



Welcome to the latest issue of the Albert Goodman e-Update specifically for medical practices.

If you have any feedback on the contents of this newsletter, or would like to discuss how this may affect your practice please click on the feedback link. Likewise, if you are not a client of ours and would like to see if we are the right team for you please forward [Keith Miller](#), our medical practice specialist, your details and he will be delighted to get in touch for an informal chat.

Thank you for taking the time to read this newsletter.

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# Taxation to get simpler?

Tax doesn't have to be taxing.... but it is taking a new Government office to try and sort things out.

An 'Office of Tax Simplification (OTS)' launched today says it will pinpoint tax system complexities for businesses and individual taxpayers with the aim of ironing them out.

The Treasury said: 'The OTS will undertake two initial reviews over the coming year. They will focus on tax reliefs and small business tax simplification (including IR35). The OTS will publish the initial findings from their work on reliefs in late autumn and on small business tax by the 2011 Budget.

'The OTS will also draw on external expertise from the tax and legal profession over the coming months. These experts will focus on specific areas of complexity in the tax system and provide additional advice to the OTS.

Chancellor George Osborne blamed the last Government for making a complex tax system worse.

He claimed: 'A decade of meddling and intervening has made the tax affairs of millions of families and businesses across the UK extremely complicated. We need to sort out this mess'.

The OTS, promised two years ago, will be chaired by Michael Jack.

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# Elderly care insurance to be investigated

The Government's new Commission on the Funding of Care and Support is to look at a range of funding ideas including voluntary insurance and partnership schemes.

A workable funding system for adult care and support is needed because in 16 years time the UK will have double the current number of 85 year olds.

One in five 65 year olds today will need care costing more than £50,000.

The Commission will recommend on the best way for people and the State to be able to meet care and support costs and how an individual's assets are protected against the cost of care.

Commission chairman Andrew Dilnot said: 'How we best look after those who need care and support is one of the most pressing social policy challenges facing our society today. With more people living longer, we urgently need to find a fair and sustainable way to pay for the care which many of us will need'.

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# Goodwill sale advice for dispensing GPs

The GPC has advised practices who are unsure if they can sell the goodwill of their dispensing businesses to check first with the Health Secretary.

Following legal advice, the committee has produced a briefing document which says if dispensing rights have been granted to a GMS/PMS practice and form part of the NHS core services, then they are intrinsically linked to the practice and it would be illegal for the practice to sell goodwill.

But in some circumstances a practice may have set up a pharmacy as a separate business which is not linked to a GMS/PMS agreement and it can therefore be sold independently. The GPC says: 'In such cases it is thought that the goodwill rules most probably do not apply'.

It points to the NHS Act 2006 which details how a person who is unsure whether goodwill attaches to the sale of a medical practice can make an application to the Secretary of State. He then has to consider the application and issue a certificate setting out his ruling.

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# GP commissioning boost under white paper

A greater role for GP commissioning is, as expected, set out by Health Secretary Andrew Lansley in yet another NHS reforms White Paper, out this afternoon.

The document, 'Equity and Excellence: Liberating the NHS', details how power will be devolved from Whitehall to patients and professionals.

Groups of GPs will be given freedom and responsibility for commissioning care for their local communities, while service providers will have new freedoms and be more accountable.

There will be greater competition in the NHS and greater cooperation – and PCTs will be scrapped.

Mr Lansley forecasts:

- Services will be more 'joined up', supported by a new role for local authorities to support integration across health and social care.
- Professionals will be free to focus on improving health outcomes so that these are 'amongst the best in the world'.
- Improving the quality of care will become the main purpose of the NHS.
- Patients will get more choice and control, backed by an 'information revolution', so that services are more responsive to patients and designed around them, rather than patients having to fit around services. The Department of Health said the principle will be 'no decisions about me without me'.

The plans says patients will be able to choose which GP practice they register with, regardless of where they live, and choose between consultant-led teams. 'More comprehensive and transparent information, such as patients' own ratings, will help them make these choices together with healthcare professionals'.

As a result of the changes, the NHS will be streamlined with fewer layers of bureaucracy. Strategic Health Authorities will be phased out along with PCTs.

The Government said management costs would also be reduced so that as much resource as possible supports frontline services.

Reforms announced today build on changes started under the previous Government.

Mr Lansley said: 'With patients empowered to share in decisions about their care, with professionals free to tailor services around their patients and with a relentless focus on continuously improving results, I am confident that together we can deliver the efficiency and the improvement in quality that is required to make the NHS a truly world class service.'

The Department of Health is publishing a batch of consultation documents to seek views on more detailed proposals.

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## GPs 'ideally placed' for commissioning

Go-ahead GPs look set to grab the chance to commission health care under the Government's NHS White Paper announced this afternoon.

Already this is seen as another 'money grabbing' opportunity by some sections of the daily press but BMA Council chairman Dr Hamish Meldrum argues that GPs are 'ideally placed' to help determine the health needs of their local population.

He said: 'Every time they see a patient they have to make decisions about their care, in partnership with them.'

'Doctors, and their staff, already take the lead on designing services and innovating new treatments for patients and will be interested in discussing how these roles will be enhanced.'

'They will wish to see how the proposed changes allow them to work collaboratively, and in partnership with their patients, to facilitate improvements in the care pathway and to see unnecessary barriers and bureaucracy removed'.

He said the BMA was looking forward to discussing the details behind these new initiatives in more depth and playing an active role in ongoing consultations.

Dr Meldrum said plans to link outcomes to NHS funding would need careful thought to ensure that any payments accurately reflected the activity and cost involved.

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## GPS threatened by commissioning plans

Today's Government 'Commissioning for patients' document, outlined elsewhere on this website, is causing concern among doctors.

BMA Council chairman Dr Hamish Meldrum said the proposals, which will change the GP pay structure, contained threats as well as opportunities.

He said there were still many questions that needed answering.

Now the BMA plans to set out its own plans for how GP commissioning could be made to work.

Added GP Dr Meldrum: 'This is a challenging agenda, but the BMA is committed to try to find workable solutions that will fully engage both primary and secondary care doctors and the public so that by working in partnership they can achieve the best outcomes for patients.'

He said the association would ensure its members' views were taken on board.

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## GPs warned don't be seduced or bullied

Londonwide LMCs is telling GPs it will not be acceptable for PCTs or groups of enthusiasts to unreasonably pressurise them to be part of a commissioning consortium they are not happy with.

It is working on guidance to help family doctors on this issue, a backbone of this month's NHS White Paper. Meanwhile it has urged GPs to beware they are not bullied into giving hard won deals away.

The group said commissioning would mean working collaboratively in commissioning consortia which are developed and owned by GPs for the purposes of effective commissioning of secondary, community and intermediate care services. But the consortia should not be foisted on GPs.

In a message to GPs, Londonwide LMCs bosses said: 'This is about commissioning of services beyond your practice. It is not about the provision of your own services which will remain governed by your GMS or PMS contracts until such time that they are renegotiated with the BMA in line with the Government's intention for one single GP contract.

'Hold on to what you have got, and don't be seduced or bullied into giving things away'.

The GPC believes GPs risk getting the blame if commissioning fails to work but it thinks family doctors are the only professionals who can make this work.

GPs are being warned that if they resist getting involved then it will only serve to promote the interests of the commercial sector and 'predatory foundation trusts seeking to vertically integrate general practice into the hospital sector'.

Londonwide LMCs said it wanted GPs to be fairly treated and fully informed about implications of changes as the detail emerged. Doctors needed a proper opportunity to influence the development of their commissioning consortium.

Doctors' leaders in the capital warned they would resist unilateral proposals from PCTs and others, and unreasonable pressure from over-enthusiastic GPs, Trusts or the commercial sector.

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## Meet now about GP Consortia, say lawyers

GP solicitors are advising some practices to act now to meet together and start setting up a provisional steering committee for their consortium.

Lockharts, of London, said its recommendation applied to practices in a geographical area which looked like it could support a single group.

It said the group could meet and establish a provisional steering committee. This could be charged with working on the documentation and the consortium's development when the necessary papers became available.

The most pressing question GPs were asking right now was whether their practice should do anything now about a local consortium, said Lockharts. But it thought there was very little else that could be done 'because we are still a long way from seeing the supporting documentation which will follow the White Paper'.

Lockharts thought that each consortium was likely to be looking after 100,000-110,000 patients.

#### NOTIONAL RENT

In a circular to GPs the firm said there was no clear answer at the moment to another commonly-asked question: 'What will happen to our notional rent/current market rent/cost rent if PCTs are to be abolished?'

It said: 'There is no clear answer to this at present, but we anticipate with some confidence that the Health Bill when it is published, will foreshadow legislation which will transfer the rights, liabilities and obligations of PCTs to successor bodies. This would follow the arrangements which have been made on past occasions when there have been structural changes'.

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## New patient outcome measures proposed

GPs and interested parties are being consulted on Department of Health proposals for how the NHS will improve healthcare outcomes for patients and judge the results.

Five areas are being looked at: preventing people from dying prematurely, enhancing the quality of life for people with long-term conditions, helping people to recover from episodes of ill health or following injury, ensuring people have a positive experience of care, and treating and caring for people in a safe environment and protecting them from avoidable harm.

Health Secretary Andrew Lansley said: 'Instead of politically motivated targets which lack clinical evidence, we will measure the outcomes that are most important to patients and that are relevant to healthcare professionals'.

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## New GP pay announced....

GPs' pay will reward commissioning success, a Government consultation paper reveals today.

It states that a proportion of GP practice income will be linked 'to the outcomes that practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources'.

The pay change for GPs is signaled in a document which gives more detail on this month's health White Paper.

Called 'Liberating the NHS – Commissioning for patients', the 40-page document says the payments will be subject to discussion with the BMA and the profession.

So what other main points do GPs' specialist medical accountants need to know? Here is a round-up of the key aspects:

....+ 20 THINGS YOU SHOULD KNOW ABOUT COMMISSIONING

### Responsibilities of GP consortia

1 Consortia of GP practices will commission the great majority of NHS services on behalf of patients, including elective hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services, and mental health and learning disability services.

2 But consortia will not be responsible for commissioning primary medical services, which will be the responsibility of the NHS Commissioning Board.

3 A new NHS Commissioning Board will calculate practice-level budgets and allocate these resources directly to consortia.

4 Consortia will be responsible for managing these combined budgets, which will be kept separate from GP practice income.

5 They will contract with providers and hold providers to account for meeting their contractual duties.

6 Consortia will have a duty of public and patient involvement.

## **Relationship between consortia and individual practices**

7 Talks between the BMA and the Government will discuss how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including a duty to be a member of a consortium and to support it in ensuring efficient and effective use of NHS resources.

## **The role of the NHS Commissioning Board**

8 The board will lead on commissioning for quality improvement, develop guidelines and design tariffs and model NHS contracts.

9 It will hold consortia to account for outcomes and financial performance.

## **Establishment of GP consortia**

10 Every GP practice will be a consortium member in order to have a list of registered patients.

11 Practices will have flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. GPs may be assigned to a consortia if necessary.

12 Consortia will need to have a geographic focus and be 'of sufficient size' to manage financial risk effectively.

## **Freedoms and accountabilities**

13 Consortia will receive a maximum management allowance to reflect commissioning costs.

14 Consortia will have freedom to use resources as they think fit but will face competition from any 'willing provider'.

15 Each consortium will hold its constituent practices to account.

16 As well as QOF there will be COF – a Commissioning Outcomes Framework – to give patients details of commissioned outcomes.

17 Consortia will have to work closely with patient participation groups and local communities in their areas, including 'Local Involvement Networks'. These will become local HealthWatch bodies.

18 Multi-professional involvement in commissioning is to be encouraged.

## **Implementation**

19 'Shadow' GP consortia are expected to begin forming this year while between 2011-12 they will gear up as the NHS Commissioning Board takes shape.

20 Formal GP consortia will be set up in 2012-13, together with indicative allocations and should be 'fully operational' in 2013-14.

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# **NHS changes could cost £3b for nothing**

The Government's NHS overhaul in England may cost £2bn – £3bn to implement with no guarantee that it will improve performance or lead to better patient care, a health service expert claims.

Kieran Walshe, professor of health policy and management at Manchester Business School, argues that there is very little evidence that past NHS reorganisations have produced much, or any, improvement.

And he says in an editorial on [bmj.com](#) that the new Government 'looks likely to make all these mistakes again.'

Prof Walshe claims health secretary Andrew Lansley 'seems to have learned little from the past history of NHS reorganisation'.

He recommends three things the new Government should learn:

1 Structural reorganisations do not work

There is little evidence to suggest that any of the different commissioning structures put in place over the last twenty years were particularly better or worse than others, he writes, or that the proposed changes will work any better than the current arrangements.

2 Transitional costs of large scale NHS reorganisations are huge

Projected savings from abolishing or downsizing organisations are rarely achieved.

### 3 Reorganisation adversely affects service performance

It is a huge distraction from the real mission of the NHS – delivering healthcare and improving healthcare quality – and can absorb a massive amount of managerial and clinical time and effort. It can also destabilise organizations or services and result in poor performance or failure.

Prof Walshe says: 'The intended costs and benefits must be made explicit and measurable ... and a systematic analysis of the impact of the reorganisation should be produced within two years of its implementation and presented to Parliament.'

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## Pension contribution advice from GPC

The GPC has set out the following advice to GPs concerning tiered contributions:

'In 2007, the GPC agreed that for the year 2008-09 there would be a one off arrangement between the Department of Health and BMA that GP tiered contributions would be based on their 2006-07 pensionable pay as declared on their annual end of year 2006-07 certificate regardless of what they actually earned in 2008-09.

'If there was no 2006-07 certificate available then the 2005-06 certificate was to be used as a yardstick. If there were no certificate or if the GP was newly qualified then the NHSPS regulations stated that the 2008-09 tiered contributions rate would have to be agreed between the PCT and the GP and be based on the GP's estimated 2008-09 income.

'However, it is very difficult to project a GP's income because no-one really knows what their practice profits are going to be or how much they may earn doing other GP work such as out-of-hours or locum work, both of which can increase total pensionable earnings considerably.

'If a GP started at a practice in July 2008 and it turned out that they earned £35k (in total) between July 2008 and March 2009 it is understandable that they may question a 8.5% tier being imposed. With tax relief the real figure is less than 8.5% and in most cases it's probably not unreasonable for the PCT in July 2008 to believe that a GP may earn more than £35k over the following nine months.

'Unfortunately under such circumstances there were always going to be some winners and losers for that year. For members at the extremes of these losses then the BMA pensions department will of course be happy to provide support and lodge a claim through the NHS Pensions Agency's internal dispute resolution procedure'.

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## Personal NHS budgets get £4m

The Government has given the personal health budget pilot scheme £4m to get going.

Personal budgets, part of yesterday's White Paper on the NHS, are meant to allow health trusts to put individuals in control of how, where and from whom they receive their healthcare, in partnership with the local NHS.

A personal health budget can either be arranged by the NHS, an independent third party, or the individual can be given the money to buy the care themselves through a direct payment.

Care Services Minister Paul Burstow said: 'I am fully committed to piloting personal health budgets to inform the way we implement them more widely and how we can combine them with social care budgets. We want to give people more choice and influence over their healthcare – giving them direct control of the cash is a powerful way of achieving this.

'A similar scheme has been a huge success in social care, letting people choose services that fit in with their life, rather than fitting their life around the service. Today's investment into personal budgets for healthcare will ensure that patients using the NHS will be able to benefit in the same way'.

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### **Keith Miller**

Keith joined Albert Goodman in 2006 from a local Somerset firm of Accountants where, having qualified as a Chartered Accountant in 1988, he had been a Partner since 1990. He recently went on to achieve further success becoming a Certified Financial Planner in 2006.

Although best described as a General Practitioner, providing financial and taxation advice to an expanding portfolio of high net worth individuals, limited companies, sole traders and partnerships, Keith specialises in assisting medical practices and solicitors on all aspects of financial and taxation advice. He leads our GP medical team and is a member of AISMA, the Association of Independent Specialist Medical Accountants.

As a qualified Certified Financial Planner, he is ideally suited to obtaining a detailed understanding of the issues facing proprietors and their personal objectives in order to make a key contribution on strategic and tax issues, as well as dealing with the very complex areas of Capital Gains Tax and Inheritance Tax planning.

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