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association of independent specialist medical accountants

AISMA Doctor Newsline

A helpful resource for the practice business

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Now promise to make these New Year resolutions!

Many GPs and their practice managers would greatly benefit financially in 2010 by making some new year's resolutions to their accountants. **AISMA member firms*** set out what they would like to see

GPs' practice managers are generally very good at providing the practice records to the accountant soon after the accounting date - but accountants spend a lot of time chasing expenses claim details from individual partners.

AISMA accountants find the annual 'big chase' one of their biggest problems and it is the area they complained about most when they were asked for their resolution ideas.

Most GPs need to know their tax and superannuation bills well in advance of the due payment dates and although estimated calculations can often be prepared, these may have to be revisited on numerous occasions as information from individual partners becomes available. This means more time spent by the accountant - and a bigger bill for the GP.

The practice tax return cannot be produced, and the individual GPs' tax calculations cannot be finalised, until the expenses figures for all partners are available.

So, no prizes for guessing that the top of the new year's resolution wish list is this -

I promise to:

1 Provide my accountants with my personal expense claim information when they are preparing the practice's annual accounts. This will ensure that my accountant is able to compare partners' expenses claims to see they are reasonable.

It will also enable my accountant to provide more accurate estimates of superannuation and taxation liabilities with the accounts.

I will remember that partnership tax returns and Annual Certificates of Pensionable Profits cannot be completed without partners' expenses claims and completion is often delayed due to one partner's late expenses claim.

And I will be mindful that late submission of a partnership tax return will result in a £100 penalty for each partner.

The other resolutions to promise are to:

2 Remember that successful businesses set their objectives then manage the business to achieve them.

With my partners I realise we should resolve to set objectives for the practice over two to three years, create a plan and budget designed to achieve those objectives, then manage and monitor the practice to ensure that progress is on course. We should also be aware that an AISMA accountant is best placed to help us at all of these stages.

3 Resolve to exercise greater control over practice expenditure.

This means being aware of and authorising expenditure before it is incurred – not when it is time to write the cheque, which is too late.

4 Ensure that I can defend the amount that I claim as business usage for my cars in the event of a challenge from HM Revenue and Customs.

I will take notice that the best way to achieve this is to keep a record of actual mileage (business and private) for a period of three or four weeks in order to establish evidence for the pattern of usage.

In addition, I will ensure this procedure is updated whenever the pattern of usage changes.

5 Stop recording practice finances on the back of an envelope. I now do realise it is becoming more and more essential for GP practices to control their finances to ensure profits are maintained.

In my practice we will consider investing, as you advise, in a computerised system which can produce information for practice use as well as assisting you.

I have noted that several systems are available - GP accounts by Iris, Quickbooks by Intuit, and for those who have some accounting experience, Sage.

My first step will be to obtain details from the providers now (see below), and then to discuss with my accountant about the setting up of the software, production of reports, and the use of the information produced. I recognise this should be done before the commencement of my financial year.

www.quickbooks.intuit.co.uk
www.healthcare.iris.co.uk
www.sage.co.uk

6 Provide my accountant with as much detail as possible about my income from the PCT.

Too often in the past, when I have been asked after a year or more what a certain receipt is for I have had no idea.

I recognise it is relatively easy to record more detail shortly after receiving the receipt than it is several months later. This will then allow my accountant to do a more detailed comparison of income from one year to another, and across practices.

7 Not take on any new borrowing without talking to my accountant about it first.

I accept my accountant will have a good idea of the best rates available in the present market and may be able to get me a much better deal than the one I am offered.

8 Provide not only all my personal tax information to my accountant by the date the accountant requests and I have promised (or even earlier) but give it in the way that has been requested, where applicable using my accountant's own questionnaire.

I recognise that this questionnaire has been drafted for a reason, ie, to record everything my accountant can think of.

Now I realise that my own spreadsheet is most unlikely to contain all the information the accountant needs, such as provision of GP Solo forms or related data, and a detailed log of the business use of my car.

9 Remember that my accountants are not thought readers and, if my partners and I have divided drawings between ourselves in any way other than the profit sharing ratio during our financial year, then we promise to provide a schedule explaining what we have done and why.

I understand that 'prior shares of profit' can then be allocated where appropriate, rather than having to have the accountant redo the draft accounts later when my partners and I suddenly realise that our current accounts have big differences that we were not expecting.

10 Keep a spreadsheet in my practice of all our claims for payment or reimbursement so we can check the schedules returned each month with our payments against what we expect to receive. On this schedule we will have a record of what we claimed and received in the same period last year.

This way, when we meet our accountants to review the accounts, we will not spend unnecessary time asking why exactly our income for particular categories is different this year – we will already know. And our accountants will then have a useful schedule to double check against their figures.

Don't take the 60% tax rate lying down

Some well-publicised changes to tax rates come into effect in April. **Anthony Brand** explains what they are, how they might affect GPs and why you should take action now

What is changing?

The changes to tax rates from 6 April 2010 are:

- Loss of Personal Allowance (PA) - £1 loss for every £2 of income over £100,000).
- 50% income tax rate for taxable income over £150,000. Taxable income is after deducting reliefs for qualifying loan interest and superannuation contributions.

Measures have already been implemented to restrict tax relief on the latter to the basic rate in certain situations. However most commentators believe that GPs' NHS superannuation contributions count as defined benefit contributions and the fact that some payments may be at irregular times (for example annually) should not render them restricted for tax relief.

What is the effect?

The table at the bottom of the page shows the income tax (ex. NIC) liability for a range of taxable incomes in three different tax years.

The tax bands are effectively:

£0 - £6,475(PA):	0%
£6,475 - £34,800	20%
£34,800 - £100,000	40%
£100,000 - £112,600	60%
£112,600 - £150,000	40%
£150,000 and above	50%

Many GPs will find themselves in the £100,000-£112,600 bracket – this final slice is taxed at 60%.

When will I be affected?

Any additional tax due in 2010-2011 will need paying by 31 January 2012. Bear in mind that payments on account in January and July 2012 will also have been uplifted by the additional tax.

But before you say 'that's ages away' please bear in mind the usual practice accounts dates that will be assessed in 2010-11:

If your year-end is 31 March: 31 March 2011

If your year-end is 30 June: 30 June 2010 – this year is in progress now!

What can I do? Simple steps

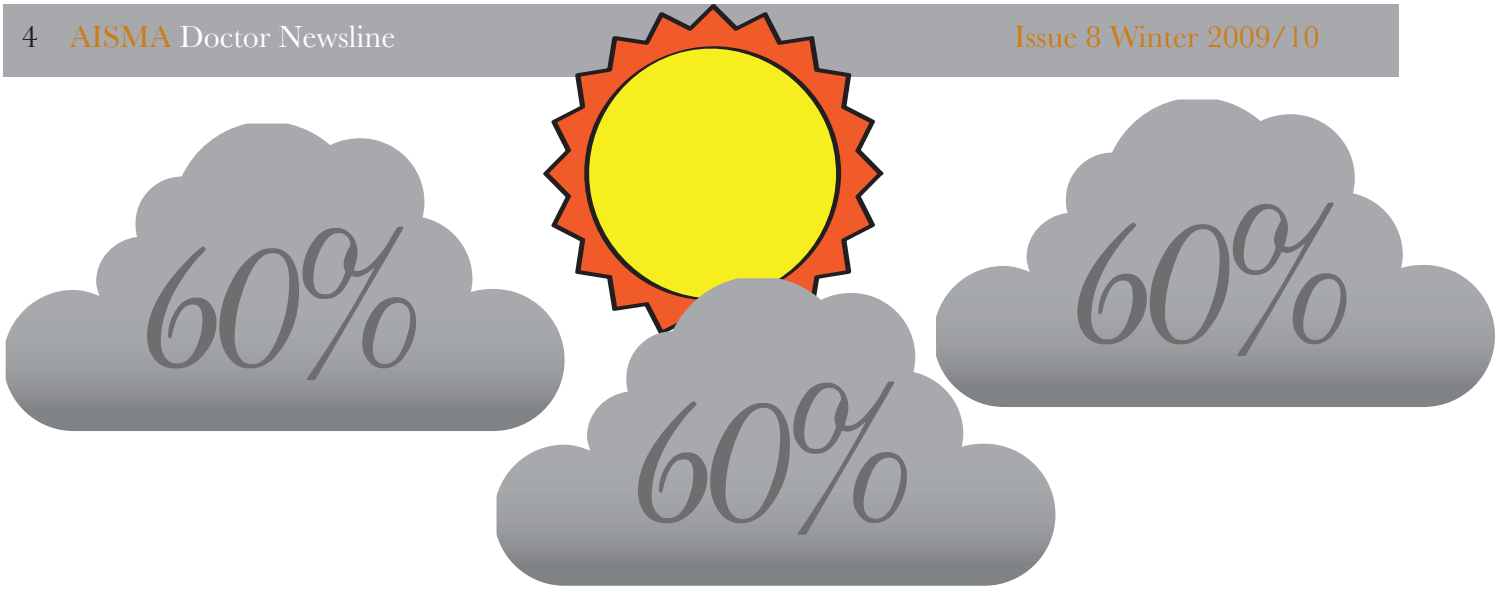
1 Ensure your accounts are accurate

In recent years payment of income such as enhanced services has become far more delayed and sporadic. Unless care is taken it is possible that income earned in one year is not identified and therefore is accounted in the following year.

It will be costly if income earned in the year to 30

Income tax liability

Taxable income	2008/2009	2009/10	2010/2011	Additional tax in '10/11
£100,000	£30,626	£29,930	£29,930	£0
£150,000	£50,626	£49,930	£52,520	£2,590
£200,000	£70,626	£69,930	£77,520	£7,590



June 2009 or 31 March 2010 was not identified in the accounts until the following year – where its wrongful inclusion might push the partners into the 50% band! Particularly:

- Enhanced services.
- Drug reimbursements.
- Release of clawbacks, for example seniority pay.
- Insurance reports and private income.
- One-off income and reimbursements.

Consider keeping your June 2009-March 2010 accounts open longer in order to identify late income. It may not be too late to reopen June 2009 accounts if necessary. You can help your accountant by telling him of any late income that you are aware of.

2 Review your expenses

Personal expenses claims should not be a last minute afterthought and must be justifiable to HM Revenue and Customs. However are you losing out? When did you last review your personal expenses?

3 Ensure that you 'pay' your superannuation in time by 5 April

Superannuation certificates should be submitted in good time to allow the PCO to deduct any shortfall in the March statements. Late processing will mean the tax relief skips a year – that could be costly.

What can I do? More complex steps

Seek advice as the following suggestions may be ineffective if legislation changes.

4 Salary and dividends

If you currently organise any of your activities through a limited company then consider paying larger than normal directors' fees or dividends to shareholders prior to 6 April 2010 with a corresponding reduction in the following year. You will need to take advice to ensure the company uses the correct procedures.

5 Limited company

A limited company may work as a tax mitigation vehicle in certain circumstances but it is definitely not a panacea for everyone. An AISMA accountant can advise you further.

6 Defer non-urgent expenditure so it falls in 2010-11 for example:

- Capital expenditure, such as equipment and even surgery extensions.
- 'Green' cars with 100% tax relief.
- Repairs.
- Staff bonuses and parties.

7 Partnership matters

- Single-handed GPs who employ their spouses, perhaps as practice managers, could consider taking them into partnership. Again seek specific advice as there are other matters to consider.
- Review the financing of partnership capital.

8 Review personal income. Consider:

- ISAs.
- Offset mortgages.
- Gifting income-producing assets (such as rental properties) to your spouse.
- Rearranging investments to make use of 18% CGT rates and the annual exemption..

What can I do? Spending money to save tax

9 Tax efficient investments

If you do not mind parting with cash to reduce your tax bill, there are investment options available, which generate tax relief of 20-30% of the cost. There are capital gains tax exemptions available on disposal. Your investment adviser should be able to provide more details.

And finally...

This problem is now with us, however some of the rules may change as the Government (or its successor) tinkers with the tax system – seek help now so you do not pay more than necessary later on.

Financial Diary

Topical jottings of a money-minded GP

Tax cutting wheezes are top priority

For GPs, the top financial priority in the first quarter of 2010 must be looking at reducing the impact of the Chancellor's tax reforms from the 6 April.

The restriction in personal allowances for those earning above £100K will affect most family doctors. I have been speaking to colleagues but unfortunately many are not aware of the change.

A few though are planning ahead. One near retiring is reducing his sessions so that he earns less than the threshold.

Another is stopping out-of-hours work. She sees no benefit giving up her spare time to give the Government 60% of her extra income.

I plan to take out a stakeholder pension to reduce my tax payments. Putting £14,000 into my pension will only cost £5,600.

New university contract brings benefits

I have been a part time lecturer with the local university for some years. I enjoy teaching medical students and it is nice to get out of the practice from time to time and engage with young and inquiring minds.

Now the university has offered me a new contract. Rather than being paid an hourly rate the new contract is fractional, based on a full time lecturer at the top of the consultant scale.

The actual hourly rate is less but as the new contract includes preparation time and holiday pay the new effective rate is slightly higher. What's more, the new contract allows me to join the university pension scheme.

For me the icing on the cake is free use of the university facilities including the library, meeting rooms and sports facilities. So I have decided the new contract is not something I will pass by!

Check-ups are good for my wealth

We have recently had sight of our draft accounts for the last tax year. They are late as a partner retired.

Our accountant is very good but it is important to always check within the practice in case there are any mistakes. I found three errors that would have affected my capital account.

Firstly I had an extra payment against my name as a cash drawing but it had been a personal payment for extra student teaching I had done in my own time.

It should not have gone through the accounts as a payment to the partnership but should have been entered in the personal salary part of the accounts.

Secondly three locum payments I had been paid for attending some meetings had been double counted.

Thirdly a PMI cost had been split among the partners - but was a personal expense of just one of us.

Top Tips

- Make plans to reduce tax liabilities
- GPs involved in student education may benefit from a fractional contract rather than ad hoc payments.
- Even good accountants make mistakes. Always check the practice accounts.
- Review the appropriateness of treatment room appointments and consider expanding the role of treatment room assistants to include dressings.
- A nurse practitioner locum might be able to see the majority of the patients a medical locum can see - at a reduced fee.

Treatment review frees-up nurse and GP time

Over the last three months there has been extreme pressure on our nursing team due to sickness and maternity leave. Our full time treatment room assistant has been absent which has meant the trained nurses have had to pick up more bloods.

I recently reviewed the use of phlebotomy appointments and found that some of the partners were using these inappropriately.

For example, one partner insisted that patients on statins should have fasted cholesterols. This was putting pressure on early morning appointments. Fasting cholesterols are not necessary.

Also, some partners were monitoring patients on anti hypertensive treatments too frequently and one partner was getting diabetic bloods too often.

In total about 20% of appointments were unnecessary because doctors were not sticking to practice protocol.

We are planning to put our treatment room assistants on a dressing course so that they can take over simple dressings from the nurses. This means these extra appointments will be well used and will free-up nurse time for more chronic disease management. This in turn should free-up doctor time.

Locum nurse practitioner fits the bill

Like many practices we have been very busy with the current flu outbreak. My colleagues have been keen to arrange a couple of locum slots to take the pressure off.

I suggested we try to get a locum nurse practitioner as this would be cheaper and most of the extra patients could be managed by her. As a rule, any medical locum usually attracts acute illness rather than anything too complicated.

I contacted a couple of nurses who work in the local out-of-hours service and one of them was happy to take on a couple of extra sessions. This worked out at half the cost of a doctor locum.

Opinion

Book your accountant for a 2010 route planner

Deborah Wood, committee member, AISMA

January sees us all looking ahead in the hope of a better year than before - but can GP practices realistically do that?

Having largely completed the round of 2008-09 accounts, tax and superannuation compliance work - which generally showed a trend towards reduced practice profits - is it likely that 2009-10 and 2010-11 will tell us a different story?

A few new enhanced services, careful cost controls, GMS practices with little or no correction factor, the odd PBC freed-up resource and deanery grant seem to be the only glimmers of good news.

Difficult negotiations with PCOs, particularly for PMS and APMS contract values, reduced fees for dispensing and personally administered drugs, harder targets for QOF points together with the impact of prevalence, the continuous whittling away at the MPIG correction factor and generally increasing overheads may only mean standing still at best.

In addition, practices will have to gear-up for Care Quality Commission accreditation, balanced scorecard performance reviews with PCTs, and the inevitable squeeze on PCO budgets imposed by huge national debt problems.

The start of the year must therefore be the time for practices to dust off their strategic plans and update them, review cash flow forecasts and get prepared for a tightening of belts.

Planning ahead is particularly difficult right now as political changes following a general election are by no means clear.

Signs of an early warning of contract changes beyond April do not seem to be materialising either. But it should be possible to spend some time usefully assessing strengths and opportunities and fully understanding the 'bottom line' implications of proposals.

In my opinion your first New Year's resolution should be to book an extra meeting with your AISMA accountant as soon as possible to take these issues forward for both the practice and at an individual level for the partners.

Local AISMA accountants are well placed to assist with this process and to help you evaluate what is achievable in the most tax and pension-efficient way.

Achieving practice quality in a cold climate

Working towards cost-effective quality is a sound starting point for the money saving marathon ahead, advises **Kathie Applebee**

The NHS financial manager's bedtime reading recently has included two challenging publications:
How cold will it be? Prospects for NHS funding: 2011-2017 (The Kings Fund) *and Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers* (The Health Foundation).

In the first, by the Institute for Fiscal Studies, there is a fullness of gloomy forecasts about funding constraints in the English NHS, described evocatively in terms of:

*'tepid' - annual real increases of 2-3%

*'cold' - zero real change, and

*'arctic' (annual real reductions of 2% for the first three years, falling to 1% for the final three years of this six-year period.

The second sets out to consider the costs of quality improvements and the accuracy of the associated calculations.

These two reports provide an interesting juxtaposition as the former assumes that quality needs to continue to improve whereas the latter tackles such interesting questions as the value of certain interventions for quality improvements, and the cost effectiveness of some which do in fact improve quality.

It suggests that managers and policy makers could be both more sceptical about generalised claims but also more adventurous in seeking out effective improvements.

In general practice, the financial squeeze has been felt for some time, exacerbated by the rising demand for services. The fiscal pressures may have had the effect of hasty solutions being sought for the former problem, and insufficient resources allocated to tackling the latter.

My choice of the word 'tackle' is deliberate: this is an evolving problem which does not have long-term solutions at local level.

Staff costs

The greatest expense for virtually every practice is its staff bill. Practices can best prepare for the chill of 2011-2017 by planning to reduce these costs.

A core generalisation involves tightening up on skill mix, so that every task is done at the appropriate level: for example, healthcare assistants (HCAs) do six-monthly blood pressure checks, where indicated, rather than GPs or even nurses. However, does this save money – and what about the quality?

Some practices might argue that the cost of an HCA could be saved by GP partners doing all such work, their days being supposedly elastic.

This is where the quality argument appears: does an overworked GP do a better job in such instances than an HCA working within a more protected timescale? And is it in the practice's interests to run its prime assets, the GPs, into the ground?

There are few simple, one-size-fits-all answers to such questions. However, there are some simple rules:

Quantity doesn't automatically equate to quality.
Don't take on additional staff if the existing ones are poorly trained or supervised.

Step back periodically and consider the workload critically.
If work is constantly being done at a more expensive level than required, there is an associated cost, which may be financial or human. The latter may turn into a financial drain if mental or physical ill health results.

Keep a sense of perspective.
Work should be challenging but not exhausting. If partners and staff have to moderate their working hours and/or income to stay healthy, the practice should strive to accommodate such changes.

The saying that general practice is a marathon rather than a sprint has never been truer than now as we peer into the financial abyss.

Those practices not yet in training need to get started, and working towards cost-effective quality is a sound starting point.

How cold will it be? *Prospects for NHS funding: 2011-2017. The Kings Fund. http://www.kingsfund.org.uk/research/publications/how_cold_will_it_be.html*

Does improving quality save money? *A review of evidence of which improvements to quality reduce costs to health service providers. The Health Foundation. http://www.health.org.uk/publications/research_reports/does_quality_save.html*

Kathie Applebee, organisational psychologist for primary care, and strategic management partner at Tamar Valley Health Group Practice
www.kathieapplebee.org.uk

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

* AISMA member contributors: Sarah Robinson, Mazars, Brighton; Anthony Brand, Haines Watts Kent, Maidstone; Andrew Goddard, Forshaws, Southport; David Clough, Charles Rippin & Turner, Harrow; Alan Smith, Barlow Andrews, Bolton; Luke Bennett, Winter Rule, Truro; Sue Beaton, Coveney Nicholls, Reigate; Liz Densley, Honey Barrett, Bexhill on Sea; Andrew Redmayne, Redmayne & Co, Kingsteignton, Newton Abbot; Mike Ogilvie, OBC The Accountants, Eastbourne