AISMA Doctor Newsline

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A quick guide to help you get on top of the new data rules

Forward thinking GP practices need to begin gearing-up for some new data protection requirements. **Fiona Dalziel** suggests how to go about it

There has been a lot of concern about how to prepare for the General Data Protection Regulation (GDPR) which becomes active on 25 May 2018.

The aim of the legislation is to 'strengthen and unify data protection for all individuals within the EU' – but leaving the EU does not mean we do not need to comply.

Practices should be along the right lines if they already comply with the DPA. However, we need to start getting informed so that we understand what requires review or documentation.

So where should we start?

The Information Commissioner's Office (ICO) main page for guidance on this legislation is at ***https://ico.org.uk/for-organisations/data-protection-reform/guidance-what-to-expect-and-when/.***

This explains the legislation and contains direct links to other guidance. At this stage, this guidance is generalised and it may be that the BMA and medical defence organisations will produce more general practice specific guidance. Find further details at ***https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/***

But how can I avoid having to read all that?

Go to the ICO's 12-step guide to preparation at ***https://ico.org.uk/media/for-organisations/documents/1624219/preparing-for-the-gdpr-12-steps.pdf***

Here are the recommended steps with my brief thoughts to start you off.

1 **Raise awareness:** GPs and practice managers need to be aware of the change and start assessing the impact on the practice. Compliance will require some changes and these will require thought, further advice and planning.

2 **Document the information we hold:** Under both DPA and GDPR, patient data is classified as sensitive and compliance is more onerous. In addition, we are employers and hold our staff's personal data. Start compiling a list of:
a) What personal data you hold
b) The source of the data
c) Others you share that data with, for example outsourced payroll services.

The practice needs to demonstrate that its policies and procedures are effective and that they adequately protect data.

3 **Communicating about data management and sharing with patients:** Many practices already have a 'Privacy Notice' in the form of a patient information sheet but this will need reviewing in all cases to include:
a) The practice's 'lawful basis' for processing data (staff and patients) - see 6 below.
b) How long the practice retains data
c) Details of the individual's right to complain and to whom.
Please note that this is not the full list of requirements.

4 **Protecting the rights of individuals**: Central to the GDPR is that the individual's rights are strengthened. This has resulted in an expanded list of rights, not all of which may be relevant in a GP practice, such as the right to erasure.

We have to demonstrate that our policies and procedures protect these rights listed in the ICO's 'Overview of the GDPR' (see above).

5 **Handling Subject Access Requests (SARs):** The new rules relating to this will impact practices. Access should be provided 'without delay' and certainly within one month. The SAR fee of £10.00 is abolished.

6 **Knowing the practice's lawful basis for processing personal data:** In the case of patients' data, the basis is that 'processing is necessary for the purposes of preventative or occupational medicine, assessing working capacity of an employee, medical diagnosis, provision of health or social care or treatment or management of health or social care systems and services on basis of law or a contract with a health professional'.

All relevant lawful bases for processing affect individuals' rights and should be documented.

7 **Seeking, recording and managing consent to data processing:** Again, the GDPR will require practices to review their procedures to demonstrate compliance. Guidance is available at ***https://ico.org.uk/media/about-the-ico/consultations/2013551/draft-gdpr-consent-guidance-for-consultation-201703.pdf***. We await detailed guidance relating to consent to processing for medical reasons.

8 **Children:** Specifically in relation to internet-based services such as social networking, the GDPR brings in new protections.

It remains unclear at this stage whether this would apply to online patient services. The GDPR currently sets the age of consent at 16 but parents can have proxy access and the age of GDPR consent may change. Practices should bear this in mind.

9 **Data breaches:** If the breach might impact an individual's confidentiality, for example, this is considered to have a high risk impact on the individual's rights and the rules describe how this should be reported to the ICO and the individual themselves.

Fines apply for failure to do this. Practices should consider the guidance and ensure they have a policy for detecting, investigating and reporting a data breach.

10 **Privacy by Design:** This approach is a core principle of the GDPR. The meaning of this is that, for instance, when using data for a new purpose, an organisation should ensure that privacy compliance is integral from the start. This is unlikely to need immediate action by practices before May 2018.

11 **Appoint a Data Protection Officer:** This is most likely to be the practice manager, and responsibilities are similar to the DPA.

12 **International:** This relates to organisations processing data cross-border and so is unlikely to apply.

Fiona Dalziel runs DL Practice Management Consultancy

OPINION

Ouch! Sorry, but a big tax hit is on the way

Chris Howe, AISMA committee

By now you will be aware of your tax bill due this month - but are you prepared for the January 2018 liability?

Thousands of GPs face a large jump in their tax bill in January 2018, due to a quirk in the 'pension tax' allowances.

Those affected are likely to be high earning GPs, with for example, accounting profits above say £140,000.

For these GPs the 'annual allowance' on pension contributions, reduces from £40,000 to perhaps £10,000.

So, for example, if your pension growth for annual allowance purposes is £46,000 you will be taxable on £36,000 rather than £6,000. The tax rate on this may be 45%, giving you a tax liability of around £16,000.

You may be thinking that this will not hit your pocket, as you will use the 'scheme pays election' to request that the NHS Pension Scheme pays the tax on your behalf. You would be wrong!

A peculiarity in the tax legislation says that only the excess above the £40,000 'normal' annual allowance can have the tax paid via the 'scheme pays election'.

This means that you will personally have to pay the tax on the part that falls between the lower £10,000 allowance and the 'normal' £40,000 allowance.

The result? £30,000 taxed at 45% giving a tax bill of £13,500. To make matters worse, the 'payment on account' for the following tax year would increase this to over £20,000.

Re-emphasising the point, this is an extra £20,000 on top of your normal personal tax bill. Where is this extra money going to come from? It is time to plan now.

This was one of the many important issues concerning our GP clients, discussed at the annual AISMA conference in May.

What you need to know about IR35

Many practices and doctors could be affected by new employment rules. **Deborah Wood*** explains the implications and recommends they take specific advice from their AISMA accountant

What is IR35?

IR35 is the shorthand term for intermediaries legislation designed to prevent disguised employment.

The general IR35 rules apply where:

- A worker provides services to a client via an intermediary, most commonly a personal service company (PSC). If the services were provided directly the worker would be treated as an employee.
- The PSC pays out net income as salary/pension or deducts PAYE/NIC on deemed salary.

In these circumstances the PSC has the responsibility to assess if IR35 applies. Each individual engagement has to be assessed separately.

What has changed since 6 April 2017?

Since 6 April 2017 specific IR35 rules have been brought in relating to public sector bodies (PSBs).

These rules mean that:

- if the client is a PSB then the PSB has responsibility to determine if IR35 applies, not the PSC
- the PSB must deal with PAYE/NIC, by deduction from the payments made to the PSC, commencing with payments in April 2017
- a PSB is defined as a public authority caught by the Freedom of Information Act
- a PSC is caught by the new rules if the worker has an interest of more than 5% in the shares (including relatives)
- if the arrangement is via an agency the PSB must inform the agency of its decision and the agency will then deal with the PAYE/NIC
- the tax suffered by workers using PSCs will therefore be the same as if they were employees
- the cost of running the PSC continues but there is no tax relief available for the expenses
- PSBs will incur additional employer NIC costs
- an incorrect decision could result in penalties for the PSB
- there is no formal mechanism for a right of appeal by the PSC on the PSB decision.

The Freedom of Information Act

The Freedom of Information Act 2000 (and its 2002 Scottish equivalent) provides that 'public authority' includes any person providing:

- primary medical services, primary dental services or primary ophthalmic services
- general medical services, general dental services, general ophthalmic services or pharmaceutical services
- personal medical services or personal dental services.

A 'primary healthcare provider' is a public authority only if it has a registered patient list for the purposes of the relevant medical services regulations. This includes:

- contractors, performers or providers, who have a registered patient list, and
- contractors, performers or providers, who must provide these patients with essential services during core hours.

In effect this means GP surgeries or practices providing NHS treatment, which are required to maintain a list of patients. APMS and private providers are unaffected by the change in rules.

Retail businesses providing ophthalmic and pharmaceutical services on behalf of the NHS are not caught by these rules.

GP practices, NHS Trusts, hospitals, CCGs, LHBs, and dental practices have to apply the rules in respect of any contractors working for them via an intermediary.

How is IR35 status determined?

The criteria for assessing whether a PSC is caught by IR35 have not changed. However HM Revenue and Customs (HMRC) has now provided an on-line checker tool to assist in the assessment process.

If a PSC had correctly assessed its engagement as not falling within the IR35 rules prior to 5 April 2017 then it should not start to be subject to IR35 after 6 April 2017.

However if the engagement is with a PSB client then the assessment has to be made by the PSB from April 2017 and it might form a different view to that of the PSC. There is a danger that PSCs were not correctly applying the IR35 rules before and so become subject to IR35 on assessment by the PSB.

Where HMRC becomes aware of a change in the status of an engagement there is a possibility that this could lead into inquiries for earlier years.

Determining factors

Prior to April 2017 the application of the IR35 rules has been assessed based on case law and precedent and in particular an understanding of the actual, deemed or hypothetical contracts in place between the client and the PSC. It is the engagement that is assessed not the person/business and status can change over time.

There are a number of tests or determining factors that need to be considered:

1 Personal service/substitution

- Does the service have to be provided by one individual?
- Is there an unfettered right to substitution? (Dragonfly 2008)
- Is the contract clause just window dressing? (JLJ services 2011).

2 Mutuality of obligation

- Obligation on both parties to do something for each other. Employment is the irreducible minimum of mutual obligation (Carmichael v National Power plc 1999 UKHL 47)

3 Supervision, direction and control

- A master/servant relationship indicates employment.
- If the client sets the task and the worker decides how it is delivered, this indicates self-employment.
- If the client controls how the work is delivered (Dragonfly 2008), this indicates employment.

4 Other factors

- Is the worker part and parcel of the organisation?

(Dragonfly 2008)
- Does the worker have financial risk?
- Does the worker use their own equipment to perform the task?

HMRC on-line checker tool

It is recommended that PSBs and PSCs get to know how the tool works before using it to assess an actual situation. Go to:
https://www.tax.service.gov.uk/check-employment-status-for-tax/setup

When using the checker to assess whether an engagement with a PSC falls within the IR35 rules, keep a copy of the report that the checker produces. This will be needed in the event of an inquiry.

Advice from the BMA and NHS

In the run up to the changes in April most NHS bodies seemed to be taking the default position that all contractors supplying the services of a worker via a PSC were considered to fall within IR35.

But in May 2017 NHS Improvement published an update on its guidance, which amends its previous position, to remind NHS bodies that each engagement has to be considered on its own facts and to accurately use the HMRC on-line checker tool in each case to assist with this.
https://improvement.nhs.uk/uploads/documents/IR35_Update_30May1.pdf

The following BMA guidance explains how IR35 is assessed for locums. Go to:
https://www.bma.org.uk/advice/employment/tax/ir35-advice-for-locums

Impact on PSBs and PSCs

If the worker falls inside IR35 for an engagement then the amounts being paid to their PSC should be paid through the PSB's payroll with tax and NI deducted at source.

The worker is set up as an individual on the payroll to effect this. As an employer, the PSB will then have to add 13.8% employer NI and generate payslips and a P60 end-of-year certificate for the worker as appropriate.

The worker does not actually become an employee and has no automatic employment rights. The payment cannot be treated as pensionable.

The net income received into the PSC is deemed as salary for the purposes of the company's corporation tax and the worker's income tax position.

As net income received matches deemed salary paid out there is no profit from which to pay any

of the company's other expenses. Hence such expenses would be incurred with no available tax relief.

There would be no distributable profits available from which to declare a dividend.

Unless the company has other non-IR35 engagements it is likely that the company vehicle is no longer serving its purpose. It may be that the company is then wound up and the worker applies to actually be taken on as an employee.

Or the PSC may decide not to engage in that type of contract with consequent further workforce impact across the NHS.

Next steps

PSBs and PSCs need to ensure appropriate contracts are in place that set out the actual basis on which the engagement is undertaken and to use the on-line checker tool to confirm whether that contract is inside or outside the IR35 rules.

If a PSC is supplying a worker that is deemed to be employed under IR35 there could also be VAT implications to consider. The supply of staff is generally a standard rated supply for VAT purposes whereas the supply of medical services is generally an exempt supply.

Historically HMRC has taken the view that a locum doctor is self-employed when they are standing in for an absent self-employed medical professional.

However there are now very many doctors in general practice under salaried employment contracts and HMRC has indicated that not all locums will automatically be viewed as self-employed.

The impact of this combined with the new IR35 rules for PSBs therefore affects PSCs used by locums.

Practices or doctors affected by the new rules should seek specific advice from their AISMA accountant.

Topical snippets from AISMA accountants

Six top tips for preparing and responding to a CQC inspection

Preparation for an inspection should be an ongoing process and not something you do shortly before the event, says **Rachel Birks**

Many GP practices now know what it is like being inspected by The Care Quality Commission (CQC). Clearly, the level of preparation that goes into the inspection from the practice's point of view varies considerably, and knowledge about the various stages of the process is also variable.

But if you prepare thoroughly you can have a real impact on the inspection outcome. And you also need to know how to respond if the inspection does not go according to plan and you want to challenge the outcome.

There are five key questions the CQC will consider on an inspection. These are:

- **Safe**
  Is the care that your practice delivers safe and are patients protected from abuse and avoidable harm?
- **Effective**
  Does the care, treatment and support given to patients achieve good outcomes, and maintain quality of life?
- **Caring**
  Do your staff involve and treat your patients with compassion, kindness, dignity and respect?
- **Responsive**
  Are your services organised so that they meet your patients' needs?

Well-led

Does the leadership, management and governance of your practice ensure that high-quality care is based around the needs of your patient population? Does it encourage learning and innovation, and promote an open and fair culture?

In order to consider these key questions the CQC will gather information from a number of sources.

It will consider local information that is collected continuously. This includes complaints and the information that the CQC are told by staff, carers and people who use services.

Information about your practice from the CQC's own records will be taken into account. Local and national data, which will include QOF data, will also be considered.

The final piece of the jigsaw is the CQC inspection, which includes observing care and looking at records and documents.

It is important that preparation for an inspection is an ongoing process, and not something you do shortly before the inspection takes place.

Here are six top tips to prepare your practice for a CQC inspection:

1 Consider what you want the CQC to know about your practice, the challenges that you face, what you do well and what you are most proud of. If the CQC inspectors don't ask you about these things then make sure that you tell them.

2 Be sure you can demonstrate that you meet the needs of your particular patient population.

3 See that you evidence the things your practice does well. Where you have staff meetings, are these minuted? Where peer reviews take place, are notes kept to reflect this? Does your complaints book reflect your complaints policy?

4 There will be scrutiny of QOF data by the CQC and how your practice compares with other practices both regionally and nationally. Have you scrutinised your data yourself? Have you looked at clinical indicators where you fall below the national average and do you have a strategy to improve your QOF data? Have you addressed matters such as high exception reporting?

5 Have you looked at the CQC's published examples of outstanding practice to identify what inspectors are impressed by and what you can introduce into your practice?

6 Make sure you consider making representations to the CQC if enforcement action is taken.

Once the CQC has sent you a draft report to consider, you can challenge the contents of the report during the factual accuracy stage.

Make sure you bear in mind this includes alerting the CQC to what is incorrect in the report but also what it has omitted. This is a vital stage of the process because although there is a later ratings review stage once the report has been published, any challenge to ratings can only be made on the basis that the CQC has not followed its own published guidance.

The scope to challenge the CQC at this stage is narrow so make sure you have included everything of relevance at the factual accuracy stage.

Our regulatory team can advise on compliance with CQC requirements and also on options if you receive a negative inspection report.

Rachel Birks is a professional regulatory partner at law firm Ward Hadaway

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* Deborah Wood is vice chairman of AISMA and a partner of Moore and Smalley LLP.

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