



medical line

News and Information from Hillier Hopkins LLP
Leading medical accountants and practice advisers

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Horror Story

It's not just things that go bump in the night that can be scary. Mike Gilbert shows how failure to have a specialist medical accountant nearly cost an outgoing partner £18,000 profit. Yet again we have come across a horror story. This only came to light after an aisma member took over as accountants and tax advisors to a five full-time equivalent partner medical practice which previously used a non-specialist's services.

Its 31 December 2005 year end accounts, when – significantly – one of the partners left the practice, had been prepared by the previous accountants who also completed all taxation returns and pension certificates for the fiscal year 2005-2006. The new accountants received all of the normal information from the previous accountants in November 2006 which enabled them to prepare accounts for the year ended 31 December. It surprised them to find the amount included in 'debtors', as amounts due to the practice, was extremely low. They knew that enhanced services for the quarter to December 2005 were unlikely to be paid to the practice until January 2006 at the earliest.

However, more relevant still, they knew that the achievement payment under QOF for the year to 31 March 2006 would not be received by the practice until one or two months later. Given that 31 December 2005 is three quarters through the QOF year to 31 March 2006 one would expect a sizeable debtor in the practice accounts. The new accountants decided to explore the situation in depth when preparing the accounts for the year ended 31 December 2006.

The new accountants began work on the 2006 accounts early in March 2007. These were prepared on a proper basis applying what's known as the 'accruals' concept.

This recognises income when it is earned, not when it is received, and expenditure when it is incurred, not when it is paid. Suddenly there was an apparent leap in profitability! Clearly the accounts included the QOF achievement payment for 21 months. The new accountants then calculated how much money included in the 2006 accounts should have been disclosed in the 2005 accounts. It turned out that the 'missed' debtor in the 2005 accounts amounted to £90,000 - £70,000 from the QOF achievement payment 1/4/05 - 31/12/05 and £20,000 from enhanced services for the quarter ending December 2005.

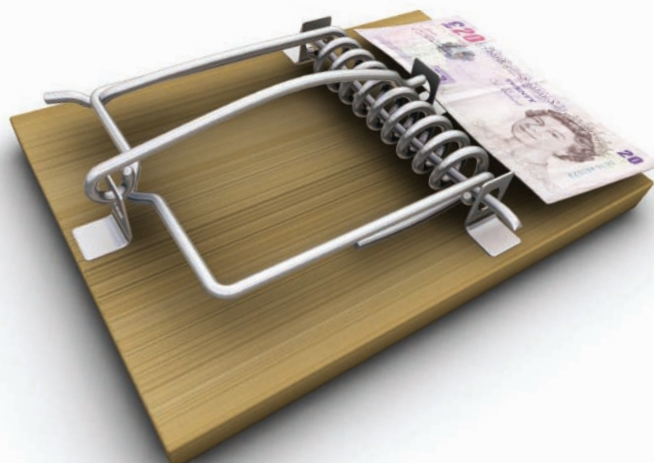
So the 2005 accounts were understated by £90,000 which now appeared in the 2006 accounts. Things might normally have been relatively easy to resolve. The correction would appear in the 2006 accounts and the 2006-2007 tax returns and pension certificates would automatically pick up the additional income. But the complication was that partnership change back in December 2005.

The outgoing partner was paid out on the basis of his partner's current account at 31

December 2005. Fortunately, he was replaced by a salaried GP so that the new accountants at least did not have to deal with any issues relating to an incoming partner. Of course he was oblivious to the fact that the 2005 earnings had been understated and that he was entitled to a share of the missing money. As the partners shared profits equally, the amount due to him was £18,000 (20 per cent of £90,000). Not surprisingly, the continuing partners were annoyed that the error had occurred in the first place. And they were further angered by realising they had to pay £18,000 to the outgoing partner.

Although they understood the basic accounting principles involved, and were keen to correct the situation once and for all, they did query the moral and legal validity of paying so much to the outgoing partner.

Unfortunately their partnership deed was of little help. It was originally drafted by a non-specialist lawyer and was woefully outdated. After much discussion, the continuing partners agreed everything should be put right and that they should



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Horror Story Cont.

now look forward rather than backwards. They paid the outgoing partner his £18,000 on the proviso that he would be responsible for any resulting tax or pension contributions. The new accountant then amended the 2005-06 tax returns and issued revised pension certificates.

Practices should always employ accountants who know what they are doing – and have relevant up-to-date partnership deeds. This horror story may not have been so horrid had the partnership deed contained this clause:

'Where an aspiration payment or an achievement payment is received outside the partnership accounting period to which it relates to it shall be apportioned on a daily basis with reference to each accounting period of the partnership and where the value of an achievement payment varies (if at all) at the end of an NHS financial year the value attributable to each accounting period shall be ascertained on a pro-rata basis'!

It doesn't apply to this particular story but the following clause might also be

useful: 'Where a succession date falls on a day other than the account date, any aspiration payments received from the PCT in respect of QOF shall be apportioned in the final accounts between the period during which the deceased or retired partner was a member of the partnership and the remaining period of the account period and any achievement payments made under QOF which are received after the succession date shall similarly be apportioned'.

Mike Gilbert, RMT

Payrise or pay ruse

The Government is currently under fire by doctors and the GPC following recommendations by the Doctors and Dentists Review Body. The pay board's report is being challenged by the BMA following indications that any pay rise will be reduced by a cut in the correction factor. Four years ago, doctors were advised that the correction factor was here to stay - whatever that meant. We all know that the MPIG was a belt and braces adjustment following the failure of the Carr-Hill formula. But lack of transparent discussion has now created a rift which is certainly upsetting for GPs, whether they are a principal in practice, a salaried doctor or a locum. The effects of a pay squeeze are already being felt with fewer

opportunities for jobs in general practice and locum work decreasing. And practice profits look like falling in many practices.

Have doctors been misled? Many incentives have been dreamt up over the past few years to retain and encourage doctors and their staff. The targets set for GP practices have mainly been achieved. But where will this leave the GP if the Government now does a u-turn and reneges on its promises? One does wonder if there is a hidden agenda. Reduced funding will have a serious effect on how primary care can be provided. Is the present setup of personal service to be replaced by larger organisations, polyclinics and alternative providers? The

lack of apparent Government direction does nothing to reassure the doctor. How far the GP will accept the predicted erosion of income is difficult to assess when additional burdens of targets, form filling, data collection and raising of standards are expected on a daily basis.

Questions are often raised as to who will benefit by all of this – probably not the patients who fund this huge machine. Hopefully the BMA challenge to the DDRB report will be successful. If doctors are being expected to be more responsible within the NHS then they surely should not be expected to take a pay cut. Perhaps MPs could set an example!

David Clough, chairman, aisma

Possible Changes in Future Income

Following confirmation of the reduction in average incomes for 2006/7 there is news of possible changes in earnings for 2009/10.

The proposals being made to the Review Body are designed to try to ensure that all GMS practices get something in 2009/10 after an effective pay freeze for the last three years. The final result will depend on what the Review Body recommends and whether it is accepted by the health department.

The proposals include further changes to the QOF points. Although there will still be 1000 points available a number of them have been reallocated and 17 points have been recycled to demonstrate 'efficiency savings'. From past experience it is likely that these changes have been made to make it harder to achieve high points scores. Similar changes were made in 2007/8, which appeared to have a similar aim, but despite that average achievements increased again in that year.

Negotiators are also working with NHS Employers to try to see how to cut practices' reliance on MPIG over a number

of years without reducing practice funding. At present around 93% rely on MPIG top up their income. For practices reliant on MPIG the increase in the global sum is generally reduced by an equivalent increase in MPIG leaving very little or no overall increase in total income.

We understand that talks are also under way concerning Seniority Pay, which is linked to profitability under the new contract. Hints concerning the fairness of these payments have been made periodically and particularly where GPs have started to draw their pensions after taking 24-hour retirement. It is possible that this could be a source of reduction of costs for the health authorities, which would mainly affect the incomes of older practitioners. However some practices include seniority in pooled amounts and in these cases it would affect all partners equally.

It seems likely that the government will review all of their expenditure in these difficult financial times. They are also helped by the negative publicity generated by the periodic articles in the Media concerning the levels of GP pay under the

new contract. In order to try to maintain profitability practices need to aim to ensure that they meet as many targets as possible. The QOF monies are the best way of mitigating any reduction in overall income and every effort to maximise the achievement pays dividends. It is also essential that practices are involved in PBC either in consortia or individually to help reduce the effect of current and proposed changes on profitability.

Michael Penn, Hillier Hopkins LLP



Beat the squeeze!



After that pay award practice finances are tighter than ever this year. Robin Stride asked some aisma accountants to share their survival strategies:

Make more from your staff

Controlling staff costs and making the most out of them is increasingly a key feature to surviving in general practice. Wages costs, including training, are significant with often over a third of a practice's income being spent in this area. In the ever-changing NHS environment it is important that this major resource is carefully managed and used in the most efficient manner. A practice must ensure that it has the right skill mix and delegation of responsibilities amongst its staff and GPs. It should check to see that every member of staff and GP has a job description. This exercise provides an opportunity to ensure a staff member is in the right role for the practice as a whole. Care should be taken when recruiting and selecting to interview for the job that is needed and not for the person being replaced.

GPs may be able to delegate, but not abdicate, some of their responsibilities downwards - say to nurse practitioners. This can free-up time to generate work from new sources, which may not be from the NHS. Increasingly practices are looking at this route to maintain and maximise profits.

Some practices would benefit from implementing documented rotas to ensure they can plan for absences such as annual leave, training and sickness. If there is a short term absence then it may be possible to cover this by utilising existing staff members and GPs. This is often a less expensive option than using external locums. Staff contracts and

partnership agreements need to cover these issues.

To meet the demands of the modern NHS, many GPs are now recruiting a strategic practice manager to plan for the future and ensure the practice knows where it wants to be and gets there. Local practices can sometimes work together with a strategic manager employed for the group rather than for one practice.

**Elaine Andrewartha,
Kelsall Steele Limited**

Review all staff arrangements

As staffing costs are usually the highest expenditure item, GPs should critically review all staffing arrangements and, where choices arise, carefully consider the alternative costs. For example, in a busy period, it is worth thinking carefully about whether a practice extends the hours of an assistant or takes on a locum. Remember that whilst the equivalent hourly rate of a locum may be higher than that of an assistant, the engagement of a locum will give rise to a 14 per cent saving of employers' superannuation and up to a 12.8 per cent saving of employers' NI. And also no holiday or sickness pay arises in the case of a locum.

Andrew Redmayne, Redmayne & Co

Manage time and delegate more

Due to static income and rising expenses, the key issues become time management and delegation. I will ask my GP clients to see if they are performing tasks which could be done by clerical staff or other healthcare professionals instead. Many will need to put in a few more hours themselves if they want to earn more. What I am looking for is the freeing up of time which can be used to generate more income -

if more lucrative services can be found. Specialisation might become the issue so that GPs can provide specific services geared to the needs of locality. Unfortunately, cutting expenses is a one-off task and cannot be repeated every year. In my book, use of time is the key issue for 2008-09.

Mike Gilbert, RMT

Join together to fight commercial opposition

An hour long meeting with a GP practice recently was partially clouded by the doom and gloom of what various companies are up to. My feelings for a long time have been that the easiest targets are out-of-hours where the cost of the opt out clause will be raised to finance the increased cost of providing the service. Many of my GP clients say they just will not cooperate but I think this will give the Government an even better excuse to let in the private sector.

I don't believe walk-in clinics will have a significantly dramatic effect on well-run surgeries that enjoy good rapport with their patients. And I suspect only new patients might be tempted to use these and the new polyclinics that will spring up. But GPs will be able to get word of mouth referrals to work for them quite easily, like in the commercial world.

However it is up to the doctors to work together as a group in a town to come up with a credible alternative to the big private sector outfits. They will always win if they work together and work with the PCTs to help them keep their costs under control which, let's face it, is what is driving all these changes.

But I fear that if the GPs in a town do not work more closely together quickly, then what will happen is that the big private sector companies will have an agenda to take over GMS/PMS contracts and gradually impose a stranglehold on areas. They will then only offer GPs salaried status and in that way save PCTs as much as £50k or often more per GP. It would be a case of take it or leave it - and GPs would have little option other than to take it. Yes they would be demoralised, but a new breed of GPs who know little else would be happy with a well paid job at £75k pa. And they would gradually take over from the demoralised existing GPs earning £125k. The alternative is for GPs to recognise they must work together with other GPs, as well as with the PCTs, and look to be more commercially aware.

This will mean, among other things, training their front of house team how to build rapport with 'clients' (not patients), how to offer WOW service on the phone and at reception areas, and for the whole

surgery team to completely review, re-evaluate, and improve the whole 'patient journey' experienced by their list.

Cash in on the value of premises

When they are forced to work an additional two hours later in the evenings and weekends, not all the doctors will be there, so I believe practice managers will need to start to think like dentists and opticians had to when they went through their own wholesale practice changes. They will have to look at what else they can use their premises for that will complement their existing services. What extra could they do 'to make their assets sweat'?

Apart from the more obvious pharmaceutical services, other examples would be alternative medicine clinics, acupuncture clinics, hypnotherapy clinics, beauty clinics (some dentists are making a lot of money out of providing Botox treatments), health clinics (linked to local gyms and health centres), and maybe even at a stretch more remote beauty treatments. For instance tooth whitening is becoming more and more commercially available, outside the dentistry fields.

The point is that the public trust their doctors. GPs will have to face up to the prospect that they might be forced by the Government and the PCTs to make the most of this trust and to provide services that their 'clients' will probably be happy to buy elsewhere. Why not from the GPs - as long as it is not the GPs actually doing the work. They have more than enough on their plates already.

Pay less tax!

GPs can be more proactive in planning to legally mitigate their tax liabilities to reduce what they have to pay on previously high earnings at a time when earnings are now under significant pressure. There are opportunities for GPs to legally reclaim tax they have paid in the last three years, without affecting their superannuation position. It is up to them to seek advice from specialist accountants who understand how this is possible.

Mike Ogilvie, OBC The Accountants Ltd

Get a better deal from your bank

You might think that the sub-prime mortgage crisis and consequent credit crunch has made it more difficult to obtain borrowing at competitive rates. But in our experience the opposite is true. Banks are in business to lend money, and whilst they may be more reluctant to lend to borrowers they view as high risk, they are very keen to lend to customers with good security, low bad debt risk and consistent cash flows. This means that the market to lend to GP practices is currently very competitive, which pushes down interest rates being charged on lending.

There is also a greater willingness to lend on interest-only terms if required, and less

insistence on partners having personal life cover or savings vehicles. A relatively new development is that it is now no longer necessary only to be able to choose between a fixed rate loan and a variable rate loan. Through the use of products such as interest rate swaps it is possible to combine some of the benefits of flexibility that a variable rate loan provides, with some protection against increases in interest rates.

A good time to review your borrowing requirements is when a partner joins or leaves the practice, or when new finance is required for a surgery extension or new development. Even if you have no borrowing, banks are also keen to service the day-to-day banking needs of practices, and so there can be an opportunity here to reduce bank charges.

However, as with everything else, cost should not be the only factor in deciding upon whom to bank with or borrow from. It is important to have a good relationship with a bank manager who understands the medical sector.

For example, does your bank manager know why the practice has a large inflow of cash in April and why bank balances are likely to be at their lowest at the end of March each year?

Luke Bennett, Winter Rule

Save employer's NI on a new partner

When planning the appointment of a new partner, the usual process that a practice would go through is to take on a doctor as a salaried GP for a set period of time and, subject to their performance, they would then be appointed as an equity partner.

But if it is felt that the doctor will almost certainly be made an equity partner in the future, then consider instead taking them on as a fixed profit share partner from the outset. The advantage of this is that the practice would save the employer's national insurance cost. Based on 2008-09 figures for a salaried GP earning £60,000 the employer's NI saving would be £60,000 - £5,435 x 12.8 per cent = £6,984.32.

An added benefit is that the employer's superannuation is then treated as a drawing rather than an employment cost. This will improve the practice profit and consequently the amount the partners are able to draw but not cash flow. The only downside of this though is that the partners will lose the tax relief on the employer's NI and employer's superannuation but this is outweighed by the employer's NI saving.

**Wayne Baker and Alan Worsdale
MGI Rickard Keen LLP**



Practice Profitability

Current financial issues continue to make general practice an uncertain occupation. It has now been confirmed that average earnings generally have fallen by 2.1% for 2006/7 and it is expected that they will show a slightly higher reduction for 2007/8. There is no certainty for future pay awards and all contract changes appear designed to reduce incomes further. In addition there are rumours of future pay awards being made as a reduction to the correction factor of the global sum. It all seems a very long time ago that the new contract was introduced to attract doctors to general practice, as there were shortages of candidates in almost all areas!

The trend of reducing profits seems likely to continue into 2008/9 as incomes continue to be squeezed and costs inevitably rise with extra wage costs to cover the additional opening hours now required. To add to cash flow pressures the superannuation earnings cap was removed with effect from 6 April 2008 other than for added years contracts and the employee's contribution rate increased from 6% to 8.5% for incomes over £100,000 reported for 2005/6. The new rates will apparently be fixed for 2008/9 regardless of superannuable profits as the NHS computer cannot cope with rate changes based on income!

There are changes being made in the structure of medical practices with more clinical employees than before. We also hear that PCTs are looking to reduce the number of sole practitioners by not offering them the chance to take twenty four hour retirement and return to their practice. They are also trying to encourage them to join into partnerships or into GP Health centres to provide care for twelve hours a day, seven days a week.

However, despite the quality points targets being changed in 2007/8 to make it more difficult to achieve, the results for England show a further improvement to an average of 96.8% as compared to 95.5% for 2006/7. The increased achievement helps to keep any reduction in profitability to a minimum. There are further changes in the basis of quality points for the current year which again appear designed to make maximum achievement harder. It is important to try to continue to reach these targets as this is the easiest way of maintaining earnings.

The department of Health have issued instructions to force all NHS commissioners to post information about tendering opportunities on a website www.supply2healthg.nhs.uk.

This should enable Doctors to be aware of all tendering opportunities to bid to do the services PCTs want. Bidding for services and practices is stressful and GPs without business training find it time consuming and difficult to identify the opportunities

that may be available. However, in the current economic climate it is increasingly important to expand the services provided in order to improve profitability and make best use of specialist services available in the practice. Those who do not take part in outside services will find their profits being reduced. It is now a new business climate for general practice and it is changing rapidly year by year.

It is worthwhile to revisit the recurring features in respect of higher and lower earning GPs.

High Earners

- Stable partnership - low partner turnover.
- Have an up to date Partnership agreement to avoid costly disputes.
- Work as a team, trust each other, plan ahead, and meet regularly.
- Top rate patient and treatment databases.
- Have similar philosophies in terms of the dichotomy between money and patient care.
- Proactive rather than reactive teams. Good time managers.
- Well organised with strong staff teams and good skills mix.
- Delegate routine tasks to nurses, health visitors etc.
- Work long hours, have low deputising costs, and a high level of non-NHS earnings.
- Have very high list sizes (normally single-handed GPs).
- Have the ability to dispense.
- Have taken advantage of growth funding and freed up time to perform more lucrative tasks.
- Heavily involved with their PCO.
- Have the most competent and skilled practice managers and specialist accountants.
- Were early fund holders.
- Prepare annual budgets and regularly compare performance against budget.

Low Earners

- Practices involved in partnership disputes.
- Have inadequate resources, such as staff, equipment and space. Have the wrong staff mix or a loyal contingent of staff who have been promoted over the years but do not necessarily have the relevant skills.
- Badly organised with excessive number of patients and poor internal controls.
- Work as individuals rather than a team.
- Gave little or no thought to fund holding or an early entrance into PMS.
- Value "time off" over and above money, who incur very high deputising
- Don't have necessary data on patients, either through neglect or through poor skills mix amongst the staff.
- Bad time managers.
- New practices with low list sizes
- Practices in very deprived areas.

Review your own practice compared to the above and establish which areas you need to work on in order to increase your future earnings potential. The following also gives you a summary of some key ways to enhance your profitability:

- Quality points (becoming more difficult to achieve).
- PMS/GMS income per patient (The average is around £120).
- Consider dispensing (alone or by way of joint venture).
- Consider level of outside income.
- Get involved in provisioning, which may require specialisation (e.g. cardiology, elderly, diabetes, palliative medicine, mental health, etc.)
- Watch your list size - money follows the patient!
- Pursue, with care any lucrative outside appointments, but always consider the opportunity cost. This means you have to measure the benefit of the outside appointment against the cost of what you are giving up. There is always a trade off. Beware of the pitfalls of this approach, such as:
 - Ego trip. Flattery, title or status are nice but is a GP a better person for simply filling a vacant post.
 - Escapism. Getting away from the surgery may be great but what is the opportunity cost.
 - Partner resentment. If income is not pooled, resentment can occur.
 - Delegation in return. You cannot compress existing surgery work into a shorter time unless you delegate properly. Determine how busy you should be. Letting work mount up is not the way to maximise profit.

As a further consideration in the pursuit of maximising profits, consider how to contain costs. Consider comparing your costs as a percentage of total income to regional statistics - Cost reduction could be achieved by:

- Delegation to practice managers, but not abdication - there have been too many horror stories.
- Joining in a buying consortia, for example, for the purchase of drugs.
- Using internal rather than external locums.
- Shopping about for the special deals, but not for your accountancy services. It is now even more important to use specialists.

GPs must realise that they need to run their medical practice like a business. The highest earners in the future will be those practices that have the right structures, roles, services, technology, people and premises. The future is continuing to be a challenge.

Michael Penn, Hillier Hopkins LLP

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.



This newsletter is for general guidance only and no liability is accepted for action taken in reliance upon these notes where appropriate professional advice should be taken.

If you would like more information please contact us on 01442 220788 or email info@hhllp.co.uk