AISMA Doctor Newsline

A helpful resource for the practice business

aisma
association of independent specialist medical accountants

Issue 17 Spring 2012

Stop restrictive covenants backfiring on your business

New case law means restrictive covenants used by GPs to protect their business may end up handcuffing them – not former partners and staff. **Andrew Lockhart-Mirams** explains

GPs with restrictive covenants would do well to check the wording following a series of recent High Court hearings in London.

The cases covered the protection of goodwill in practices and businesses - and the enforceability of restrictive covenants after employment is terminated.

Although the issues related to bosses and workers in the financial markets the same law applies to any medical practice.

What is now clear is that in many cases, especially where legal advice is not taken, restraint of trade clauses are overly optimistic about what the law will allow.

GPs and managers in future need to decide what the business wants to protect, and what is likely to be reasonable in the circumstances, before seeking to impose their terms.

Careful drafting and identification of appropriate issues capable of protection is the key to having meaningful restraint of trade clauses in an employment contract.

In general practice there are normally two types of protection which are relevant and looked for by partners.

Doctors joining practices wish to defend the goodwill of what they have come into. They want to prevent outgoing partners from whom they have acquired a profit share from setting up in competition immediately after they join.

And those with established practices want to stop

doctors, and others, in the practice from going and taking the patients with them.

Business transfers

The typical restrictive covenants found in a partnership agreement or a deed of retirement include a:

- Non-competition clause
- Non-solicitation clause, and a
- Non-dealing clause.

An incoming partner's legitimate interest lies in protecting the value of the business which he or she has gone into.

He or she has an obvious interest in preventing the retiring partner from competing in such a way as to erode the value of what the new partner has just acquired.

The law recognises this as a legitimate interest, especially if the retiring partner seeks to compete by attracting patients of his former practice, its staff, or by using confidential information.

But practices should note that although the law recognises these legitimate interests, it does not do so unless they are qualified.

So for a restrictive covenant to be enforceable it must be reasonable and go no further than is necessary to protect the legitimate interest.

The duration, scope and geographic extent of restrictions are all matters which should be considered when GPs are preparing to move into, or retire from, a practice.

There are many potential traps for the unwary in any practice transfer - and restrictive covenants are a big one.

Any doctor involved should take expert advice early in the process to ensure their protection throughout the transfer and afterwards.

Employees

Of course, all GPs' employees should have appropriate contracts setting out their duties and rights in the practice.

But what many don't know is that restrictive covenants can be included in employment agreements, where appropriate, just as they can in partnership agreements.

Whether there is a contract in place or not, it is a breach of duty for an employee to misuse confidential information belonging to the sole practitioner or the partners.

An example would be copying and taking a patient list in order to contact patients following departure.

Practices can obtain an injunction against former staff members under a so-called 'springboard'. This restrains the use of confidential information, or benefit, arising from a provable previous wrongdoing.

However, assuming that an employee has done no wrong in leaving the practice but merely wishes to set up in competition, it will not be a breach of the duty of fidelity.

For a practice to restrict with whom, for whom and where an individual may provide their services following departure, that individual must have restrictive covenants in their contract.

A restrictive covenant is considered an unlawful restraint of trade unless the employer or continuing partners can show it goes no further than is reasonably necessary to protect his or their legitimate business interests.

Restraint of trade

GPs should be aware that the Courts will not uphold a covenant in restraint of trade by amending its ambit or duration to what the Court considers reasonable.

This means that if you use a clause aiming to prevent the former partner or employee working within five miles for five years, then this will not be reduced to two miles for six months if the original clause is found to be unreasonable.

GPs should give careful consideration to this because a restraint of trade clause seeking too much may be worth nothing compared to one that has been carefully considered and is justifiable as reasonable.

For employers to enforce a restriction in an employment contract they must be able to identify some advantage or asset inherent in the business that is their own property.

They would have to show it would be unjust to allow the employee to make use of this for his own purposes, for example details of the practice patient list.

A restraint of trade clause just to prevent competition will not be upheld. There must be something in which the business has a legitimate interest in protecting.

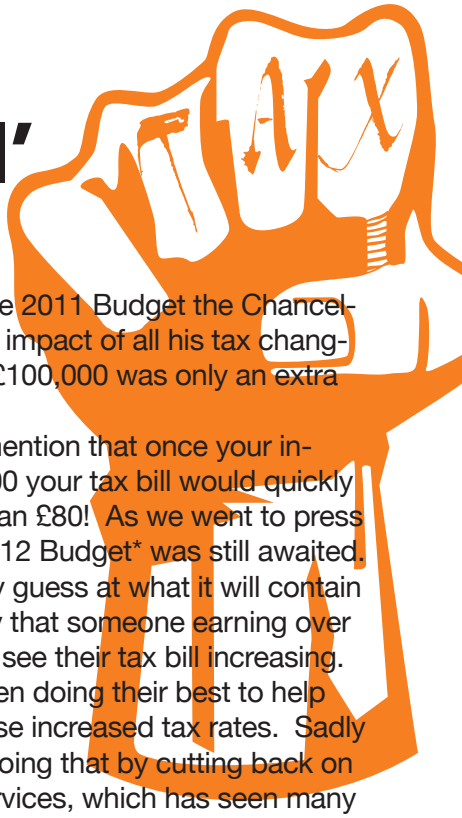
In a recent case a 'springboard' injunction and award of damages were made where the employees had taken part in significant wrongdoing prior to their departure from a business.

But the restraint of trade clauses all failed before the Court and were held to be unenforceable because the business could not find any objective basis for imposing terms to restrain trade.

Andrew Lockhart-Mirams is senior partner at Lockharts Solicitors

OPINION

Why GPs are feeling the pinch in 'tax gloom tunnel'



Bob Senior, Chairman, AISMA

After the excitement of Christmas, January generally brings people back down to earth with a bump. It is a cold, dark and seemingly endless month, which concludes for the self employed with the stark reality of a tax bill. 31 January 2012 proved to be no exception.

The potential for an unpleasant increase in many GPs' tax bills had been flagged up by AISMA members for some time. Doctors who sent in the information needed to complete their tax returns were given precise figures as early as last summer.

But it only seems to have become real for most GPs when the tax payment actually had to be made.

So why did the last tax bill come as such a shock to many?

Let's start with the previous government. It took a view that anyone who earned more than £100,000 a year should expect to bear an increasing share of the tax burden by gradually losing their tax free personal allowance.

For the tax year 2010-11 that allowance would have amounted to £6,475. However it started to be lost at the rate of £1 of allowance for every £2 of income above £100,000.

So by the time an individual's income reached £112,950 the allowance had vanished. That loss effectively cost someone earning more than £112,950 an extra £2,590 in tax. And it exposed them to a 60% tax rate on £12,950.

Due to the way the tax system works, all that extra tax became due for payment on 31 January 2012. But the payment on account for the next tax year was also due to be paid on the same date. And that increased by £1,295 - resulting in the overall tax payment being £3,885 more than would have been paid last July.

That's all bad enough. However the Liberal Democrats are keen that by the end of this Parliament the tax free band will be increased to £10,000.

If the same mechanism that was applied last year continues, which it has for 2011-12, then in the next three years the effective 60% tax band will stretch from £100,000 to £120,000.

The present Government has, perhaps surprisingly for a Conservative-led coalition, apparently continued to regard £100,000 as some sort of glass ceiling for 'ordinary' tax payers.

When he announced the 2011 Budget the Chancellor stated that the overall impact of all his tax changes on someone earning £100,000 was only an extra £80 tax a year.

Strangely he failed to mention that once your income crept over £100,000 your tax bill would quickly increase by a lot more than £80! As we went to press with this Newsline the 2012 Budget* was still awaited. While as I write I can only guess at what it will contain it seems fairly safe to say that someone earning over £100,000 is only likely to see their tax bill increasing.

PCTs have however been doing their best to help reduce the impact of these increased tax rates. Sadly they have usually been doing that by cutting back on funding for enhanced services, which has seen many practices' income reduce as a result.

While lower profits will indeed result in lower tax bills it also reduces a GP's effective take home pay, which is rather less helpful.

Given the pressures being applied to GP profits have we therefore seen the last of the 31 January tax surprises for a while?

For many GPs, perhaps. But for others I am sorry to say a further tax horror may be hiding in the shadows. This relates to the potential tax charge that will be applied to any GP whose pension fund increases by more than the new Annual Allowance.

That allowance is currently £50,000, which sounds like a massive amount. But for GPs in the 1995 scheme who only contribute to the NHS pension scheme it equates to an annual growth in their pension of just £2,631.

Calculating exactly which GPs will be affected requires complex calculations, and quite a lot of data from the NHS Pensions Agency. That data will take some time to obtain and process.

But, for the time being, any high earning GP aged over 48 who has worked full time for all their career should be regarded as being at risk.

And any high earning GP who is paying Added Years contributions is also likely to be at risk.

* **The Budget and you!**

Check out the AISMA website for a rundown of how the 2012 Budget affects GPs - and what you can do about it. Go to www.aisma.org.uk

Redundancy

When it's time to consider the cost of not grasping the nettle

Restructuring and redundancy are ongoing necessities in many GP practices as they seek to stay profitable during these lean times. **Kathie Applebee** runs through the cost implications and advises where you can get help

The NHS and the wider society it belongs to are constantly changing and general practices have to evolve to keep up.

It is worth remembering that it is less than a decade since paper appointment books were the norm for many practices and receptionists pulled and filed paper records for every patient encounter.

The changes which accompanied computerisation and fundholding, for example, were seismic and often resulted in new staff being recruited.

Existing staff tended either to adapt to new ways of working or they left voluntarily, and redundancy was a rare event.

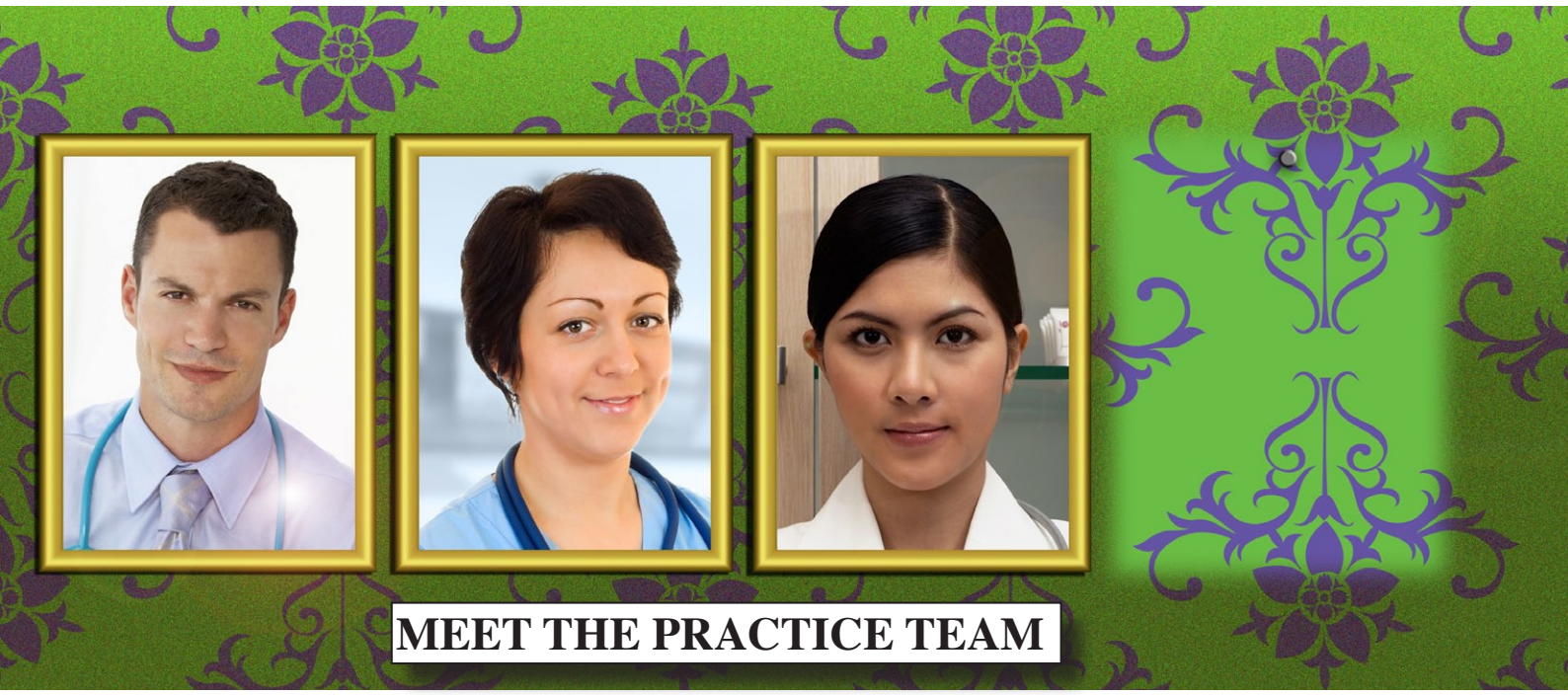
Making roles redundant

Redundancy is never about an individual but only about a role. The need for the role may diminish or end – for example, a former filing clerk may retrain to scan hospital letters but then face the prospect of reduced working hours as electronic discharge summaries reduce the scanning workload.

Other reasons for redundancy, apart from a job being made unnecessary due to new technology or systems, include the need to cut costs, and business closure or moves.

The costs of redundancy are based on the length of the employee's continuous employment, their age and their weekly rate of pay, to a maximum of £430, and can easily be calculated[1].

For example, an employee of 55 with a gross salary of £17,000 who had been with the practice for



20 years would be entitled to 27 weeks of statutory redundancy pay at a rate of £326.92 per week which totals £8,826.84[2].

If the employee stayed on for those 27 weeks, they would cost the practice more than that due to the add-on costs (the employers' NIC (national insurance contributions) and pension contributions, and the costs of covering holidays, study and sickness leave). And, if truly redundant, they would simply be helping others to do their own work.

Considering redundancy

Externally imposed changes such as the end of fundholding are perhaps easier to deal with than those that may occur as a result of internal restructuring.

The latter may result from identified inefficiencies, such as the desk receptionist having less work to do due to electronic check-in screens, or from the more generic need to reduce staffing costs.

Obviously, practice principals and managers may feel reluctant to disrupt working patterns and relationships and be understandably uncomfortable at the prospect of depriving someone of all or part of their income.

But sadly, there are times when there is no alternative and the financial implications of not taking action need to be considered.

There is advice on redundancy available from Direct-Gov and ACAS[3], and the ACAS helpline (08457 47 47 47) is an indispensible first port of call when considering any staffing changes.

If you hold insurance against tribunal costs you must talk to your insurers before taking any action. But an initial call to ACAS, a free service, often helps clarify the issues involved.

The ACAS staff are refreshingly helpful and matter of fact, and can be surprisingly robust in their recommendations.

They understand that businesses have to be profitable and, while seeking to prevent unfairness to employed staff, will help employers review the implications of potential action to promote efficiency and cut costs.

[1] http://tinyurl.com/awxvxj
[2] Redundancy calculator http://tinyurl.com/lv6jcu
[3] http://www.acas.org.uk

Kathie Applebee is organisation psychologist for primary care, strategic management partner at Tamar Valley Health Group Practice, and chairman of the National Vision User Group

Time to refer yourself to a GP pensions specialist

Professional pension planning has never been more vital for GPs. Especially when it is so easy to make costly mistakes. **Gareth Rose** and **David Walker*** report

There has been much coverage recently in the press over the forthcoming changes to the lifetime allowance for pension saving. In summary, from 6 April 2012 the lifetime allowance will reduce from its current level of £1.8m to £1.5m.

As part of the changes HMRC has introduced a form of protection, known as fixed protection, which individuals can apply for. Fixed protection must be applied for before 6 April and essentially 'fixes' the lifetime allowance at its current rate of £1.8m.

But in order to keep fixed protection in place very strict criteria must be adhered to, such as ceasing payments to private pension schemes and testing regularly against growth limits for members of schemes where continuing contributions are permissible.

Also, an application for fixed protection involves revoking enhanced protection, if in place. Enhanced protection is very often a better form of protection - particularly for GPs.

Applications for fixed protection and its implications must be considered very carefully. In particular the revocation of enhanced protection can have drastic effects for GPs.

For those individuals currently in the NHS Pension Scheme the decision as to whether or not to apply for

fixed protection is complex.

So it is essential that you discuss your personal circumstances with an independent financial advisor who has detailed specialist knowledge of the NHS scheme.

But it cannot be stressed enough how thorough the approach needs to be when obtaining advice on the tax and pensions implications arising from the new Annual Allowance (AA) and Lifetime Allowance (LTA) issues.

Take this example based on a real GP's case:

Dr Prodit has a pension sharing order in place for approx £33k (currently) for his ex-wife. He will turn 60 in 2016 but is adamant that he wants to leave the scheme now and defer taking benefits until 60.

While he undoubtedly enjoys a cash advantage for the next few years of around £29k annually, it is not as much as one might have thought.

This is because with the lack of relief on contributions he falls considerably into the 50% band that he previously avoided. And the pension could reduce by £23k a year, which also takes into consideration potential reductions for AA and LTA charges recovered from the benefits.

With an additional loss of the tax free lump of £72k, the cash advantage is almost instantly wiped out.

Similarly, dropping sessions or dropping sessions and ceasing added years provide similar results.

Even well informed GPs may be making decisions based on short term thinking without considering all options.

When providing pensions advice the FSA regulations require the IFA to appropriately consider all the options with their clients before making a recommendation.

Unfortunately we have seen recent examples of inappropriate advice being given by non-specialist IFAs to doctors.

Tax planning options ahead

With the advent of more APMS contracts, and the possibility of any qualified provider type contracts through GP commissioning and restricted core contracts, tax planning may well involve greater interaction with the use of corporate structures.

There are clauses in part 6 of the Health and Social Care Bill that allow LLPs for General Dental Services contract holders which may provide restructuring options. Can GP practices be far behind in being permitted this structure?

Certainly the understanding of the interaction between tax and superannuation on business and personal cash flow will become even more complex and will need detailed consideration in advance.

Some quick tips to ponder for the financial year ahead

AISMA members** give a round-up of tax and profit-making ideas

Cutting capital gains tax

With the replacement of taper relief with entrepreneur's relief, it is becoming more common for partners to have a capital gains tax liability when they retire and sell their interest in the practice surgery.

Consider splitting the disposal of the property interest into two parts falling in different tax years.

This will make use of an extra capital gains tax annual exemption and could save over £1,000.

Tax relief on pensions

While higher earning and longer serving GPs may be hit by the new annual and lifetime restrictions on tax relief on pensions, there are still opportunities for other GPs to make tax savings by well timed personal pension contributions.

For GPs with taxable income between £100,000 and £115,000, tax relief of 60% is achievable.

Ltd company or LLP

Ask for advice about the benefit or otherwise of using a Ltd company or LLP as part of your organisation.

If your spouse or adult children are not using up their lower rate tax band then you should definitely think about it - perhaps to deal with non GMS income or to reduce profits for superannuation purposes.

Ask your accountant about the benefit or otherwise of using 'split-contract' services in your LLP or Ltd company.

Cars

To get the greatest benefit from 100% capital allowances available, only buy a car with low CO2 emissions.

Invest in EIS

With good Enterprise Investment Schemes you can get 30% tax relief to take the sting out of current tax bills.

Premises

If you own your own surgery premises, make sure you have fully claimed for the capital allowances on 'embedded equipment' such as pipes, plumbing and wiring in your surgery premises.

Ensure you get paid for work done

If you use locums, check that you really do have clear systems for them to follow to be certain that the correct claims can be made for the work they do.

This is particularly something to watch out for where locums are not used to using your type of software – and it is a recurring reason why employing practices are still losing money.

Where you suspect they are not recording correctly, make sure someone is able to follow up their work and pick up anything that is missed promptly.

And do not leave it until the end of the year.

The same of course goes for partners, salaried doctors, and nurses. Hopefully your in-house training has already been able to tighten up on this.

But accountants still hear stories of lost money because someone did not realise that they had to record something in a particular way.

Make your assets sweat

Rent your premises in evenings and weekends to other non GMS providers, for example stress counsellors, acupuncturists, and weight management specialists.

AISMA Doctor Newsline is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK. www.aisma.org.uk

AISMA Doctor Newsline is edited by Robin Stride, a medical journalist and former finance editor of Doctor magazine. robin@robinstride.co.uk

*Gareth Rose, financial planning consultant and David Walker, senior tax manager Healthcare Services, Moore and Smalley LLP (Moore and Smalley are regulated by the Financial Services Authority); **Luke Bennett, Francis Clark LLP; Liz Densley, Honey Barret; Mike Ogilvie, OBC The Accountants.

Rotherham Office:
The Old Grammar School
13 Moorgate Road
Rotherham
S60 2EN
Tel: 01709 828400
Fax: 01709 829807
Email: info@allotts.co.uk

Doncaster Office:
Sidings Court
Lakeside
Doncaster
DN4 5NU
Tel: 01302 349218
Fax: 01302 321739
Email: donc@allotts.co.uk

Website:
www.allotts.co.uk

Directors:
Tony Grice BA FCA Cert PFS
Jackie Saunders BA FCA DChA
Steven Pepper FCA
Neil Highfield FCA
Steven Watson BA ACA CTA

Associate:
Mark Garrison BCom FCA DChA

Specialist Sectors:
Farming & Agriculture
Charities & Not for Profit
Education
Medical Services
Sage Support
Professional Practices
Solicitors
Trusts & Estates

Allotts Services:
Business Services
Corporate Services
HR Services
Independent Financial Advisors
(Provided by Allotts Financial Services Ltd)
IT Services
Payroll Services
Taxation Services
VAT Services
Wealth Management