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AISMA Doctor Newsline

A helpful resource for the practice business

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Tips to cut your tax and save you hassle

The new financial year starting this month will do GPs' finances few favours. So here is a round-up of useful tips from **AISMA members*** to help ease your tax burden in the months ahead

1 Use a credit card for personally purchased practice expenses. The account should be used purely for that purpose and repaid monthly – but it will record accurately and free of charge the expenses for your accountant and the tax man.

2 Review the spread of income between yourself and your spouse or partner to ensure personal allowances and lower rates of tax are used wherever possible, especially in the light of tax at 50%.

3 Be prepared for a possible uplift in tax next January which may coincide with a reduction in income. Calculate your tax liability for 2010-11 as soon as possible as the loss of the personal allowance and a 50% tax rate may increase the January tax payment to a higher than normal level.
New tax bands and allowances took effect from April 2010 but the self-employed earner who pays tax by six-monthly installments under Self Assessment may not yet have felt the effects of those changes.
Higher paid GPs particularly should be prepared as they may then face the double whammy of a higher-than-usual balancing payment for the previous year and a bigger interim payment for the current year.

4 Review claims for use of home as these are often the cause of a tax inquiry. Payments to a spouse must be justifiable, and actually paid. Ensure you are paying a reasonable rate for the work done.

5 Keep details of professional mileage to support claims. To assist with preparation of your claim complete a 'mileage log' for a representative period of time, detailing all business mileage.

This enables an accurate calculation of a private percentage use of your car and provides evidence to justify a claim made on your tax return. And it will also help if the HMRC makes an inquiry into the return.
A mileage log should preferably be kept all year round but at least for a minimum period of, say, two months a year in order to support the business use proportion. In most circumstances it is not acceptable to claim a rate per business mile travelled, and accurate records of costs incurred must be kept.

6 Reassess your year end – with profits dropping this could be the time to change June year ends to March year ends, although with the threat of new superannuation deadlines, it might be tempting to keep June year ends.

7 Consider incorporating if your PCT will accept your practice becoming a company, or take advice to consider possible benefits of a corporate partner to shelter at 20% any profits not available for drawings, for example loan repayments. Incorporating a core GMS/PMS practice can significantly reduce the partners' superannuable earnings and therefore their final pension. The decision needs to be made not just from a tax point of view but also from a pensions point of view, possibly in conjunction with a specialist IFA. Note that a GMS contract cannot be held by a partnership that includes a corporate partner.

8 If you are a higher earning GP is it worth working harder? If you are a 50% taxpayer paying maximum added years with pension contributions that are not getting tax relief, you are only taking home 16.5% of any extra NHS earnings.
Okay, in that situation you may be able to take 24 hour retirement or leave the NHS scheme or convert the income into non pensionable by putting it through a company or LLP (for OOH work for example). But if you just carry on as before, it is really not worth the extra effort.
If you are not such a high earner you could theoretically be paying even more if you fell into the band which effectively means 60% tax (between £100,000 and £114,900 for 2011-12) but it is less likely in that situation that you would be paying too much in pension contributions. If in doubt, talk to your accountant about how much net you will get for any additional income, before deciding whether to take on extra work.

9 Ensure that you and your partners provide the necessary information to your accountant in a timely manner so that your tax returns can be submitted on time and the liabilities can be established well before the due dates.

10 In the event of an HMRC inquiry, accountancy fees can soon mount up but it is possible to buy an insurance policy to cover them. If a practice policy is purchased, this will often include cover for the tax returns of the individual partners and their spouses, provided that non-practice earnings are within certain limits.

11 Other than working fewer hours there are still a number of strategies that can be applied to reduce taxable earnings. These include taking advantage of the currently more generous capital allowances regime in respect of capital expenditure, purchasing environmentally friendly equipment and cars, rearranging borrowings to maximise tax relief and making Gift Aid contributions.

12 Take care with electronic PAYE payment dates. Many employers have taken advantage of the electronic payment option which generally gives an extended date for the payment of PAYE of 22nd of the month.
But where the 22nd falls on a non banking day, the payment may need to be made earlier to ensure that

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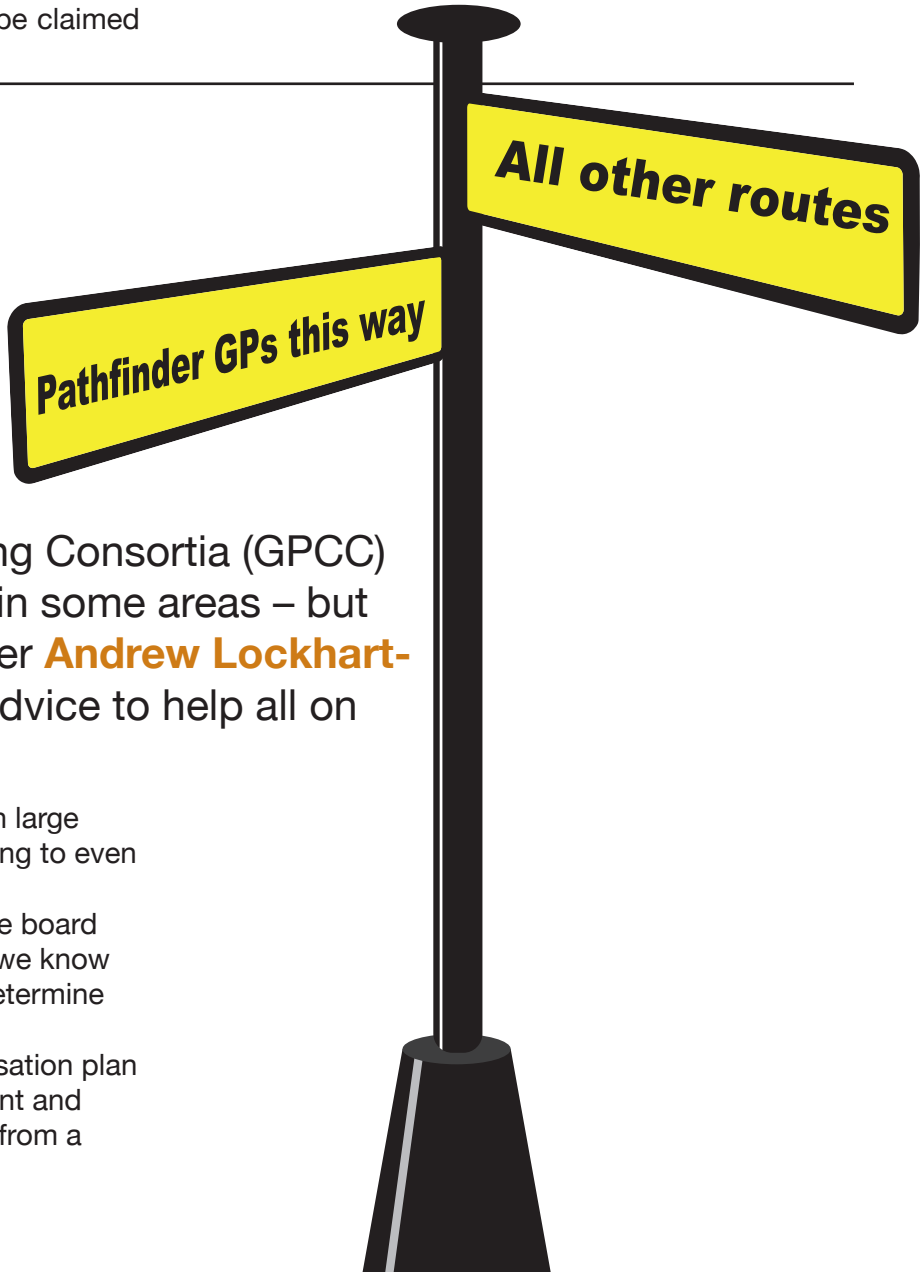
HMRC has cleared funds by the last bank working day before that date.
Two important dates arise early in the new tax year. Good Friday falls this year on Friday 22 April 2011. As this is also the last payment date for 2010-11 PAYE, it is important that the cleared payment is received into HMRC's bank account by Thursday 21 April 2011.
Then, in the next month, the 22nd falls on a Sunday. You must ensure that cleared funds reach HMRC's bank account by Friday 20 May 2011.
HMRC may issue penalties to any employer who makes late payments of PAYE more than once in a tax year. These penalty notices will not be issued until after the end of the year.

13 When a GP retires and sells his share of the practice premises he or she should be able to claim Entrepreneurs' Relief to reduce the capital gains tax payable on this to 10%. But there are several pitfalls associated with being eligible to claim this relief:
The relief is not automatic and needs to be claimed on or before the first anniversary of the 31 January following the year in which the disposal is made.
The disposal of the property must be made within a three year period beginning with the date of retirement or cessation.
If a retired partner receives rental income for the property after he/she retires but before he/she sells the property, then Entrepreneurs' Relief is restricted.
If practice A sells its premises and merges with practice B to practice in new premises, the partners of practice A will not be able to claim Entrepreneurs' Relief on the sale of their original premises. This is because the partners are not ceasing or significantly reducing their trade.

14 Consider investing in Venture Capital Trusts (VCTs). There is upfront income tax relief of 30%, meaning a £10k investment would reduce that year's income tax bill by £3k. Annual dividends are free of income tax and when the VCT shares are sold there is no capital gains tax to pay on any gain arising.

Ease your pathfinder journey



Pathfinder GP Commissioning Consortia (GPCC) are already well established in some areas – but others have problems. Lawyer **Andrew Lockhart-Mirams** gives some timely advice to help all on their way

It is becoming increasingly obvious that in large parts of the country consortia are struggling to even get off the ground.

Issues such as electing the first executive board have caused problems and in two cases we know of, GPs have been holding elections to determine how to elect their leaders.

In some places the lack of a clear mobilisation plan is leading to feelings of disenfranchisement and confusion where, for example, eight GPs from a

locality have to take time out of their practice work to attend meetings on how to elect a committee or executive board to take matters forward.

GPs expressed concern at a recent Pulse seminar of partners' unhappiness with their involvement in the consortia process as they are unable to dedicate all their time to their practice work, leaving them in a dilemma as to what to do.

Others have expressed concern regarding the lack of openness and absence of information from emerging consortia.

In some cases the commissioning systems which have already been established have failed to involve GPs in the consultation process. That has led to a breakdown in communication and doctors' unhappiness at how their locality has dealt with the issues.

Without doubt there is a need for detailed guidance on how the election process should be managed to cover the arrangements up to 1 April 2013. Fortunately our legal team has been able to advise a number of putative GPCCs about this.

Interestingly, NHS London - leading on mobilisation and pathfinders in the capital area - is tendering for consultants to work in a leadership and organisational support programme. There appears to be a strong recognition here that the GP leaders who are chosen locally will need a great deal of help as they will not necessarily be the leaders who would have come to the top of the pile with modern employment and psychometric testing.

The core team

Once a core team has been established it is necessary to develop a set of rules that will govern the operation of the putative/pathfinder consortium in the period up to 31 March 2013. From 1 April 2013, consortia will take the form of statutory bodies - a corporate body expressly established by statute to carry out a specific purpose. Their duties and powers will be conferred by and limited by that statute. Consortia cannot take the form of companies limited by shares or guarantee.

It was clearly stated in last July's White Paper that the Government will devolve power and responsibility for commissioning services to GPs and their practice teams working in consortia.

Practices will be given flexibility to decide how to form consortia in ways they think will secure the best healthcare and health outcomes for their patients and locality. GP consortia will need a sufficient geographical focus but will be able to choose the size most appropriate for them to manage financial risk and allow for accurate allocations.

They will be free to decide what commissioning activities they undertake for themselves and which they wish to buy in support from external organisations. So as well as the 'must do's' there is flexibility to be creative.

Delegated commissioning

But what is far less clear is the status of putative/pathfinder consortia in the 'shadow' period up to 31 March 2013. They will be expected to work with other health and care professionals and in partnership with local communities and local authorities.

This work will focus around gradually assuming delegated responsibility for commissioning, although PCTs will remain legally responsible. Any delegated power is exercised on behalf of the PCT by quasi officers. They will owe duties of care to the PCT to exercise delegated powers in its best interests.

But these obligations could put practitioners in conflict with their work and aspirations as members of putative/pathfinder consortia. Any practitioner exercising delegated authority should in my view obtain a full set of indemnities from the PCT in respect of their commissioning work.

Pathfinder format

Some have suggested pathfinder consortia should form as companies limited by shares or guarantee. But as these vehicles will have to be dismantled as they will have no further use after 31 March 2013 the reasoning for this is unclear.

If former PCT staff are employed then issues will arise under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) and there will be considerable difficulties on taking over or providing comparable NHS Pensions.

Similar TUPE difficulties will arise on the further transfer of staff to consortia in statutory body form, although the pension position should be secure as it is understood the statutory bodies will be NHS employing authorities.

Given that pathfinders will be assisted by PCT staff in the development phase I suggest the best solution is to let pathfinder members stand as unincorporated associations who are, so to speak, 'in training' or understudying for the roles that they will eventually take in statutory form. If PCT staff are seconded to work for consortia it is essential that proper secondment agreements are put in place.

Finance

Inquiries made of Lloyds TSB indicate that it is

perfectly acceptable for bank accounts to be opened in unincorporated association form. This will give the pathfinder group the ability to use the development funding for clinical backfill, training and organisational development.

One difficulty with the development funding of £2 per patient is that it will not come on stream until 2011-12 and so it is unlikely that any pathfinder GPCC will see a first draw down until mid May at the earliest.

This is placing many in great difficulty. Some are 'borrowing' unspent PBC funding. But there have to be concerns about this as entitlement to this money rests in accordance with agreed PBC arrangements which may, for instance, relate to an area and to member practices that are not the same as the area/practices to be represented by the GPCC.

A further finance issue that is causing concern is the use of a practice's 'No 2' account to hold such funding – usually PBC monies – as is available.

Almost certainly the signatories to such an account will be the practice partners. If all is happy in the practice there is no more than a theoretical concern.

But if a partnership dispute arises the situation could very quickly become impossible and certainly so if one dissatisfied partner seeks to freeze all the bank accounts!

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Why GPs cannot afford any consortium inertia

Your choice of consortium can have a big effect on your practice and its income. **Kathie Applebee** looks at the issues

Practices in England are facing a period of unprecedented uncertainty as the NHS political landscape shifts and reforms nationwide.

Meanwhile, practices in Scotland, Wales and Northern Ireland are watching with interest due to their history of often taking on subsequent adapted versions of English-piloted changes.

The uncertainty and the changes are varying from area to area, with historical and geographical influences playing their parts. In some parts of the country, consortia are being formed in what appear to be PCT replications, whereas other places are taking the opportunity to establish new alliances.

Geography is resulting in some being constrained while others spill across previously sacrosanct county boundaries.

The degree of practice involvement also varies, from those that are fully engaged to those who are apparently pretending that nothing is happening.

There are also differing views about the timescales involved: some feel that 1 April 2013 is sufficiently far-away to be of little concern, whereas others (myself included) are acutely aware of the need to set up shadow consortia by 1 April 2012 – less than a year hence.

Full implications

The full implications for practices are not yet clear, with uncertainty still remaining at the time of writing regarding the funding of GP premises and computer systems, and further information due on the 10-15% of practice income predicted to be linked to commissioning outcomes.

Such uncertainty only makes it more, rather than less, important to pick the right consortium for this voyage into the unknown.

What is the right consortium? The GPC has issued guidance on sizes, giving the advantages and disadvantages of the various permutations.

The form and structure of GP-led commissioning consortia points out the economies of scale needed to manage and run a consortium which has not only to manage commissioning but also to take on

a wide range of duties and responsibilities currently managed by PCTs.

However, size is not everything and the cohesion and leadership of the consortium is of equal importance to its size-related viability.

Here, complications may arise in multiple formats. There are two common ones to note. One is former practice-based commissioning (PBC) representatives morphing into GP-led commissioning roles without other GPs and managers becoming truly involved.

The other is, conversely, PBC representatives feeling that they have reached the end of their capacities and wishing to hand on the baton to a new group who may be hesitant to volunteer for novel roles.

The implications of either type of involvement include practice members needing to be freed up to participate in developing the new consortia.

In a small consortium, the workload may be such that even small practices may be called upon to provide some representation. In large consortia, such practices may feel themselves distant from events and choose to leave it to others to do the work.

Either extreme of size poses potential problems, but it may not be possible to opt for a compromise, mid-range configuration.

Because the activities of a consortium will have a direct influence on its practices – on their referral and prescribing patterns, and ultimately on their practice income – leaving it to others to establish the structures and set the strategy may be risky.

Even the uninterested are advised to keep abreast of local developments because they cannot afford to remain aloof from the ways in which their chosen consortium may affect their future development and income.

- *The form and structure of GP-led commissioning consortia (GPC) http://www.bma.org.uk/images/whitepapergpcguidance5nov2010_tcm41-201578.pdf*

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

Building for a profitable future

GP premises should not be forgotten during such a big time of NHS change. **Chris Johnson** takes a look at things to consider

Good surgery premises can help GPs meet the new demands they face and earn additional income too.

With patients able to choose which surgery they want to attend, practices should consider practical improvements to ensure their premises appeal and meet patients' needs.

Even small changes such as a regular programme of internal maintenance can have a huge impact on perception and improve patient experience.

Other changes worth considering include number and size of treatment rooms and improving access. Premises' improvements not only help GPs provide better services but should also have a positive impact on the perception and value of the surgery. This in turn can have a positive impact on income through the rent reimbursement received.

Under the current system, GPs who own their own premises are reimbursed by their PCT through one of two ways - cost rent or notional rent.

Cost rent is more closely associated to the costs involved in building or extending GP surgeries, as opposed to the associated rental levels. Its purpose was to reimburse the cost of finance from providing new or considerably modified buildings.

But many doctors and practice managers may not know that after the first few years of receiving

cost rent they could receive a higher level of reimbursement if they were on notional rent. If a practice is on cost rent, I would recommend they request a current market rent (CMR) review triennially. It may be financially beneficial to move over to notional rent to ensure equity is maximised.

This investigation does not mean just getting the district valuer's opinion but rather having it valued and negotiated by experienced chartered surveyors.

The surgery is not obliged to move from cost rent but once the transition has taken place the surgery cannot elect to move back. If doctors are unhappy with the new notional rent figure they must be explicit in not accepting it, even if they initially request to move from cost rent.

Also remember that when outstanding finance has been paid off under the cost rent scheme, the PCT must be informed and the surgery must move onto notional rent. Failure to do so may result in the PCT clawing back money.

With notional rent, triennial reviews are done to assess the current level of rent. It is very important to get a chartered surveyor's professional advice to check the figure is correct. District valuers often make mistakes and GPs could lose out on valuable income, equating in many cases to five-figure sums.

If GPs ensure they get the correct rent level it should:

- Positively impact on the surgery's capital value.
- Allow for greater expenditure on the premises.
- Allow for quality improvements to be made, meaning greater patient experience.

In surgeries with surplus space, GPs/landlords could consider renting to a complimentary service such as pharmacy, optician, or physiotherapist, which would help turn the surgery into a one-stop-shop. But get advice before agreeing leases to ensure maximum benefit. The rent received may exceed the equivalent rent reimbursement for that space from the PCT, creating extra income.

Of course, extension or development work can be considered if a practice wants new premises which are designed specifically to meet their needs. But do be sure to send a full business plan to the PCT for approval before you incur any unnecessary costs.

Also note that property owners frequently miss out on the opportunity to claim valuable capital allowances when they acquire or develop new premises. This is because qualifying plant and machinery may not always be immediately obvious.

Specialist surveyors can make a detailed inspection to ascertain the value and can work with the doctors' accountants to prepare a capital allowances claim.

Lastly, from 1 April 2012 all 8,500 GP practices in England will need to register with the Care Quality Commission. Practices must be able to demonstrate compliance of 16 standards in order to maintain their registration which includes the safety and suitability of premises.

They must ensure service users are protected against the risks of unsafe or unsuitable premises. Factors to be considered by the practice include:

- Suitable design/layout.
- Security.
- Maintenance of the premises and surrounding grounds.
- Compliance of legal requirements relating to the premises.

Practices requiring advice before the registration applications open from October 2011 onwards should seek advice from a professional company.

Chris Johnson works for GP Surveyors, providers of a range of surveying and consultancy services for GPs