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AISMA Doctor Newsline

A helpful resource for the practice business

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Opinion 3
Whatever you do - keep your eye on the ball

Tax alerts 3
Watch out for tax pitfalls in 2011

Provider companies 5
Be sure to avoid a conflict of interests

You and your pension 6
Why some timely advice is needed

Make your resolutions a team effort

Happy new year! But be sure to hit it running and you will stand a better chance of surmounting the hurdles ahead, says **Kathie Applebee**

Back in April 2006 I presented a seminar entitled '2006 – a year of challenges'. The first slide provided the following list:

- The NHS Plan and how it affects primary care.
- Implications of the 2006 White Paper.
- New Quality and Outcomes Framework (QOF).
- New enhanced services, including practice-based commissioning.
- PCT reorganisations.

This was a formidable list but general practice weathered that year and the years since.

However, 2011 has a 'last chance at the OK Corral' feel about it that should banish any complacency.

English practices have to contend with preparation for GP-led commissioning and compulsory registration with the Care Quality Commission (CQC), while practices throughout the UK are facing financial pressures in addition to workload demands which seem to increase in inverse proportion to the availability of free time and surplus income.

For many, this will be a demanding but exciting year. Others, however, may hide behind ignorance or lack of interest in what is coming, preferring to use their current workload as an excuse for insularity.

While such an approach is understandable, it is of little help to those practices that may not be operating efficiently and who still need to address potentially costly problems within their core systems.

The first quarter of each year, which is also the last quarter of the NHS financial year, has probably been used in recent years for completing outstanding QOF work.

This year, practices may wish to use it for a form of spring clean so as to gauge preparedness for the

challenges ahead.

Although much of the work involved in meeting new challenges is likely to be done by a minority of a practice's members, it is important that the entire team is fully aware and at least nominally supportive. They may be required to fill their own roles and meet practice goals with less reminding, support and supervision than in previous years.

Ideally, practices will have systems such as the following already in place:

- Staff: contracts and job descriptions in place, appraisals and training plans completed, and staff handbooks and adherence to employment legislation up-to-date.

- Finance: robust systems for monitoring income and expenditure, and the regular analysis of cash flow forecasts and budget targets.

- QOF: outstanding work completed as early as possible rather than being left until March, and practice members able to function independently rather than having to be constantly reminded of requirements.

- Enhanced services: annual audits and returns ready to be done in a timely fashion, and all associated requirements met.

- Premises and equipment: documented adherence to fire and health and safety regulations, for example, and expenditure management systems in place for regular reviews of costs.

- IT: active training plans for new users, and a culture of seeking to develop each user beyond a 'bare minimum' level of expertise; and no reliance on paper systems, especially for vital functions.

- Data quality: data entry and extraction protocols which provide the practice with ready access to essential information, and expertise in monitoring indicative commissioning budgets.

- Governance: documented adherence to the requirements of clinical and information governance, financial probity and GMS/PMS contracts. An external standard, such as the RCGP Quality Practice Award, is good preparation for CQC registration. The CQC is said to be planning a 'light-touch' review of practices with this award.

- Patient-access systems: flexible appointments, alternative means of access, extended hours, and various forms of electronic access, including the ordering of repeat prescriptions.

- Recall systems for chronic disease management to provide a framework for the treatment of such patients rather than relying on ad hoc demand.

Practices may find it helpful to list any outstanding requirements, such as audits for enhanced services, on a year planner which can be either paper or electronic.

A further enhancement is to use one or more Gantt charts to show the deadlines, the time period allowed for the lead-in to these, and the need for certain activities to be completed before others can be commenced.

Committing the year's aims and challenges to some form of graphic display may help those team members who either distance themselves from such matters or else hope that these will not come to pass.

Having this essential workload on view, with specific dates and named people against each outstanding area or task, may help to galvanise those who are either apathetic or cynical about the challenges facing general practice in 2011.

Kathie Applebee, organisation psychologist for primary care, and strategic management partner at Tamar Valley Health Group Practice

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Opinion

Keep your eye on the ball in these changing times

Bob Senior, Chairman, AISMA

The Government's White Paper *Equity and Excellence: Liberating the NHS*, has massive implications for general practice over the next five to ten years.

But in reality it only sets out the bare bones of Government plans. It spells out the need for GPs to take charge of commissioning and to work in consortia, and much of GPs' attention has been focused on those points.

While the commissioning proposals will undoubtedly have an impact on GPs' working lives, and any failure to stay within budget will have a detrimental knock-on effect on QOF income, the potential for a financial upside is limited.

Unless practices become actively involved in providing additional services, and it is perhaps unlikely that all practices will wish to or be in a position to do so, then the best that can be hoped for is more work for the same money.

However, Government proposals go on to seek £20 billion of 'NHS efficiency savings' by 2014 and seek to abolish the roles of Strategic Health Authorities and PCTs. They also go on to seek to have one unified GP contract for 2013.

These proposals will undoubtedly affect GP practices.

A unified contract may well only be achievable if the current allocation formula is reviewed. The current rounds of aggressive PMS reviews, and the resulting massive cuts in funding that some practices have seen, suggest that the Minimum Practice Income Guarantee arrangements might not survive a new unified contract.

Premises funding has always been heavily reliant on PCTs and their predecessor organisations. If they are scrapped, is there a risk that premises funding might change? Might it be rolled into a new global sum funding formula?

Any changes to premises funding or the global sum funding could have a massive impact on some practices. The only way to hope to counteract some of these effects will be for practices to start improving their operating efficiency now.

While practices need to be involved in local discussions about commissioning and consortia they must not allow that to take their eye off the day job.

Commissioning will bring whatever commissioning will bring. Patients will still however be in front of you tomorrow. How efficiently you deal with them will ultimately determine how much money you take home.

Beware the icy tax track ahead

Watch out for those slippery tax pitfalls. **Tony Brand*** highlights some topical danger zones to be aware of

It is clear from the coalition Government's policy announcements that higher tax rates are here for the foreseeable future. So I would urge any GP who has not yet done so to sit down with their accountant and independent financial adviser (IFA) and review their own circumstances in 2011.

Topics might cover:

- Should I pay more pension contributions? (but see below!)
- If I do, will I get tax relief or a tax penalty?
- What structure (partnership or company) is right for our practice and our needs?
- Can I structure my non-practice income differently?
- If I do, will it affect my superannuation?
- Is my expenses claim realistic?

However it is easy to concentrate solely on tax planning and in doing so forget that there are many tax pitfalls just waiting to trip up unwary GPs – and cost them as much if not more than the rise in income rates.

The GP as employer

Pitfall 1: Gift vouchers

Another Christmas has just passed and many practices may have rewarded their staff with shopping vouchers. But not everyone is aware that the taxman treats these as any other pay or perk – they are taxable.

Strictly they are a benefit in kind, therefore they are disclosable in either form P11d or P9d at the end of the tax year. Failure to complete this form could result in a penalty.

But imagine how your employee will feel if, having given them a £50 voucher at Christmas, their tax code gets adjusted next summer to collect the £10 or £20 they owe in tax.

A more sensible solution is entering into a PAYE settlement agreement whereby the practice as employer settles the tax – it costs you more but it is considerably cheaper than a penalty and a disgruntled employee!

Pitfall 2: Locums

A tax case in 2010 could have a profound effect on the way HMRC regards locums. Tax inspectors will normally try to reclassify a locum as an employee if they believe the locum is akin to a salaried GP. The practice picks up the PAYE bill and it could be expensive if the locum has been 'in post' for a while.

One of the facets, or badges, of self-employment is the ability to send a substitute to do the work in times of absence and AISMA members have always advised practices to include a clause in any agreement with a locum that the locum must arrange a substitute if they cannot attend the session themselves.

The WeightWatchers case [Weight Watchers (UK) Ltd & Others v HMRC (TC367)] takes matters a step further because HMRC largely disregarded the existence of a substitution clause where the substitute is paid by the organisation, as in this particular case.

Therefore, to accord absolutely with this ruling: if a locum (Dr A) cannot attend but finds a substitute (Dr B) the practice should continue to pay Dr A, who should agree his own terms with Dr B and pay him himself.

Other areas

Pitfall 3: Selling the surgery premises – capital gains tax (CGT)

In his first Budget, Chancellor George Osborne increased Entrepreneurs' Relief (ER) to a lifetime limit of £5m and maintained the CGT rate for these gains at 10%. Non ER gains after 22 June 2010 are taxed at 18% or 28% depending on your income.

To qualify for ER a partner needs to be disposing of all or a major part of his business. Let us look at an example:

The Upside Medical practice is finally moving to a new health centre and the partners are really pleased – they can sell the old surgery and realise a gain of £300,000. All three partners own the surgery equally. They are all in their late forties so do not intend to retire just yet.

Q: What rate of CGT will they pay?
A: Probably 28% - not 10% because they are still in their original partnership – the partnership has not ceased but merely moved. No partner has disposed of their interest in the partnership, they have just sold an asset. So instead of an expected tax bill of £10,000 each they are facing £28,000.

If you are in this predicament consult an AISMA member – there may be a possible solution.

Pitfall 4: Pensions

While the Chancellor increased CGT allowances he reduced the Lifetime Allowance (LTA) on pensions from £1.8m to £1.5m. These could affect many high-earning, long-serving GPs such as dispensers.

Dr Jones (who on retirement will have achieved 40 years service with 35 years as a high-earning GP) has a pension review showing career earnings of £5m, giving a pension estimate of £70,000 a year. He also has a small personal pension with a fund value of £80,000.

His pension values are:

20 x annual pension = 20 x £70,000 =	£1,400,000
1 x lump sum	£210,000
Value of personal pension	£80,000
Total	£1,690,000

Excess

£190,000 x 55% = £104,500 (deducted from lump sum)

It is recommended that you review your pension position with your IFA - having first obtained the most up-to-date pension estimate that you can from the NHS Pensions Agency.

Remember this – your tax bill is not just about minimising income or maximising expenditure. It is about avoiding the pitfalls too!

● Pension number crunching produces a warning for GPs. See page 6

Take steps to avoid a consortia conflict of interests

GPs with provider companies need to seriously consider how they will handle conflicts of interest, warns solicitor **Andrew Lockhart-Mirams**

Entrepreneurial GPs were setting up provider companies, often quite small units, to offer services to PCTs within days of the launch of Practice Based Commissioning (PBC).

A wide range of services were covered, mostly comprising either fairly straightforward secondary care services which could be delivered in a primary care setting or some of the more specialist GP services, provided by GPs with Special Interests (GPwSIs).

Sometimes the services were provided in conjunction with hospital consultants but generally speaking Acute Trusts and certainly Foundation Trusts resisted there being any consultant involvement. They feared competition between the services on offer by the provider company and those available at the Trust.

In a limited number of cases Foundation Trusts actually threatened consultants with a breach of contract claim if they worked for or became shareholders in provider companies.

Strangely however, the early documentation on PBC from the Department of Health made no mention at all of the possibility of a conflict of interest arising between one or more doctors who were members of a PBC group and the same doctors who were shareholders in the provider company.

In fact over 12 months passed before the issue was fully identified by the Department although the potential problems had been addressed much earlier in documentation prepared by my firm for PBC groups.

From the very outset PBC has been dogged by having the wrong title because the most a group has ever been able to do is to act as a think tank, sending suggestions to the PCT as to how care pathways might be better improved or more economically provided.

It has always been and remains the responsibility of PCTs to commission services and although they are permitted to delegate such commissioning power we are unaware that delegation to a PBC group as such has ever taken place.

Notwithstanding this restriction, whereby only PCTs can commission, it is clearly improper that a person who has any influence over a decision made by a PBC group should subsequently benefit financially from that decision if a contract were awarded by a PCT.

Declarations

PBC rules should provide that anyone interested in a provider group being considered for the supply of services should retire from the room and take no part in the decision.

At the start of any annual session a declaration of interest should be made to the members of the PBC group setting out all interests that could give rise to a conflict and the chairman of each meeting should call for declarations of possible conflict in respect of any business that is tabled for discussion.

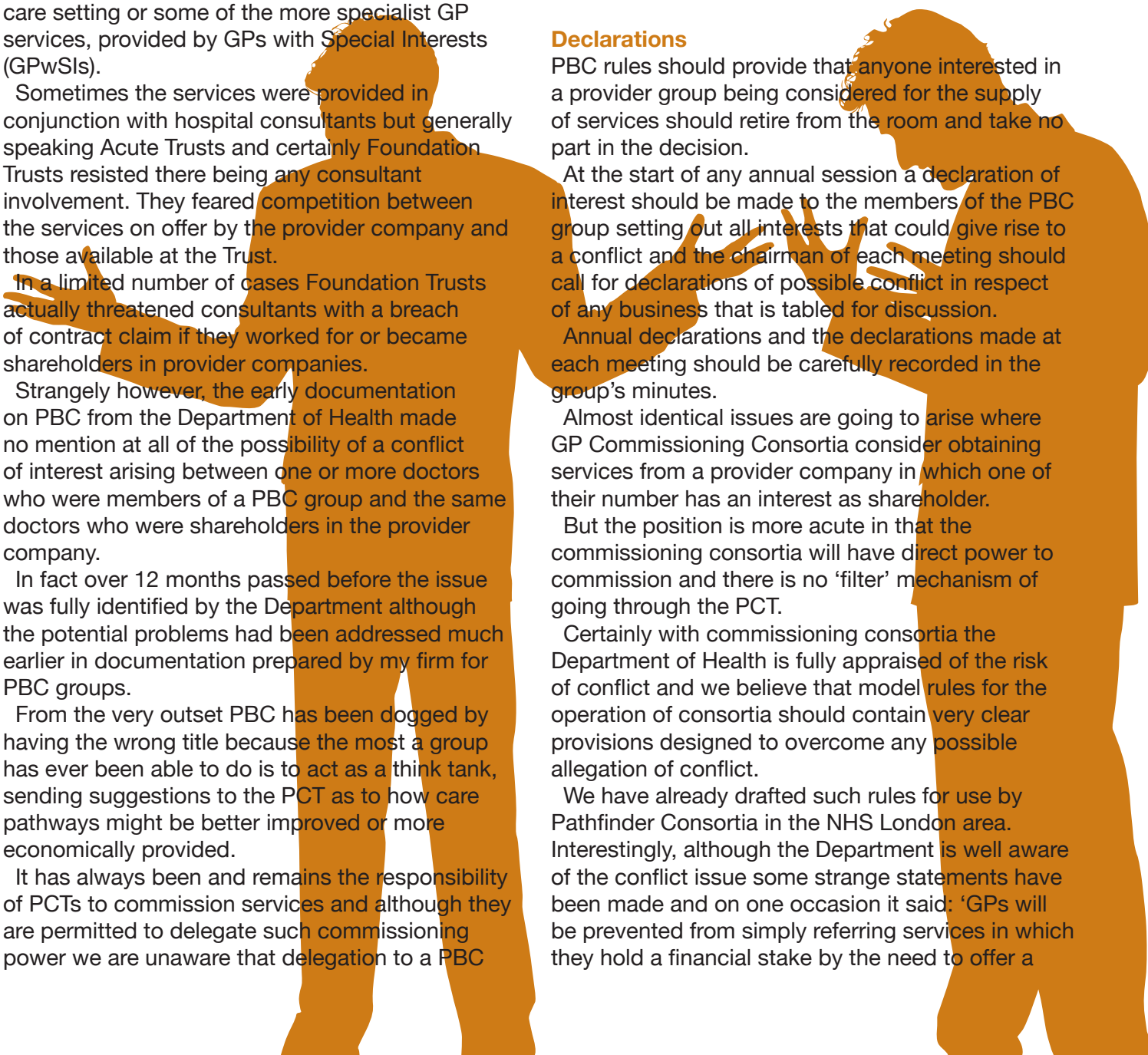
Annual declarations and the declarations made at each meeting should be carefully recorded in the group's minutes.

Almost identical issues are going to arise where GP Commissioning Consortia consider obtaining services from a provider company in which one of their number has an interest as shareholder.

But the position is more acute in that the commissioning consortia will have direct power to commission and there is no 'filter' mechanism of going through the PCT.

Certainly with commissioning consortia the Department of Health is fully appraised of the risk of conflict and we believe that model rules for the operation of consortia should contain very clear provisions designed to overcome any possible allegation of conflict.

We have already drafted such rules for use by Pathfinder Consortia in the NHS London area. Interestingly, although the Department is well aware of the conflict issue some strange statements have been made and on one occasion it said: 'GPs will be prevented from simply referring services in which they hold a financial stake by the need to offer a



full choice' (Andrew Lansley, Secretary of State for Health - 3 November 2010).

While a full choice for patients is clearly desirable it is not understood how offering a full choice is any prevention from undesirable conflicts of interest arising. *Pulse* recently identified that 25% of GPs were already involved in provider companies/units of one sort or another and this percentage is bound to increase as more GPs turn to additional provision to provide more income as the core contract comes under further pressure.

Apart from the possibility of purchasing conflicts, GP Commissioning is also going to raise a further raft of conflict issues which may require difficult explanations for patients.

Undoubtedly searching questions will be raised by patients as to why consortia may not be affording the cost of certain treatments when it is known to the patient that savings could be reflected in premium payments made to a consortium.

This is quite apart from numerous 'postcode' difficulties that will arise where a different range of drugs or treatment are available in adjoining consortia areas.

Conflicts of interests have always been a difficult topic and it is certainly one that is not going to go away.

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Time to take a hard look at your pension

Number crunching of GP pension figures indicates many doctors have some serious thinking to do ahead of April next year, warns **Andrew Goddard****

Restrictions on the tax relief available on pension contributions for individuals who, like many GPs, earn over £150,000 a year were announced by the last government.

It aimed to prevent the use of pension contributions to avoid or mitigate the impact of the new 50% tax rate. The rules were extremely complex and the coalition Government has acknowledged that they were too complicated to be workable.

But the simplified rules could affect those earning less than £150,000 a year.

Annual allowance

From 5 April 2011, every individual will have an annual pension allowance of £50,000. If your pension saving is more than the annual allowance you will pay a tax charge on the amount over the annual allowance, regardless of your total income.

This rule is clear-cut where contributions are made to a private pension scheme but are far more complicated where contributions are made to a defined benefit scheme, such as the NHS Pension Scheme.

For a defined benefit scheme, the amount of the 'pension saving' is not the amount of pension contributions paid in the tax year, on which tax relief is claimed. Instead, the pension saving is based on how much the value of the pension you expect at the end of the period (i.e. 31 March 2012 for the NHS Pension Scheme) has gone up compared with what it was at the start (i.e. 1 April 2011).

These expected values are calculated by multiplying by 16 and adding the anticipated lump sum; the value at the start of the period is uplifted for inflation, as measured by the Consumer Prices Index (CPI).

Assuming dynamisation equal to CPI, a GP in the

1995 Section of the NHS Pension Scheme without any other pension arrangements would be affected by this rule if his or her pensionable earnings were in excess of £187,970 a year.

The increase in pension would be 1.4% x £187,970 = £2,631.58 a year; and the increase in lump sum would be 3 x £2,631.58 = £7,894.74. So the total increase in the pension saving would be £2,631.58 x 16 plus £7,894.74 = £50,000.

Assuming dynamisation equal to CPI, a GP in the 2008 Section of the NHS Pension Scheme without any other pension arrangements would be affected by this rule if his or her pensionable earnings were over £167,112 a year.

However, if dynamisation were at a higher rate than the increase in CPI, the level of pensionable earnings at which the pension saving exceeds £50,000 would be less than the above thresholds. The impact is greater the longer the GP's service. For illustration, consider a GP in the 1995 Section of the NHS Pension Scheme, without any other pension arrangements. He or she has 10 years' service with average dynamised earnings of £160,000 a year.

Assume dynamisation is 1% above CPI. The expected value at the start of the year would be £160,000 x 10 x 1.4% x (16 + 3) = £425,600. The expected value at the end of the year excluding the effect of the year's contributions would be £425,600 x 1.01 = £429,856, an increase of £4,256.

If this is added to the effect of the year's contributions (£160,000 x 1.4% x (16 + 3) = £42,560), the total pension saving is £46,816, which is still below £50,000.

By contrast, if the same GP had 30 years' service, the expected value at the start of the year would be £160,000 x 30 x 1.4% x (16 + 3) = £1,276,800. The expected value at the end of the year excluding the effect of the year's contributions would be £1,276,800 x 1.01 = £1,289,568, an increase of £12,768.

If this is added to the effect of the year's contributions (£160,000 x 1.4% x (16 + 3) = £42,560), the total pension saving is £55,328, which is above £50,000 and will therefore give rise to a tax charge on the excess.

It is clear from the above analysis that the threshold for the new tax charge will reduce as length of service increases.

As the £50,000 annual allowance covers all pension schemes, the earnings threshold for the new tax charge will also be lower for GPs who have private pension schemes in addition to their membership of the NHS Scheme.

Fortunately, you will not be required to calculate the pension saving within the NHS Scheme. If you ask your scheme administrator for a pension savings statement, it is proposed that they should give you this by the later of:

- 6 October following the end of the relevant tax year; or
- three months after receiving your request.

It has not yet been announced how this will work for GPs, where the expected value of the pension will depend on the submission of the Certificate of Pensionable Profits, the deadline for which must fall after the tax return deadline, which is considerably later than 6 October following the end of the relevant tax year.

Lifetime allowance

HMRC has announced that the Lifetime Allowance (LTA) will reduce from £1.8m to £1.5m and it is proposed that this further change will take effect from April 2012. The final details of how the LTA change will be implemented, including any transitional protection for those who will have accrued benefits based upon the £1.8m limit, are still under consideration.

The LTA is normally applied at the point at which benefits come into payment, and it is a limit above which any excess benefit received is subject to a specific tax charge.

For GPs, the value of the NHS pension for LTA purposes is equal to 23 times the annual pension. Again, the value of any private or other pension must be added to the value of the NHS pension when calculating whether the LTA has been exceeded.

A GP in the 1995 Section of the NHS Pension Scheme without any other pension arrangements and with 40 years' service would exceed the LTA if average dynamised earnings were to exceed £116,460 a year. This is clearly likely to have a more widespread impact on GPs than the changes to the annual allowance.

Subject to any transitional protection rules that may be announced, GPs who expect to exceed the proposed LTA of £1.5m should consider whether or not it would be beneficial to take their benefits before April 2012, when the reduction in the LTA takes effect.

GPs should seek appropriate advice from a specialist medical IFA to consider whether or not it would be beneficial to take their benefits before April 2012, when the reduction in the LTA takes effect, or to consider other methods to mitigate the potential charge.

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