Care Boards (ICBs):* ICBs will take over NHS commissioning functions from CCGs and from some parts of NHS England. They will be responsible for commissioning primary care. The boards of ICBs will as a minimum include a chair, a CEO and representatives from NHS providers, general practice and local authorities. ICBs will have flexibility beyond this minimum

"It is clearly going to be extremely important over the coming months for GP representatives to closely monitor the detail of how the changes proposed in the Bill will be implemented"

requirement to determine their own governance arrangements, including the ability to create committees to carry out delegated functions. But NHS England will be responsible for agreeing ICB constitutions and for holding them to account. We expect model constitutions to be published in due course.

- *Integrated Care Partnerships (ICPs):* ICPs will be joint committees formed by the ICB and local authorities together with other local representatives which could include, for example, social care or housing providers.

The ICP's role is to develop a strategy to address health, social care and public health needs in its area and to support partnership working. Crucially however, the ICB is required to 'have regard' to this strategy but is not bound to adopt it.

ICSs are currently voluntary partnerships, but the Bill will put them on a statutory footing from April 2022. It is expected this will lead to ICSs being more transparent and accountable.

Other key points of the Bill are:

- The Secretary of State will have increased powers over various matters, including proposals to reconfigure services at the local level; and
- Collaboration replaces competition as an organising principle. NHS organisations and local authorities will have a duty to collaborate although guidance is still awaited on what these duties will mean.

The House of Commons Health and Social Care Committee (HSCC) has previously recommended that non-statutory providers, which would include practices, PCNs, GP provider organisations and federations, should not be eligible to hold an integrated care provider contract.

Putting ICSs on a statutory footing and the Bill's focus away from competition and towards collaboration hints at the likelihood of single integrated care provider contracts (ICPCs) being awarded at system level.

Key points for general practice for the next few months and beyond:

- General practice will have representation on each ICB, but it is as yet unknown how strong or 'diluted' that voice might be as that will depend on its overall composition.
- It is unclear what role PCNs will play in the new ICSs beyond the end of the current network contract directed enhanced service. Those services could be brought within the scope of system or place level ICPCs and have a considerable adverse effect on general practice.
- Many GP provider organisations/federations already cover the place geography and may be well qualified to take on ICPCs as well as representing their member practices within the ICS.

GP provider organisations may need to review their constitutions to ensure that they can fulfil this role.

But there is no doubt that this provides an exciting new opportunity for GP provider organisations.

It is clearly going to be extremely important over the coming months for GP representatives to closely monitor the detail of how the changes proposed in the Bill will be implemented.

They will need to know how those changes will affect primary care and ensure their views are represented at system, place and neighbourhood level.

Alison Oliver and Ross Clark are partners in the primary care team at Hempsons. They advise GP practices, provider companies and primary care networks on partnership and company law issues, NHS contracting, collaboration and governance arrangements. Hempsons is a leading health and social care law firm ranked as one of the best specialist law firms in England and Wales in 2020.