

## MEDICAL UPDATE

*For Clients & friends of Williams Denton Cyf*

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*Summer 2007*

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### *Notice to readers*

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## CONTROLLING PRACTICE COSTS

At a time when we know that there has been a nil pay award, the expenses incurred in running a GP practice again becomes an issue. Some practices may find it difficult to identify new sources of income, either because of time availability, quality of life, or restricted resources (such as the nature of the surgery premises). However, the Survey into the earnings of GPs for 2005/06 demonstrated that on average expenses had risen by 7% during that year. It therefore follows that if income does not rise but expenses do rise by say 7% again, earnings of GPs must surely fall, probably by as much as 8%. Doing nothing does not therefore seem to be an option as practices move forward.

*--Williams Denton Cyf Medical Update Summer 2007--*

Controlling costs is an ongoing process, but it is only likely to achieve a one-off boost to earnings. At some point practices will have to consider income streams as a priority. Nevertheless, cost control involves a number of simple points which do not constitute "rocket science".

- GP Partners can delegate but not abdicate the control of costs to practice managers. Thus, a partner should always review the monthly payroll for example and for that matter all monthly payments.
- Regularly review staff numbers, staff mix, staff skills and staff pay levels.
- Use buying consortia to obtain discounted prices.
- Restrict, so far as is possible, the use of external locums and organise yourselves internally to meet the need.
- Regularly consider the "return on investment" you achieve by employing salaried GPs, career starts, registrars, flexible career scheme GPs, and retainers.
- Shop about.

Controlling costs, therefore, is not a particularly difficult exercise. The problem is identifying the expenses that require your attention. To assist you, the result of the survey into the accounts of GPs may prove to be an ideal starting point. The first relevant statistic concerns staff numbers. The number of full time equivalent staff per full time equivalent GP (including salaried GPs) is approximately 2.5. If salaried GPs are ignored then the number of full time equivalent staff per full time equivalent partner (or provider) becomes approximately 3.0. In this context practice staff includes practice nurses (but not nurse practitioners), those responsible for direct patient care on the payroll, all administrative and clerical staff, and other staff. For this purpose clinical assistants such as salaried GPs, retainers, locums, career start, flexible GPs etc are excluded. Why not compare your own practice to these figures - it will give you a clue as to your own staffing levels.

As a next step, you can compare your own performance on a per patient basis against the following figures from the survey:

Expenses per patient (after reimbursement):

	<b>Non Dispensers</b>	<b>Dispensers</b>
	<b>£</b>	<b>£</b>
Staff costs	33.60	44.62
Medical expenses	12.16	48.70
Premises	7.32	7.38
Administration	5.20	6.21
Financial	1.46	2.23
Depreciation	<u>0.52</u>	<u>0.79</u>
Total	<u>60.26</u>	<u>109.93</u>

For dispensers, medical expenses are clearly affected by the purchase of drugs. In the above context, medical expenses include deputising and locums, salaried GPs and other clinical assistants, locum insurance and subscriptions. A registrar appears under staff costs which also includes staff pay, pensions and training. Again by comparing your practice with the above numbers, you will be able to determine which of your expenses are high and may need addressing. It should be stressed that the above figures include the personal expenses of the partners, so that motor expenses are included in administration, subscriptions are included in medical expenses, spouses' salaries are included in staff costs and use of home is included in premises costs.

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As an alternative approach, you can also compare your expenses to the AISMA survey's comparison of expenses as a percentage to total income which includes reimbursements - the result was as follows:

	<b>Non Dispensers</b>	<b>Dispensers</b>
	%	%
Staff costs	31.5	24.0
Medical expenses	10.0	30.0
Premises	6.0	3.5
Administration	4.0	3.0
Financial	1.0	1.0
Depreciation	<u>0.5</u>	<u>0.5</u>
Total	<u>53.0</u>	<u>62.0</u>

Again, this comparison should identify where there is a problem with costs, if one of course exists.

Having dealt with practice costs GPs have no option but to turn their attention to income, but this involves the most critical of all decisions - the desire for money or quality of life or both. The top 10% of GP earners somehow achieve both, but the problem is that GP partners often do not know where their fellow partners lie in this apparent dichotomy. The solution to this problem lies in an away day when all partners declare, in total honesty, their desires and objectives. This is of course a mammoth subject in itself and beyond the purpose of this article, but it does need addressing. Once you have control of costs, an away day is essential to produce a strategy for the future. Without it, the political arena is dictating a decline in income which may be unacceptable for many.

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## TAX TOPICS

Now that the Chancellor has presented his Budget statement, there are a number of announcements that could significantly effect GPs. In this article we concentrate on three issues - capital allowances, incorporation and penalties. In passing, it is worth mentioning that he declared that the basic rate of income tax will drop from 22% to 20% from April 2008. The threshold for the top rate of income tax will also rise in 2009 from £38,000 to £43,000. However, these measures will be accompanied by a scrapping of the 10% starting rate and alignment of the upper earnings limit for national insurance contributions. Perhaps he is confident of a further term of office for the Labour Party.

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## CAPITAL ALLOWANCES

The 50% rate of first-year allowances for capital expenditure by small businesses (including medical practices) on plant and machinery will be extended for a further 12 months to 5 April 2008. The following changes to the capital allowances regime are to be introduced from 2008/09:-

- An annual investment allowance of 100% of the first £50,000 of expenditure on plant and machinery in the general pool will be introduced.

- The rate of writing-down allowances (WDAs) for plant and machinery in the general pool will be reduced to 20%.
- The rate of WDAs on certain fixtures integral to a building will be set at 10%.

The above changes are unlikely to have a significant effect on the day to day running of a medical practice. However, for those GPs embarking on a major surgery development which they will own, these changes will have a significant effect on their tax position.

Assume a GP practice undertook a new build at a cost of £2 million which was completed in their accounting period to 30 June 2004. Assume also that the accountant has identified £600,000 of this cost which qualifies for capital allowances. The capital allowances claim for Income Tax purposes (Capital Gains Tax is not affected) would have been as follows:-

2004/05 year to 30 June 2004 - first year allowance (50%)	300,000
2005/06 25% WDA	75,000
2006/07 25% WDA (on reducing balance basis)	56,250
2007/08 25% WDA (on reducing balance basis)	42,187
2008/09 10% WDA (on reducing balance basis)	12,656
<b>Total Capital Allowances Claim against Income Tax for first five years</b>	<b><u>£486,093</u></b>

Assume now that the cost is the same but the development was completed in the accounting period to 30 June 2008 with again £600,000 being identified as qualifying for Capital Allowances claim.

It would appear that the Capital Allowances claim for Income Tax purposes will be as follows:-

2008/09 Year to 30 June 2008 Annual Investment Allowance	50,000
2008/09 10% WDA	55,000
2009/10 10% WDA (on reducing balance basis)	49,500
2010/11 10% WDA (on reducing balance basis)	44,550
2011/12 10% WDA (on reducing balance basis)	40,095
2012/13 10% WDA (on reducing balance basis)	36,085
	<b><u>£275,230</u></b>

It follows that in the first five years the Capital Allowances claim is significantly reduced. The key point to remember is that Capital Allowances will now be spread over a far greater period than hitherto.

## INCORPORATION

As GPs will be aware incorporation is not possible for an entity with a patient list, either in GMS or PMS. However, incorporation is possible for private practice, APMS, or a separate entity distinct from main provider to contract for out of hours services, and other additional and enhanced services. The question is whether it makes sound commercial or tax sense.

The Chancellor announced that the headline rate of Corporation Tax will be reduced from 30% to 28% from 1 April 2008. However, the rate for small companies will increase from 19% to 22% by 2009, in a series of stages, with the expressed aim of clamping down on individuals who artificially incorporate as small companies with the aim of avoiding tax.

For the self employed, the highest rate of tax is 40% with an extra 1% National Insurance surcharge, a total of 41%. The effective rate of tax on a director's salary in a company for a higher rate taxpayer is 47.7%. The only alternative would appear to be dividend extraction. However, due to the Chancellor's announcements, the effective rate of tax on dividends up to £300,000 for a higher rate taxpayer is:-

2006/07	39.25%
2007/08	40.00%
2008/09	40.75%
2009/10	41.5%

Thus, within a couple of years, the tax system will favour the self employed. Accordingly, incorporation will soon cease to be an attractive option for GPs attempting to make tax savings. However, a corporate partner within a practice is possible if the GPs want, for any reason, to reduce their superannuation contributions.

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## PENALTIES (FOR ERRORS)

For Tax Return periods starting after 31 March 2008 and filed after 31 March 2009 there will be a single new tax penalty regime for all taxes if H M Revenue and Customs (HMRC) "thinks":-

that there are errors in certain documents sent to them;  
that the taxpayer (or their agent) fail to report errors in assessments from H M Revenue and Customs.

These new penalties are to be tax geared.

The penalties for errors and inaccuracies are to be dependent upon behaviour and will be calculated as a percentage of potential lost revenue as follows:-

Careless (failure to take reasonable care)	30%
Deliberate but not concealed	70%
Deliberate and concealed	100%
Failure to report error in assessment	30%
Error resulting in delayed tax	5%

There will be reductions for disclosure but the reductions will depend upon the "quality" of disclosure in terms of timing, nature and extent, as follows:-

<b>Penalty</b>	<b>Unprompted</b>	<b>Prompted</b>
30%	≥ 0%	≥ 15%
70%	≥ 20%	≥ 35%
100%	≥ 30%	≥ 50%

HMRC will also be able to suspend penalties in the following circumstances:

- As an incentive to improve record keeping and systems to ensure future returns will be accurate.
- Only for careless inaccuracies.
- Suspension up to two years but cancelled if conditions of suspension breached or liable to another penalty.

It should also be noted that the taxpayer is liable to the penalty if the agent makes a careless error, unless the taxpayer took reasonable steps to avoid the error. An officer of a company is also liable up to 100% of the company's penalty for deliberate inaccuracy.

The moral of the story must surely be - get it right first time!

## WHERE IS THE CASH GOING?

It is noticeable that many practices are currently experiencing difficulties as regards cash flow. The golden days have surely come to an end and practices are genuinely finding it difficult to adjust to the changing circumstances. Pressure on cash flow has been caused by a number of factors, namely:-

- The delay in receiving QOF payments.
- PCTs delaying the payment for enhanced services.
- The zero pay award.
- Rising expenses at a time of static income.
- Superannuation shortfalls being collected in March.
- An understandable reluctance to reduce drawings.

For those practices who consider doing nothing as an option, earnings are inevitably going to fall. Instead, practices have to be run as a business with the correct structures, roles, services, technology, people, and in suitable premises. This means that partners have to work together as a team, trust each other, plan ahead, and meet regularly. In particular GPs must look at ways of generating income outside the contract through specialists services and practice based commissioning. With alternative providers moving in, GPs have to be proactive to engage in the services that are available. All of this was covered in a previous issue of this newsletter in an article entitled "Going for Gold". The key point so far as concerns cash flow is the need to budget forward to ensure that drawings levels can remain at least constant. For those practices who do not embrace change and budget forward, it is recommended that partners' drawings are reduced by 5% with immediate effect.

To make matters worse, there is another potential cash time bomb looming in the distance and this relates to pension changes. Some practices are already struggling to cope with a shortfall in superannuation contributions which are collected in the March following the end of the relevant fiscal year. However, at the end of the 2007/08 fiscal year (ie 5 April 2008) the earnings cap is lifted, added years comes to an end, and the employees' contributions are amended from 6% to a graded scale as follows:-

### Superannuable Income

0 - £15,107	6%
£15,108 - £60,880	6.5%
£60,881 - £100,000	7.5%
£100,001 and above	8.5%

Since the new pension regime came into force on 1 April 2004, PCTs have generally been unable to cope with GPs subject to the earnings cap when deducting monthly amounts from the GMS or PMS Contract sums. Rather, the earnings cap GPs were dealt with annually through the shortfall or excess in contributions.

Let us now consider the example of a fictitious GP with superannuable income of, say, £140,000 but who did not join the NHS until 1990. He or she is therefore subject to the earnings cap which for 2007/08 is a maximum superannuable income of £112,800. Thus, assuming he or she has no added years contributions, the superannuation contributions are currently:-

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

However, for 2008/09, the calculation will be as follows:-

Employers at 14% of £140,000		19,600
Employees £15,107 at 6%	906	
£45,773 at 6.5%	2,975	
£39,120 at 7.5%	2,934	
£40,000 at 8.5%	<u>3,400</u>	
		<u>10,215</u>
		<u>£29,815</u>

This GP is thus facing an increase in contributions of £7,255, for hopefully some benefit in the distant future. The point is, that if the PCT does not increase the monthly deduction during 2008/09, or if the practice do not instruct the PCT to increase the deduction from April 2008, then the whole of the £7,255 will become payable to the PCT in March 2010, causing yet another drain on cash flow. Practices are now warned of the potential superannuation time bomb.

In these difficult times the message is clear. Practices do not only have to forecast income and expenditure but they also have to budget and plan the cash flows. Without doing this, GPs could well get nasty surprises in the guise of enforced reducing drawings.

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## SUBJECT - PROTECTING YOUR WEALTH

### **How do you spend £10 to save many thousands of pounds?**

**Set up a Pilot trust.** You can create a discretionary trust with an initial investment of £10. The trust is then available to receive further investments, for example, the proceeds of a life insurance policy or Death In Service benefit under an occupational pension scheme such as your NHS pension.

Should you die whilst a member of the NHS Pension Scheme, two times your Superannuable income is payable to your estate, and normally you would have nominated your spouse. In addition, they would receive the proceeds from any life assurance policies held and in most cases there may be a mortgage debt to be repaid from these funds.

However, Death in service benefit is paid tax free, and if simply paid to the spouse, will be added to their own estate thus swelling the family wealth and eventually possibly being taxed at 40% when Inheritance Tax becomes payable in later years. Most Doctors would anticipate their spouse would need all of the death in service benefit to supplement their own incomes and possibly help towards maintenance of children. If your overall estate is relatively small and your children are very young, then this may well be the best course of action.

If all life insurance proceeds and/or death benefits are paid to your spouse on your death, this increases the survivor's estate and therefore increases the potential liability to inheritance tax on the survivor's death. If the survivor's estate is already over the nil rate band (Currently £300,000) the potential saving by setting up a pilot trust is therefore up to 40% of the trust fund, which is a pretty good return on your initial investment of £10!

With many GP's earning over £100,000 then death in service in this instance would be £200,000. A tax saving of 40% is £80,000 and that is worth saving.

By nominating that your life insurance proceeds and/or death benefit are paid into a pilot trust, the monies are outside the survivor's estate but can still provide for your spouse and family, who are beneficiaries of the trust. The trustees can pay income to the beneficiaries and capital can be advanced if necessary.

Setting up a Pilot Trust is very simple and involves very little effort on your part. It is normally a good time to review your will as, if you have one in place, it may well be out of date and no longer relevant to your family circumstances, which brings us on to another subject which does affect almost every Doctor in the country.

## **A Horror Story**

Picture the Scene....

Dr Jim Smith and Miss Julie Brown have lived together for 12 years and they have a 2 year old child Jack. Jim is an equity partner at the surgery and Julie works part time as well as looking after Jack. They have a decent income and a nice home with a mortgage.

Jim is killed in a car accident at the age of 32.

Following the initial horror and shock, Julie receives a letter from the NHS pensions agency saying they have a death in service benefit payment and a small pension to pay out. However, as she is not Jim's wife and Jim has not completed a new nomination form since he joined the scheme at age 23, the proceeds of the lump sum will be for the benefit of Jack until he reaches age 18, being Jim's next of kin.

Jim had a share in the practice which was subject to a practice loan which has been repaid from the proceeds of the life policy he held. Jack, therefore being Jim's next of kin also inherits Jim's share of the practice.

Their residential mortgage is repaid via the proceeds of a life policy which a joint policy held by Jim and Julie.

So where, financially does this leave Julie and little Jack?

Upon seeking legal advice, Julie is horrified to find that she will have to take her own son's now rather substantial estate to court to sue for a regular payment to be made to Julie, from Jack's funds to provide her with enough money to live on.

This whole situation could have been avoided if Jim had made an adequate will leaving part or all of his estate to Julie.

There is no automatic entitlement to assets in someone's estate just because you live together, unmarried couples need a will.

Married couples also need a will as the rules of intestacy (what happens if you die without a will) are very restrictive and will probably not reflect your own wishes.

### **How do you save your estate up to £120,000 of Inheritance Tax?**

**A well drafted Will** If you and your spouse have estates over the current nil rate band of £300,000, you would be well advised to ensure that your Wills are drafted to utilise part or all of the nil rate band on the first death to pass money direct to the next generation or into a discretionary trust. A nil rate band discretionary trust incorporated into your Will is a useful tool if you do not have sufficient assets to make cash legacies on the first death.

If you leave all your assets on your death to your spouse, although this transfer is exempt of inheritance tax, the transfer of assets swells the survivor's estate. On the second death, the estate will be taxed at 40% on assets over the nil rate band.

Therefore, if your combined estates are over £600,000 and you do not fully utilise the nil rate band on the first death you are losing the opportunity to save 40% thereof which is currently £120,000. Of course the nil rate band is increasing from £300,000 - £350,000 by 2010 and therefore the potential inheritance tax savings could be even greater.

### **How can you save more inheritance tax?**

**Lifetime gifting** For larger estates, you could also look at making lifetime gifts direct to your chosen beneficiaries. This is known as a PET (Potentially Exempt Transfer) and you must survive seven years for the monies to be outside your estate. You can also look at making gifts of money or assets into trust during lifetime, which offers the benefit of reducing your estate whilst at the same time allowing you to maintain control over the assets at all times.

There are a number of additional Inheritance Tax Planning tools available to the GP who has maximised their own nil rate Bands via effective wills but still has a substantial estate which they wish to pass to their children, but are not yet ready to give up control of the assets yet.

Helen Ennis Financial Planning Manager, RMT Financial Management Limited  
Written in conjunction with Katherine Ayris, Solicitor at Crutes Law Firm, Newcastle

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## **THE HORROR STORY SECTION**

Continuing with our series of horror stories, on this occasion instead of relating one horror story in depth we tell a number of short stories. Readers will have noticed that most of the horror stories thus far emanate from one of our members taking over the accountancy work from a non-specialist accountant. However, it would be totally unfair to suggest that all horror stories arise in this way, as we are about to demonstrate.

Our first story concerns a dispensing practice client who registered for VAT on 1 April 2006. The situation is that the practice has yet to receive any refunds of VAT. The practice has received two visits from a VAT officer of H M Revenue and Customs. However, the VAT officer is refusing to authorise any repayments of VAT on the basis that in his opinion the practice manager has failed to understand the process. Fortunately, the practice have had the sense to call in their accountant who has been able to sort out the situation and is now hopeful that the practice is about to receive a £75,000 refund to bring matters properly up to date.

Our second story concerns taking over the accountancy affairs of a practice from a non-specialist accountant. The story is best described as "a can of worms". In a nutshell the new accountant has discovered that the previous accountant had been using the wrong basis periods for each of the fiscal years running from 1997/98 to 2004/05. Thus for example, the accounts for the year ended 30 April 1999 forms the basis for the fiscal year 1999/2000 and profits should be allocated for 1999/2000 on the basis of what happened in the accounts for the year ended 30 April 1999. However, the previous accountant had allocated the profits in the accounts for the year ended 30 April 2009 on the basis of the profit sharing ratios prevailing in the fiscal year 1999/2000 - and he had done this for eight successive years. This is truly a nightmare situation and the new accountant has spent considerable time in preparing calculations to rework all of the tax payments by partner for the eight years in question. Having completed the exercise it transpires that the practice as a whole have overpaid tax amounting to £25,000. The problem now is that of the £25,000 some partners have overpaid tax, some partners have underpaid tax, and some partners are neutral. To make matters worse, new partners have joined the practice, partners have left the practice, and partners have retired so that the constitution of the practice at the end of the eight year period bears little resemblance to what it was at the beginning of the eight year period. It would be almost impossible to agree all of the revised calculations for the eight year period with H M Revenue and Customs and then collect the tax and refund the tax to all of the relevant partners, both old and new. But somehow an equitable solution must be found.

Whilst no final decision has been reached the favourite option is to leave H M Revenue and Customs alone, receive £25,000 from the previous accountant (who has agreed to do same), and allocate the £25,000 to the partners based on the new calculations but slightly favouring those who have overpaid the most tax.

Our third story... In February 2005 the accountant prepared the pension certificates of a three partnered practice which were duly signed and forwarded to the PCT. The superannuation shortfall was correctly processed by the PCT and the appropriate deductions were made in March 2006 on the GMS schedule of that month. However, on the same schedule the PCT made a further deduction of £4,800 purporting to be the AVCs of one of the partners but neither the practice manager nor any of the partners noticed this spurious deduction. Eventually, during the preparation of the accounts for the year ended 30 June 2006, the firm noticed the deduction and queried how it was to be dealt with in the accounts. On enquiry, it transpired that the partner in question was not contributing to AVCs. On further enquiry with the PCT it transpired that the deduction was indeed a clerical error and they agreed to return the amount forthwith. The moral of the story is absolutely clear - someone in every practice must check the monthly PMS or GMS schedule and ensure that all items are correct and appropriate. A specialist accountant may ultimately spot the error but it is doubtful whether a non-specialist accountant would.

Our final story yet again concerns a case where a non-specialist accountant was changed. The first accounts prepared by the new accountant were for the year ended 31 December 2006. It should also be noted that the practice manager of the practice was a new

appointment. During the course of the accounts preparation the firm noticed that the reimbursement for drugs was considerably less than the value of drugs purchased suggesting that there may be a problem with forms FP10 which are forwarded to the Prescription Pricing Authority to trigger the reimbursement. On further examination, it was noticed that the monthly drug reimbursement was relatively constant throughout the year, which is odd in itself because it is expected that in one month the reimbursement will be much higher than all other months due to the reimbursement of flu vaccinations. The practice received the enhanced service for flu vaccinations and it became clear that the reimbursement for the cost of the drugs had not been received. On further enquiry it transpired that the new practice manager had not been told to make a claim. She thought that it was an automatic reimbursement from the PCT rather than an FP10 claim to the PPA. However, having been alerted, she decided to discover what had happened in previous years and found that claims for the previous two years had also not been made.

The end result of this story is an FP10 claim for three years flu vaccinations reimbursement amounting to £40,000. The alarming feature of this story is that this was the third occasion this firm had come across missed flu vaccination reimbursement claims in the space of three months. The moral of the story is again clear - GP partners can delegate but not abdicate responsibility for the finance function of the practice.

