



# Medical Update

from the experts at *FK* Medical

Issue 4 March 2008

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### \*\*\* STOP PRESS \*\*\*

Budget speech 12th March – visit our website [www.fkca.co.uk](http://www.fkca.co.uk) for the latest updates.

We'll discuss how GPs will be affected in future issues.



## Notice to Readers

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## 10 Steps to Better GP Finances

*With a challenging year ahead for practice's finances, ten AISMA members offer their advice on how GPs can keep things on an even keel.*

### 1. Draw up a budget

Prepare a budget for the forthcoming year and refer to it regularly to compare your actual results with those you predicted. Keep a spreadsheet detailing the enhanced services you should be getting paid for and make sure that the payments are actually made. This should also result in you becoming aware of any overpayments. Paying it back may be painful but at least you will be prepared.

**Liz Densley, Honey Barrett**

### 2. Monitor PMS income

If you are a PMS practice, monitor your income carefully since payment for enhanced services is not always made correctly. Changes in your list size or the services your practice provides must also be reviewed regularly. You should not leave your accountant to question income sources at the time they are preparing your practice accounts. PMS practices are sometimes lulled into a state of 'security' since their income is pre-determined by a budget. Do not forget that enhanced services and incentives must be claimed.

**David Clough, Charles Rippin & Turner**

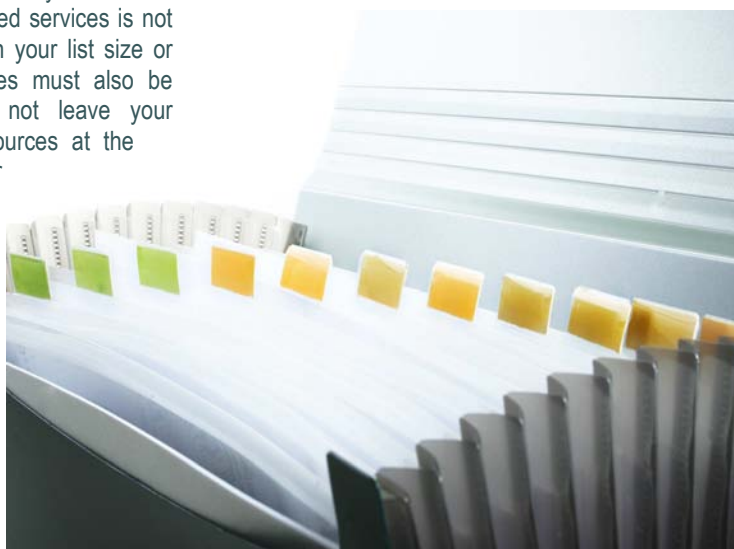
### 3. Plan strategically

Practices with a strategic plan that

shows where they want to be and how to get there have a better chance of succeeding. Here are some tips on how to start the process:

- To plan properly all partners and key managers need to meet. The hardest part of the exercise is recognising that you all need to invest your time in doing this
- A facilitator can guide the discussion (a number of professionals offer this service). The session should certainly not be a lecture and may not even have a formal agenda
- Participants must write down their personal objectives before the session. The practice should be run to help meet, not conflict with, the broad thrust of these objectives

*(Continued on page 2)*



# 10 Steps to better GP finances (continued)

- Consideration needs to be given to, amongst other things, income, workload, risk and retirement plans
- Partners need to have similar personal objectives, otherwise the practice will be pulled in different directions. Once personal objectives are established, practice objectives can be discussed and set
- The principal objective must be the practice's ongoing purpose. You will need to look at: structure; sources of income, existing and future; work/life balance; needs and resources
- You should also look forward and consider: changes to services; staff skill and numbers; relationships with PCT, patients, staff and the local community
- The outcome of the meeting should include an action plan and regular follow-ups so that implementation can be prioritised and monitored.

**Anthony Brand, HW Chartered Accountants**

## 4. Collaborate with local practices

Work with, rather than competing against, other local practices so that patients and doctors can all benefit from new initiatives. Without a strong local cluster, external organisations could encroach onto your patch and the benefits will go primarily to their shareholders, not you. You may have to accept that you cannot maintain the levels of control that you enjoy in your own partnership. There are simply too many practices involved in a cluster for everyone to have control.

**Debbie Wood, Moore & Smalley LLP**

## 5. Plan for year-end paperwork

Help your practice manager at the end of the practice financial year by allowing enough time to reconcile the bank account and to collate the information and records required by your accountant. This will help your practice manager meet a pre-agreed timetable to deliver information to your accountant, enabling an accounts review meeting relatively soon after the year-end.

**Chris Howe, Foxley Kingham**

## 6. Private income and personal expenses

Are your documents for your personal affairs in order? Or do you simply empty the contents of your filing cabinet into your accountant's lap each year and pay them to sort them out? If so, you could resolve to save yourself some money by becoming a bit more organised. If this sounds too much of a challenge, at least keep your paperwork for private income and personal expenses separate from everything else. Buy yourself a box file and put everything related to private medical income and personal expenditure in it. To help your accountant even further (and to therefore reduce the time they spend on your affairs), sort your paperwork into categories at the year-end. These could include income; motor expenses; mobile phone bills; utility bills if you are claiming 'use of home' allowance; books and equipment; subscriptions; and course fees. The most efficient doctors hand their accountants a fully itemised, typed list of personal affairs at the end of the year with a file of supporting paperwork.

**Fiona Wood, Page Kirk**

## 7. Avoid missing out on pension tax relief

First ensure that all GP superannuation certificates have been

submitted to your PCT by the 28<sup>th</sup> February deadline. Then check the March GMS/PMS statement from the PCT carefully to ensure that the actions required have been followed through. If a GP is due a refund, has it been credited? Have underpayments for other GPs been picked up? For a practice that has been making relatively small payments on account for superannuation, this could turn out to be quite costly if the balancing payment has been missed by the PCT. This is because tax relief is only given in respect of superannuation that has actually been paid in the fiscal year. If you check the statement quickly, there should be time to send a cheque to the PCT to ensure that the payment is made before 5<sup>th</sup> April and, therefore, that the tax relief will be available in the correct year.

**Laura Wilkinson, Sanders Swinbank**

## 8. Save on accountancy fees

Avoid paying unnecessary fees and speed up the advice coming from your accountant about tax liabilities and pension contributions by submitting details of your personal expenses to your accountant at the same time as the practice records.

**Luke Bennett, Winter Rule**

## 9. Update partnership agreement

Resolve to finally get down to preparing or updating the partnership agreement that you have been meaning to do for ages. Disagreements with former partners where there was no partnership agreement, or where it was out of date, only benefit the lawyers involved in untangling the mess. The time and emotional costs are even greater than the huge financial costs.

**Pauline Scott, Condie & Co**

## 10. Make the best use of your accountant

Use a specialist medical accountant and value them as a professional financial planning partner, sharing with them your financial and business goals for the year ahead. You will not get the best value from your accountants if you view them simply as paid assistants, used to satisfy Her Majesty's Revenue & Customs. Your accountant can advise you on new ideas for making your practice more effective. Here are some tips to help run things smoothly:

Ask your accountant for a data input spreadsheet so a personal balance sheet can be prepared for you and your spouse or partner as at 1<sup>st</sup> January. You can then monitor the net value of all your assets and liabilities and the future annual movement in their net values.

Ask your accountant to review the Wills for you and your spouse or partner. These can then be updated to allow for the latest inheritance tax planning opportunities.

Review your personal balance sheet and goals with your accountant to plan the various ways in which you can reduce your tax and, where possible, claim back tax paid in the previous three years.

Review your investments with your accountant to maximise the opportunities for capital gains relief before 5<sup>th</sup> April 2008 and then in the remaining months of 2008.

Complete your personal income and expenditure details for your accountant by 30<sup>th</sup> June, using any input spreadsheets provided.

**Michael Ogilvie, OBC The Accountants**

# Topical Bits and Pieces

As so much is happening in the medical profession, we thought it appropriate to raise a number of issues that we have recently come across in practice which will be of interest to GPs.

## PCT Mergers

There can be little doubt that restructuring of PCTs has caused confusion, delay, and error, and GPs are advised to be particularly attentive to all financial schedules emanating from their PCT. One AISMA member was confused to discover that a three partnered practice received £70,200 from QOF in 2006/07 compared to £63,300 in 2005/06 and yet the points achieved had fallen from 970 to 815 respectively. On further investigation it was discovered that the clinical domain elements of the 2005/06 QOF had been calculated at 520 points multiplied by £75 per point to arrive at £39,000. Of course the calculation should have been at the higher rate of approximately £125 per point for that year. There was therefore an underpayment of £26,000. On taking the matter up with the PCT the latter argued that they were not liable to repay the £26,000 as the PCT at the time no longer exists and 2005/06 finances had been "signed off". No doubt a friendly solicitor has now reminded the PCT of its common law obligations on merger and recovered the amount outstanding.

## Practice Errors

Recently, a four partnered practice recruited a new practice manager. They also changed their accountants to an AISMA member at the same time. Between them they discovered that the previous practice manager had failed to submit forms FP10 to the PCT, being the claim for reimbursement of drugs purchased for personal administration. This had occurred for at least three years. In particular, the practice had failed to claim reimbursement for the cost of flu vaccinations for two years. The new practice manager negotiated with the PCT in respect of these back claims and was met with a rejection on the grounds of clause 17.15 of the Statement of Financial Entitlements which states that payments are only payable if the contractor has:-

"noted, counted and sent all prescriptions in respect of drugs or appliances in respect of which it wishes to claim reimbursement to the PPA, Bridge House, 152 Pilgrim Street, Newcastle upon Tyne, NE1 6SN, not later than the 5<sup>th</sup> of the month following the month to which the prescriptions relate".

Furthermore it was argued that PCTs do not have the facility to carry over funds from one year to the next. The AISMA accountant referred the practice to specialist solicitors and the BMA, and at the time of writing the matter is not yet resolved. It is worth pointing out that flu vaccinations are not administered by way of prescriptions and therefore clause 17.15 may not apply in this respect. It is also worth pointing out that one PCT made an error in respect of contract pricing on all their practices within the PCT, in that in 2004/05 they double counted the amount of employer's superannuation to go into the global lump sum. Of course, they felt they were at total liberty to claw this back in 2006/07 and 2007/08 once the error was discovered. Referring back to drug claims, GPs are reminded that the PPA reimburse drugs in accordance with their published tariff. This means a practice can pay more out for a drug than they get reimbursed. Practices are advised to impose a check on purchase and reimbursement prices and if it is found that they are in a loss situation, then write a script and send the patient to the local chemist.

## PCT Errors

Probably due to the various mergers, it is noticeable that the number of financial clerical errors emanating from PCTs has been on the increase over the last year. Our latest experience involves the deduction of employer's and employees' superannuation contributions of a salaried GP from the practice's monthly contract sum. The PCT correctly deducted the salaried GP's contributions at the same point in the schedule as the GP partners. However, they then proceeded to deduct the same contributions again as a special item on the second page of the schedule. This double count resulted in a



# Topical Bits and Pieces (continued)

repayment to the practice of £7,000 after the accountants had made the discovery. The moral of the story is to ensure that each and every monthly schedule, whether PMS or GMS is checked in the practice. In particular, practices **must** ensure that there is a valid reason for any contract variances. Practices cannot assume that the PCT's schedules are accurate, as demonstrated by previous horror stories.

## Seniority and Pension Certificates

The Exeter System employed by PCTs to account for monthly superannuation deductions, and annual shortfalls and excesses, is linked to the GP's entitlement to seniority. Entitlement to 100% seniority is based upon a GP having superannuable earnings of at least two thirds of the national average. Between one third and two thirds attracts only 60% of the seniority entitlements, and less than one third nothing at all. The difficulty relates to those GPs who have taken 24 hour retirement and returned to practice. One common belief is that they no longer have to complete a pension certificate as they are no longer liable to pay contributions. This might appear logical but what about their entitlement to seniority?

Indeed, some PCTs have expressed the view that as they have no superannuable income they have no right to any seniority at all. This has to be challenged. Of course they have superannuable income – it is just that they do not pay contributions on their superannuable income. Accordingly, pension certificates should be completed for **all** GPs in practice. For those who have taken 24 hour retirement, the certificate will disclose the superannuable income but the boxes for contributions thereon will show "nil". This at least **should** protect their seniority entitlement, provided of course the Exeter System can cope with a variance.

## Accounting after 24 hour Retirement

Profit sharing following a 24 hour retirement can be a source of mis-understanding. What basically happens is:

A partner takes 24 hour retirement and draws his or her pension. The profit share on that day is zero.

With the permission of the partners (which should be in writing), the partner returns to the practice and for 28 days performs no more than 16 hours per week at whatever profit share is agreed between the partners.

Thereafter, a profit share is agreed normally by reference to the number of sessions undertaken.

A potential problem exists – given that this partner no longer contributes to the NHS pension scheme, what should he or she draw compared to other partners on the same sessions? What happens to the employer's contributions included in 2004/05 in the practice global lump sum whether GMS or PMS? The fact of the matter is that whatever was included in the global lump sum remains, so that no deduction is made if a partner retires and no addition is made if a partner joins. In other words, the PCT contribution to employer's superannuation contributions is **fixed** and does not vary – it is "lost" in the global sum for perpetuity. This clearly suggests that an individual partner cannot identify his or her employer's superannuation contributions within the global sum, rather that it is general practice funds. Accordingly, all of the partners will benefit from the 24 hour retirement as such although the retiring partner most of all. This is because the **deduction** of both the employer's and employees' superannuation contributions are **charged** to individual partners. No adjustment is therefore required to profit shares. However, the returning partner will not be charged with superannuation contributions so that his or her Capital or Current Account will be enhanced by not having this liability. It therefore follows that the drawings of this partner should be greater than that of a fellow partner on the same share by the amount the fellow partner is paying for both employer's and employees' superannuation contributions. Life certainly does not get any easier, but at the end of the day, the partners can agree whatever profit share they like.

NEWS



# The **HORROR** Story Section

Yet again, this issue's horror story stems from a practice changing accountants from a non-specialist to an AISMA member. This urban practice prepared accounts annually to 31 March and in March 2007. They interviewed the new accountants with a view to taking over matters for 2006/07 as the 2005/06 year in terms of tax, accounts and pension certificates had been completed by the outgoing accountants.

The interview in March 2007 went well for both parties, the meeting being both productive and congenial. The new accountant was particularly impressed with the surgery premises which were obviously new and "state of the art". Upon enquiry, it transpired that the practice had undertaken a major renovation and refurbishment exercise in 2004/05 which was completed in March 2005 at a total cost of £270,000 financed entirely by bank loan. Upon even further enquiry, the practice explained that they had undertaken a similar renovation and refurbishment of their branch surgery which was completed in January 2005 at a total cost of £250,000 and also financed entirely by bank loan. The accountant's only thought on the matter was that due to the incidence of capital allowances it was unlikely that the six partners paid much tax in 2004/05.

The new accountant undertook the usual tasks involved in setting up a new client which included writing to the outgoing accountant to obtain all of the information necessary to commence acting. The request on this occasion included accounts and all tax returns for 2004/05 and 2005/06. Normally, the request might only be for one year, ie, the most recent year 2005/06, but the new accountant was alerted to the fact that 2004/05 was a special year because of the property renovations and related capital allowances claims.

The new accountant studied the documents supplied by the outgoing accountants. She discovered the following. First, in the accounts for the year ended 31 March 2005, there appeared two items of additions to freehold property being £270,000 and £250,000 respectively. This was odd in itself because with major refurbishments one would expect much of the above amounts to be allocated to fixtures, furniture and fittings. The tax computations for 2004/05 showed a small capital allowances claim but only in respect of items brought forward from the previous year – there were **no** additions to the capital allowances "pool" for 2004/05. The situation was no different in 2005/06. More alarming still, the tax liabilities of the partners actually increased in both 2004/05 and 2005/06 following the effects of the new contract.

The new accountant set to work immediately and made due enquiry with the practice as follows:

- Did your accountant discuss capital allowances with you?  
Answer : NO
- Did your accountant ask you to obtain a priced bill of quantities from your architect or quantity surveyor?  
Answer : NO
- Did you receive an improvement grant for any of the works?  
Answer : NO

The new accountant asked the practice to obtain a priced bill of quantities and forward it to her immediately on receipt.

Some weeks later, the new accountant received the priced bill of quantities for both premises which was indeed a very bulky document to scrutinise. Nevertheless, after much hard work she identified the following costs which would qualify for capital allowances claim at each of the surgery premises:

Main surgery    £80,000 out of a total cost of £270,000  
Branch surgery   £70,000 out of a total cost of £250,000

Thus, she had identified a total capital allowances claim of £150,000 which would result in the following claim for Income Tax purposes in the first five years:

2004/05 - first year allowance at 50%	£75,000
2005/06 - 25% writing down allowance (on reducing balance basis)	£18,750
2006/07 - 25% writing down allowance (on reducing balance basis)	£14,062
2007/08 - 25% writing down allowance (on reducing balance basis)	£10,547
2008/09 - 10% writing down allowance (on reducing balance basis)	£3,164

<b>Total Capital Allowances Claim against Income Tax for first 5 years</b>	<b>£121,523</b>
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Consequently, over a five year period the above claim generated a tax saving of £49,824 (being £121,523 at 41%). As the 2004/05 and 2005/06 fiscal years had already passed before this exercise was undertaken, the new accountant was able to obtain a tax refund for these two years which amounted to £38,437 (£75,000 + £18,750 at 41%). The practice actually received £40,000 as the amount included an interest supplement.

The practice were of course delighted even after they received a fee from the new accountant of £1,500 plus VAT for this special exercise.

One word of caution – the system is changing on 6 April 2008 whereby the claims will be spread over a much longer period. We dealt with these changes in this newsletter two issues ago.

# Pensions Update

Confused by the forthcoming NHS Pension scheme changes? You will be.

Lets TRY to keep it simple.

From 1 April 2008 there will be two schemes: the current NHS Pension scheme with updated rules and benefits (applying to anyone who is an active member on and before 1 April 2008) and the New NHS Pension Scheme (for anyone who joins on or after 1 April 2008).

So, what are the principal changes to the current scheme?

Firstly, and perhaps most importantly, the contribution rate! Instead of 6% on all annual FTE pensionable pay as it is now, tiered contribution rates apply from 1 April 2008. For those earning up to and including £19,165 the rate is 5% (a saving!) but between £19,166 and £63,146 it will be 6.5%, from £63,417 to £99,999 7.5% and for £100,000 plus 8.5%.

The “double whammy” for higher earners is the removal of the so called “earnings cap” which is currently £112,800. There will be no earnings limit for future service. In other words, you will pay 8.5% on your entire pensionable pay and not just 6% up to £112,800 as it is now.

(On the subject of contribution levels, please also note that employee contributions will be limited to 100% of pensionable pay from 1 April 2008 and not 15% as they are now (subject to a current tax year overall annual allowance of £225,000 and £1.6m fund limit).

Probably the most publicised change has been that to Added Years contracts. From 1 April members can purchase additional annual pension of up to £5,000 per annum but will NOT be able to buy Added Years anymore. So, time is very much of the essence if you have not as yet taken advice in this area!

However, it's not all bad news.

One of the more interesting changes is the ability from April onwards to give up part of your pension (“commutation”) for an increased tax free lump sum up to 25% of the pension value. This will almost certainly be higher than the current 3 x annual pension currently allowable.

Advice will be needed as the additional cash would need to provide an investment return of 8.33% gross per annum linked to inflation to cover the lost income. This is because you exchange at a rate of £12 of lump sum for each £1 per annum of pension given up.

One significant change for “practitioners” is that all pensionable earnings from 1 April will be revalued by dynamising factors determined by changes in the Retail Prices Index (R.P.I.) plus 1.5%. Currently, dynamising factors are determined by changes in the earnings of each practitioner profession.

Other less publicised changes include those to membership limits, flexibility of retirement, abatement, ill health retirement, survivor benefits

and pensions on death in service, and child allowances. These can be summarised as follows (source: NHS Business Services Authority Pensions Division):

	NHS Pension Scheme (pre 1 April 08 terms)	NHS P (1 April Effective)
<b>Membership limits</b>	<ul style="list-style-type: none"> <li>From age 16 to 70</li> <li>40 yrs at age 60 &amp; 45 yrs overall</li> </ul>	<ul style="list-style-type: none"> <li>Fro</li> <li>Ove</li> <li>ser</li> </ul>
<b>Flexible retirement</b>	<ul style="list-style-type: none"> <li>Pensionable re-employment if you retire on ill-health grounds, draw a pension and return to the NHS under age 50</li> <li>No pensionable re-employment after drawing a pension on any other grounds</li> <li>Pension payable on retirement only</li> </ul>	<ul style="list-style-type: none"> <li>Per</li> <li>reti</li> <li>per</li> <li>age</li> <li>Per</li> <li>Ste</li> <li>pro</li> <li>taki</li> </ul>
<b>Abatement</b> Practice of reducing a pension if the combined amount of pension and salary in NHS re-employment exceeds the pre retirement level of pensionable pay	<ul style="list-style-type: none"> <li>Takes full pension into account</li> <li>No abatement after age 60 or after 50 where pension is actuarially reduced on Voluntary Early Retirement (VER)</li> </ul>	<ul style="list-style-type: none"> <li>Tak</li> <li>acc</li> <li>No</li> <li>wh</li> <li>on</li> </ul>
<b>Ill health retirement</b>	<ul style="list-style-type: none"> <li>Ill health retirement benefits up to 10 years extra service</li> </ul>	<ul style="list-style-type: none"> <li>See</li> <li>Em</li> <li>Det</li> </ul>
<b>Survivor benefits</b>	<ul style="list-style-type: none"> <li>For legal spouse and registered civil partnerships from 2005 (backdated until 1988)<sup>4</sup></li> <li>Partners normally lose pension on re-marriage</li> </ul>	<ul style="list-style-type: none"> <li>All</li> <li>pen</li> <li>All</li> <li>pen</li> <li>hab</li> </ul>
<b>Survivor pensions on death in service</b>	<ul style="list-style-type: none"> <li>Initial widow/widower/civil partners(s) pension paid for 3 months or 6 months subject to dependent children</li> </ul>	<ul style="list-style-type: none"> <li>Initi</li> <li>mon</li> </ul>
<b>Child allowances</b>	<ul style="list-style-type: none"> <li>Payable under the age of 17 and from 17 if still in full time education (beyond 23 if physically or mentally dependent)</li> </ul>	<ul style="list-style-type: none"> <li>Pay</li> <li>age</li> </ul>

There are some areas which are not changing.

For practitioners, the scheme will continue to be a Career Average Re-valued Earnings (CARE) arrangement with an accrual rate of 1.4%.

Death in service lump sum benefit remains at twice annual pensionable

pay.

The two Money Purchase Additional Voluntary Contributions (MPAVCs) and Stakeholder Pension partners continue to be Standard Life and

Old Pension Scheme (1 April 2008 & after terms) Effective from 1 April 2008	New NHS Pension Scheme Effective from 1 April 2008
Minimum age 16 to 75 Overall membership limit, for future service, of 45 yrs	<ul style="list-style-type: none"> <li>From age 16 to 75</li> <li>Overall membership limit of 45 yrs</li> </ul>
Pensionable re-employment if you return on ill-health grounds, draw a pension and return to the NHS under age 50 Pension payable on retirement only <sup>1</sup> Draw down – voluntary pension protection where pay is reduced on taking a less demanding job	<ul style="list-style-type: none"> <li>If you retire on or after 1 April 2008 and before the choice exercise pensionable re-employment is available in the New Scheme after a break of 2 years</li> <li>Pensionable re-employment on return to work after retirement and re-join the scheme</li> <li>Draw down – taking part of pension whilst continuing in a less demanding NHS employment</li> </ul>
Takes only part of the pension into account <sup>2</sup> No abatement after age 60 or after 50 where pension is actuarially reduced on Voluntary Early Retirement	<ul style="list-style-type: none"> <li>Takes only part of the pension into account<sup>3</sup></li> <li>No abatement after age 65 or after 55 where pension is actuarially reduced on Voluntary Early Retirement</li> </ul>
See separate review by NHS Employers and NHS Health Unions. Details at <a href="http://www.nhsemployers.org">www.nhsemployers.org</a>	<ul style="list-style-type: none"> <li>See separate review by NHS Employers and NHS Health Unions. Details at <a href="http://www.nhsemployers.org">www.nhsemployers.org</a></li> </ul>
All qualifying partners <sup>5</sup> eligible for pension backdated to 1988 <sup>6</sup> All qualifying partners keep survivor pension even when re-marry or co-habit	<ul style="list-style-type: none"> <li>All qualifying partners<sup>7</sup> eligible for pension</li> <li>All qualifying partners keep survivor pension even when re-marry or co-habit</li> </ul>
Initial Partner Pension to be paid for 6 months in all cases	<ul style="list-style-type: none"> <li>Initial Partner Pension to be paid for 6 months in all cases</li> </ul>
Payable to dependent children up to age 23 in all cases <sup>8</sup>	<ul style="list-style-type: none"> <li>Payable to dependent children up to age 23 in all cases<sup>9</sup></li> </ul>

Prudential.

And, finally, what is so different about the new NHS Pension Scheme?

The major change is that normal pension age will be age 65 (minimum

pension age 55) and accrual rate 1.87% for practitioners.

Like the updated version, there will be no “earnings limit”, the same tiered contribution rates, the facility to take 25% of the pot as tax-free cash, and, for practitioners, the same dynamisation treatment of pensionable earnings (see above for details). There is, it cannot be denied, improved flexibility on retirement.

Active members of the updated scheme will be offered the choice (from 1 July 2009 to 30 June 2010) of moving to the new scheme which may suit some members’ retirement plans.

However, do you really want to retire at age 65?

<sup>1</sup> Deferred members who return to the NHS after 5 years will be able to draw their deferred pension at 60 while continuing in pensionable employment in the New Scheme

<sup>2</sup> Only takes into account any additional pension over and above what would have been paid had benefits been actuarially reduced in the same way as for VER

<sup>3</sup> Only takes into account any additional pension over and above what would have been paid had benefits been actuarially reduced in the same way as for VER

<sup>4</sup> All service for legal female spouses and from April 1988 for male spouses and civil partners. Civil partnership refers to same sex partners who have entered into a legal civil partnership

<sup>5</sup> Partners defined as someone you are married to, have entered into a civil partnership with, or a partner you have nominated who you have an exclusive and long-term committed relationship with of at least two years in which you are financially dependent or inter-dependent

<sup>6</sup> All service for legal female spouses and from April 1988 for male spouses and civil partners. Civil partnership refers to same sex partners who have entered into a legal civil partnership

<sup>7</sup> Partners defined as someone you are married to, have entered into a civil partnership with, or a partner you have nominated who you have an exclusive and long-term committed relationship with of at least two years in which you are financially dependent or inter-dependent

<sup>8</sup> This allowance will be payable indefinitely as long as the child, through physical or mental impairment, remains unable to earn a living and the condition existed at the member date of death

<sup>9</sup> This allowance will be payable indefinitely as long as the child, through physical or mental impairment, remains unable to earn a living and the condition existed at the member date of death

# Surgery Premises - Capital Gains Tax

The Finance Act 2008 will introduce significant changes to the Capital Gains Tax (CGT) regime, although at the time of writing this newsletter, draft legislation is not yet available. In his pre-budget report of 9 October 2007, the Chancellor referred to the following changes to apply from 6 April 2008:

- The rate of CGT will be 18% for all gains
- Capital Gains will no longer be taxed by reference to Income Tax rates and bands
- Rebasing of cost to 31 March 1982 value will be compulsory for assets held at that date
- Taper relief will be scrapped
- Indexation relief will no longer be available

It was apparent from an early stage that the above changes would detrimentally affect GPs who own part or all of their surgery premises. Prior to 6 April 2008, the maximum rate of tax suffered by GPs tended to be 10%, but with a combination of the above reliefs currently in force, the rate was more than often well below 10%. The immediate reaction was to advise all those GPs who were approaching retirement to dispose of their share of the surgery premises before 6 April 2008.

Since the pre-budget report there has been a major clamour from the leaders of industry who saw the proposed changes as a disincentive to business in general. Fortunately, the Chancellor has heard the outcry and announced further changes to reduce the apparent hardship on business. He proposes to introduce an Entrepreneur's relief which will be available in respect of gains made on the disposal of certain business assets. "A business" in terms of this relief will be any trade, profession or vocation, excluding property letting business, but including furnished holiday letting. Thus, the first £1 million of lifetime gains on qualifying business assets will be charged to CGT at an effective rate of 10%. Gains in excess of £1 million will be charged at the normal 18% rate. An individual will be able to make claims for relief on more than one occasion, up to a lifetime total of £1 million of gains qualifying for this type of relief.

The new entrepreneur relief would certainly seem to help GPs when they dispose of surgery premises, but there are certain questions that remain unanswered at the time of writing. For example, does the lifetime allowance start rolling on 6 April 2008 or from date of birth? There are other issues relating to GPs that need clarification:

- If a partner retires and continues to own a share in the surgery premises after retirement, does this convert the asset from a business asset to an investment asset? If so, does the potential rate of tax on disposal move from 10% to 18%?
- What happens if the surgery premises are not included in the balance sheet of the practice but are held by a number of partners in a separate property partnership who charge the practice a rent equal to the cost or notional rent? Presumably, the property partnership is not deemed to be a business and the entrepreneurs' relief is lost, so that the potential rate of tax is 18% and not 10%.
- If GPs are entitled to the entrepreneurs' relief, is this as good as the situation prior to 6 April 2008?

The third question can best be answered by using a hypothetical example.

Let us assume that Dr A bought into his surgery premises on 1 April 1988 at a price of £60,000 and that he intends to retire in March or April 2008 and dispose of his share of the surgery premises for £160,000. Is he better off completing the transaction before 6 April 2008 or after 5 April 2008?

	£	
<b>Old Rules</b>		
Proceeds—say, on 31st March 2008	160,000	
Cost	(60,000)	
Unindexed Gain	100,000	
Indexation relief $(\frac{162.6 - 105.8}{105.8} \times £60,000)$	(32,212)	
Indexed Gain	67,788	
Taper relief at 75%	(50,841)	
	16,947	
Annual Allowance 2007/08	(9,200)	
Gain Chargeable to CGT	7,747	
Tax at 40%		3,099
<b>New Rules</b>		
Unindexed Gain (as above)	100,000	
Entrepreneurs relief (4/9)	(44,444)	
	55,556	
Annual Allowances (assumed 2008/09)	(9,500)	
Gain chargeable to CGT	46,056	
Tax at 18%		8,290
<b>Additional Tax to Pay Under the New Rules</b>		<b>5,191</b>

In advance of studying the draft legalisation, the current conclusions are:

- Whilst entrepreneurs' relief has helped there will still be additional tax to pay beyond 5 April 2008.
- Surgery premises should be disclosed as a partnership asset in the balance sheet of the practice, and not held "outside" as an investment.
- Retention of ownership after retirement will trigger a higher tax charge.

We now await the legalisation – watch this space!

# Pay Negotiations - A Useful Tool

After two successive years of a nil pay award, the profession do not appear to be any better placed to negotiate an acceptable award for 2008/09. For all practices it seems that any pay award will be linked to additional services, particularly perhaps extended opening hours. PMS practices seem to be threatened the most in that the Department of Health (DOH) are apparently questioning the value of money aspects of PMS contracts. In other words, whilst it is accepted that PMS GPs generally earn more than their GMS counterparts, the DOH seem to doubt the achievement of a realistic return on this investment. It is therefore no surprise that PMS practices have been specifically targeted by PCTs and in this respect Suffolk and Northumberland were apparently used as "test" cases for new contracts to be rolled out over the entire country.

As negotiations in Suffolk appeared to come to a grinding halt, all eyes turned to Northumberland who operate almost a county wide PMS. Northumberland were perhaps a strange choice as they have much rurality and inevitably have slightly more doctors per head of population than most other parts of the country. Without boring the reader with the details, suffice to say that negotiations have been severely strained to say the least. The first offer from the PCT amounted to £63.87 per patient made up of the basic GMS amount of £54.72 per patient plus an extra £9.15 per patient for services provided under PMS (14 services in all). The effect of this offer might have been:

Some practices would lose in excess of £100,000 of their gross income.

Most practices would lose about 9% of their contract value.

Consequently, there would be an inevitable cut in services.

Redundancies would occur, particularly amongst salaried GPs.

Overall, would the PCT be any better off? The saving made from PMS contracts would surely be spent on paying local hospitals for the services that would no longer be viable in PMS practices.

Fortunately, negotiations have moved a long way forward from the above initial offer, and it is now hoped that a deal can be struck. Nevertheless PMS practices face a 3% cut in the contract value, although it is hoped that this may prove manageable. Had negotiations not moved in this direction, the whole issue would have been subject to judicial review. Furthermore, any

threat by the PCT to cancel the PMS contract and revert to GMS with no MPIG would presumably have been countered by a threat to withdraw from the NHS altogether. Common sense appears to be prevailing in the end.

There can be no doubt that the negotiations in Northumberland will now have a repercussion on all PMS contract negotiations around the country. In this respect GPs are advised to "stick" together, perhaps through their LMCs, and not break rank in an attempt to negotiate on a practice by practice basis. To assist in this process we set out below an extract from the AISMA survey into practice accounts for 2005/06. This sets out the basic global sum per patient in PMS and GMS practices, ignoring the other headings in the new contract such as PCO administered income, enhanced services, QOF, premises, information technology and dispensing. The negotiations in Northumberland were influenced by these numbers along with GP list sizes. The reader will notice that the figure of £63.87 does not sit well with the figures below – in fact, most GMS practices beat the Northumberland initial offer because of MPIG.

We hope that the following will help in your own negotiations and that at the end of the day, common sense will prevail.

## PMS/GMS Global Sum Per Patient (including MPIG but less Opt-Outs)

	All Practices £	Dispensing Practices £	Non Dispensing Practices £	GMS Practices £	PMS Practices £
<b>By Country:</b>					
England	69.69	70.64	69.42	64.41	76.15
Scotland	66.59	76.94	66.05	65.66	74.89
Wales	63.58	66.86	63.02	63.58	N/A
UK Total	68.95	70.67	68.52	64.56	76.11
<b>By Region in England:</b>					
Anglia and Oxford	71.03	71.69	70.48	65.39	78.49
North Thames	68.13	73.33	66.53	65.55	74.22
North West	66.26	68.54	65.97	63.78	70.92
Northern and Yorkshire	74.86	75.14	74.80	65.52	81.26
South West	69.49	71.39	68.65	66.28	73.31
South Thames	70.44	68.20	70.75	64.04	81.41
Trent	64.90	64.21	65.12	60.94	68.75
West Midlands	67.07	66.52	67.18	61.32	75.28

**Note:** The above figures were extracted from the AISMA survey of practices in the UK for 2005/06 which covered over 16% of practices in the UK.

All figures ignore PCO administered income, enhanced services, QOF, premises, information management and technology and dispensing fees.

## Cash Flow Warning

A combination of two of the pension changes due to occur on 6 April 2008 can cause severe cash flow problems which must be heeded by practices. The two relevant changes are:

The increase in rate of the employee's superannuation contributions from 6% to a maximum of 8½%.

The abolition of the earnings cap which for 2007/08 was £112,800.

The potential problem arises with a high earning GP (maybe a dispenser) who up to 5 April 2008 was capped for pension purposes. Let us assume that he or she has superannuable income of £150,000. In 2007/08 the contributions are:

Employers at 14% on £112,800	=	15,792	
Employees at 6% on £112,800	=	<u>6,768</u>	
			22,560

If earnings remain constant in 2008/09, the contributions are:

Employers at 14% on £150,000	=	21,000	
Employees at 8.5% on £150,000	=	<u>12,750</u>	
			33,750

<b>Increase</b>			<u><u>£11,190</u></u>
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It is the practice who has to fund the increase of £11,190 even though this amount is charged to the individual partner. For such partners, drawings will probably have to be reduced, particularly bearing in mind a positive pay award is not at this moment in time in sight. Do not rely on PCTs making the appropriate monthly adjustments. If they do not do so there will be a shortfall due in March 2010. If they do not do so there will be a shortfall due in March 2010.

**You have been warned!**

## Tax Update

On 9 October 2007 the Chancellor presented his pre-Budget Report. This, taken with previous and subsequent announcements, enables us to piece together what we are likely to face in the months to come.

The following matters are of general relevance to GPs:

1	Income Tax	2009	2008	2007
		£	£	£
	Personal Allowance	5,435	5,225	5,035
	Taxable income at 10%	nil	2,230	2,150
	Taxable income at 20%	38,000	nil	nil
	Taxable income at 22%	nil	32,370	31,150
	Higher rate, 40% on taxable income over	38,000	34,600	33,300
2	National Insurance			
	Class 2 weekly rate	2.30	2.20	2.10
	Class 4 rate	8%	8%	8%
	Annual lower limit	5,435	5,225	5,035
	Annual upper limit	40,040	34,840	33,540
	Excess over upper limit (Class 4)	1%	1%	1%
3	Other Matters	2009	2008	
		£	£	
	Inheritance Tax nil rate band	312,000	300,000	
	Main corporation tax rate	28%	30%	
	Small companies corporation tax rate	21%	20%	
	CGT annual exemption	9,600	9,200	
	Capital Allowances:			
	First Year Allowance	nil	50%	
	Annual Investment Allowance	£50,000	nil	
	Writing down allowance	20%	25%	
	Writing down allowance on certain fixtures integral to a building	10%	25%	

Let us therefore consider what the impact of the tax changes are in the case of a GP earning £120,000 in the year to 5 April 2007, £115,000 in the year to 5 April 2008, and £115,000 again in the year to 5 April 2009. These figures are assumed to be before the deduction of employer's and employees' superannuation contributions.

	2009	2008	2007
	£	£	£
Earnings before tax	<u>115,000</u>	<u>115,000</u>	<u>120,000</u>
Superannuation	19,550	17,250	18,000
Personal Allowances	5,435	5,225	5,035
	<u>24,985</u>	<u>22,475</u>	<u>23,035</u>
Chargeable to tax	<u>90,015</u>	<u>92,525</u>	<u>96,965</u>
Income tax at 10%	nil	223	215
Income tax at 20%	7,600	nil	nil
Income tax at 22%	nil	7,121	6,853
Income tax at 40%	<u>20,806</u>	<u>23,170</u>	<u>25,466</u>
	<u>28,406</u>	<u>30,514</u>	<u>32,534</u>
Class 4 NIC	3,518	3,171	3,145
Class 2 NIC	120	114	109
	<u>32,044</u>	<u>33,799</u>	<u>35,788</u>
% Liability to Income net of superannuation	<u>33.6%</u>	<u>34.6%</u>	<u>35.1%</u>

There are a number of interesting features arising from the above:

On the surface it appears that the overall burden is falling in percentage terms, but this hides the real truth.

From 2007 to 2008 earnings fell and so there was a lesser burden in terms of income tax at 40%. This causes the apparent fall in the percentage burden.

From 2008 to 2009 the tax burden falls by £1,755 but this is taken away by the increase in employees' superannuation contributions which will cost an extra £2,300 for some unknown dubious return in the future. Notice the hidden tax - the increase in Class 4 NI contributions which was hardly noticed by many commentators.

Over the three years, the effective take home pay is as follows:

2009 - £63,406  
2008 - £63,951  
2007 - £66,212

The reality is that the tax burden does not get any easier. The shuffling of the numbers does not make a GP better off, but, of course, we all hear the political announcements in the media - we just have to remain sceptical.

Finally, we continue to be asked by those GPs who save to pay their own tax liabilities, how much of their income is set aside for the rainy day. As a rule of thumb guide only we hope that the following table assists you in making the appropriate savings.

Profits after personal expenses and employers' superannuation £	Tax & Class 4 NIC Liability £	Saving required %
170,000	59,304	34.9%
160,000	55,439	34.7%
150,000	51,563	34.4%
140,000	47,688	34.1%
130,000	43,812	33.7%
120,000	39,938	33.3%
110,000	36,062	32.8%
100,000	32,187	32.2%
90,000	28,312	31.5%
80,000	24,436	30.5%
70,000	20,562	29.4%
60,000	16,686	27.8%
50,000	12,811	25.6%



# Meet the FK Medical Team



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## Further Information Request Form

For more information on any of the subjects featured in this issue, or to request a FREE initial consultation with one of our specialist Medical Advisors, please make your request using the form, right, and FAX back to **01582 480901**

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