

## HM Revenue & Customs Tax Health Plan

Doctors were given an offer from the taxman they may find difficult to refuse. 'Shop yourself if you've underpaid – or we will be down on you like a ton of bricks'.

All 'medical professionals' are being 'encouraged' under what the taxman calls 'The Tax Health Plan' to tell inspectors if they have understated income, or overstated expenses.

In return for complete and accurate disclosures, HMRC is offering to accept a reduced fixed penalty of 10% of the total unpaid tax and national insurance (NI), with no penalty at all where the unpaid duties are less than £1,000.

Over the last few years, HMRC has been selecting enquiries into medical professionals primarily based on, in its view, excessive business mileage expenditure claims and similarly high capital allowances claims. Secondary expenditure 'risks' were the use of home as office claims, wages paid to family members and meeting/conference travelling costs. In many cases, HMRC found the record keeping to be incomplete. This was attributed to medical professionals being overstretched because of their NHS and private practice commitments.

After in-depth review and analysis of the business records and the business bank deposits, HMRC discovered several cases where the medical professionals had not declared all of their private practice income, or their private practice awards and commissions received from BUPA, Sun Life and other medical insurers.

### Making a disclosure

- The first deadline was 31 March 2010. This is the date by which HMRC had to be notified of the intention to make a disclosure.
- The second deadline is 30 June 2010. This is the date by which the disclosure has to be made, as well as payment of all of the additional tax, NI, interest and penalty arising.

It is important to remember that the disclosure has to include all undeclared

liabilities, whether in the form of additional income received or excessive expenditure claimed.

### Potential dangers

The calculation of any additional income to be declared should be relatively straightforward, depending on the paperwork and evidence to be gathered and the number of years involved. However, the disclosure of excessive expenditure claims is more problematical.

The mileage issue is still a highly contentious area. Medical professionals have typically been treating their homes as their business base with regard to their private work and claiming business mileage on journeys to visit their private patients. HMRC has sought to disallow the mileage from and to the home on duality grounds and argued that the business base is the hospital or clinic at which the private client is treated.

Medical professionals have responded by stating that their home is used as a business base to conduct research, issue, maintain and store paperwork and, in some cases, to conduct initial examinations and treatments.

There are several other types of expenditure doctors claim and that HM Revenue & Customs are currently interested in.

Spouse's salary can be allowed if it is for secretarial services, telephone answering, appointment making. The salary must be commensurate with the work done. The actual amount of salary should be transferred to the wife's bank account. There is also a chance to make a personal pension contribution to the wife based on her salary.

Conference fees are a further item. These must be relevant to the GP's work and be wholly exclusively and necessarily for business use.

The business proportion of home telephone and broadband costs from home can also be claimed.

HMRC is happy to allow a reasonable use of home as office claim i.e. their flat rate of £3 a week but has called into

question some of the amounts claimed, particularly those that include a mortgage interest element.

There are various other expenses which may also be allowed i.e. staff entertaining up to a limit of £150 a head per annum. Also accountancy fees for personal practice expense claims and locum services.

While the undeclared income to be included in a disclosure under the THP may be quantifiable with relative ease and accepted by HMRC, deciding what to disclose as disallowable expenditure is more troublesome.

A situation could arise in which HMRC is happy with the undeclared income disclosed but unhappy that no expense related adjustments have been made. This could lead to an enquiry and the incentive of the reduced 10% penalty lost. Where this is the case, HMRC has signalled that the minimum penalty is likely to be 30%.



## Marketing of GP Earnings

GPs will be able to market their services to patients far out of their geographical area under consultation plans released by the Department of Health.

The consultation is seeking views on a wide range of proposals, in particular around the issues involved in arranging home visits, co-ordination of community based services, safeguarding access for local residents, and access to hospital and specialist treatment.

According to the health department, most patients are happy with their current GP practice but a significant minority would like to have a different doctor.

Doctors in city areas could benefit from the changes as research shows some patients would like to register with a practice closer to where they work.

But other GPs could get more registrations from more local people who move to them to take advantage of longer opening hours or extra services.

Some patients also want to stay with their present GP even if they move away from the area.

Health Secretary Andy Burnham said: "Giving people more choice of GP services will help drive up standards and improve quality. It is the right move at the right time. This policy will drive change, and allow for more responsive primary care for all. We know that to make this work, some changes will be needed, for example, how we organise home visits for those people who choose to register with a practice further away from where they live.

"That's why we would like to hear from patients, GPs and practice staff with their views on how the new system should work and how we ensure patients have a wider and more meaningful choice of GP practice."

Mr Burnham made his comments on a visit to a medical centre in Wandsworth. Managing Partner, Dr Seth Rankin, commented: 'Having a wider choice of GP services and being able to register at practices that are nearer to your place of work or your community is something that many patients would really appreciate. If the problem of home visiting patients living long distances away can be worked out it is an exciting new challenge for general practice which we look forward to'.

## Pension relief problems

The Government has brought in proposals to restrict tax relief on the pensions of high earners to 20% from 40%. This encompasses all those pensions that are greater than £20,000 and paid into an unprotected pension scheme.

Your scheme is 'protected' if it was in existence at 20 April 2009 and regular monthly or quarterly payments have been made to it. The proposal will affect GPs earning more than £130,000 a year and who pay into a private pension as well as the NHS scheme. They will need to know if they have exceeded this £20,000 limited.

A calculation will have to be done by NHS Pensions Agency to determine whether the £20,000 limit has been reached. If this is the case, and you have received too much tax relief on your pension, this will have to be repaid.

At the moment, the Pensions Agency are unable to do the calculation until the Superannuation Certificate is submitted. This is usually after the accounts and tax returns have been completed. This causes a problem in that the figure will not be known in time for the tax return submission. Hopefully, a solution to this problem will be found in the near future.



## Direct payments set to put more people in control of healthcare

Direct payments for healthcare have recently moved a step closer with a new consultation launched by Care Services Minister, Phil Hope.

Personal health budgets are being piloted in primary care trusts until 2012 – direct payments will form part of these. Personal health budgets will help to create a more personalised NHS by giving people more choice and control over how money is spent on their care.

The three ways that a personal health budget can work are:

- A notional budget held by a commissioner, such as their doctor or primary care trust;
- A budget managed on the individual's behalf by a third party, such as a charity or user trust; and
- A cash payment to an individual and managed by them (a healthcare 'direct payment').

Trusts are already able to offer the first two options, which do not involve giving money directly to individuals. The consultation seeks views on the rules for making direct payments as well as proposals for setting up and evaluating direct payment pilots. The consultation closed on 8 January 2010. The power to make direct payments is in the Health Act that received Royal Assent on 12 November.

“There are some really inspiring stories already from people whose lives have been transformed by personal budgets – they get more choice and control over their own care. By making direct payments available in healthcare, I know many more people will feel the benefits. We want to make sure we get this right and I want everyone to have their say to make sure we do. **Phil Hope**”



## Doctors' pay award 'fair' claim NHS employers

The Government accepted all but one of the Review Body's recommendations for General Medical Services (GMS) and General Dental Service (GDS) contracts.

NHS Employers said 'We support pay restraint for GPs and dentists and are pleased that the Government has taken into account the evidence we submitted on affordability and that such awards should take into account any efficiencies that practices may achieve. The Government has also decided that it would not be unreasonable to expect GPs and dentists to make a 1% efficiency saving on their expenses'.

Andrew Clapperton, head of primary care workforce and contracting at NHS Employers, said: 'We have consistently made the argument over a number of years that these awards should take into account prospective efficiency savings and can understand why the Government has made the decision that it has'.

NHS Employers said a pay increase of 1% for salaried GPs, salaried dentists, speciality and associate specialist grade (SAS) doctors and doctors in training in England was acceptable 'however, we acknowledge that it creates a pressure as the increased cost has to be met by individual trusts already facing financial difficulties'.

Gill Bellord, director for core membership services at NHS Employers, said: 'We welcome pay restraint for consultants in the NHS. The evidence we gave to the Doctors and Dentists Review Body (DDRB) called for constraint as increases would not be

helpful in the context of such difficult economic times. In addition, we understand the Government's decision not to increase the pay of board level senior managers. It is reasonable that senior staff in the NHS should lead by example and demonstrate their commitment to meeting the current financial challenges'.

'The award includes a new 5% pay supplement for the small number of year one foundation (FY1) doctors in posts attracting basic pay (approximately 10% or 600 posts) and this places an additional financial pressure on trusts. This is designed as an interim adjustment to pay pending the work which we have been commissioned to undertake to look at the effectiveness of the current contractual arrangements for junior doctors'.

Ms Bellord added: 'We believe that overall the outcomes for doctors, dentist and very senior managers, which were announced, are fair while reflecting the need for efficiencies that all NHS organisations are being asked to deliver'.

Initial reaction to the doctors' pay award is one of disappointment from GPs and hospital doctors.

'The Government has also scaled back the uplift that was essential to counter increases in GP's expenses, which has resulted in another pay cut for family doctors'.

GPs have been told they will receive an overall gross uplift of only 0.8%. This will result in no net increase in their pay.

NHS Employers said the uplift was to meet expenses and took into account a 1% saving on the expenses component.

In what is yet another disappointing award for doctors generally, the Government's decision on Review body recommendations for 2010-11 are:

- No change for the salaries of medical and dental consultants.
- General dental practitioners will receive an overall gross uplift of 0.9% which will result in no net increase in dentists' pay. The uplift is to meet expenses and takes into account a 1% saving on the expenses component.
- Speciality and Associate Specialist (SAS) doctors and all junior doctors in England will receive an increase of 1% although there will be a new 5% pay supplement for FY1 doctors in posts that only attract basic pay.

The Government has decided to freeze pay for certain very senior managers in the NHS following recommendations from the Senior Salaries Review Body (SSRB). This applies to board level staff in PCT's, ambulance trusts, strategic health authorities and special health authorities in England. It was 'interesting' that the Government accepted in full the salary increases recommended for MP's 'yet chose to penalise dedicated and hard-working doctors who strive to lead and deliver improvements in care whilst working in exceptionally challenging circumstances'.

## PBC makes care more cost effective, say GP Commissioners

GPs believe practice-based commissioning (PBC) is now improving its impact on patients experience and their local community by bringing more cost effective care closer.

The quarterly PBC GP survey, has been updated to ask more accurate questions directly to commissioners themselves, rather than a random sample to GP practices.

According to the Department of Health, this better measures the impact of PBC and the level of support PCTs give to practice-based commissioners in helping improve services.

From data collected between October to December 2009, 80% of practice-based commissioners believe that their work investing in better quality, better value, and better-designed health services, is showing some impact to their patients to bring about improvements in local health.

80% of practice-based commissioners consider that PBC had had some impact in bringing care closer to home, and 77% said their efforts have improved the patient experience to some degree.

Other key findings show that:

- 77% say their actions have made care more cost effective;
- 80% of practices have agreed a commissioning plan with their PCT, compared to the previous survey reporting 64% of practices of July to September 2009;
- 81% have submitted business cases for service re-design to their PCT this financing year- of these 80% have had at least some of these approved, and 66% have had at least some implemented;
- 82% of respondents rate their relationship with the PCT as good, compared with 60% of practices in the previous quarter's survey;
- 84% of PBC groups and independent practices have received an indicative budget, compared with 61% of practices in the July to September 2009 survey; and
- 57% rate the quality of management support as good, compared with 50% of practices rating it good in the previous quarter's survey.



### The Budget 24 March 2010 – an overview

#### Income Tax rates for 2010/11

These are frozen at 2009/10 levels

- 20% tax on income up to £37,400
- 40% tax on income greater than £37,400
- 50% tax on income above £150,000
- Personal allowances frozen at 2009/10 level (£6,475 for person under 65)
- Personal allowances taper away once income exceeds £100,000. Earnings between £100,000 and £113,000 are effectively taxed at 60% due to loss of allowance.

#### Capital Allowances

Annual investment relief increased from £50,000 and £100,000.

#### Stamp Duty

1% rate of stamp duty extended to residential properties up to £250,000 where property bought by first time buyer as sole/main residence. This applies where date of completion was on or after 25 March 2010 and before 25 March 2012.

Stamp duty tax is increased to 5% on residential property where consideration exceeds £1million.

#### Capital Gains Tax

Capital Gains tax rate is to stay at 18%.

Entrepreneurs relief lifetime limit increased from £1m to £2m with effect from 6 April 2010.

#### ISA's

Limits increased in 2010/11 to £10,200 per individual, £5,100 can be in cash. ISA limits to be index linked in future.

#### Inheritance Tax

The nil rate bade for inheritance tax will be frozen at £325,000 until the end of the tax year 2014/15.

#### VAT

VAT rate to stay at 17.5%.

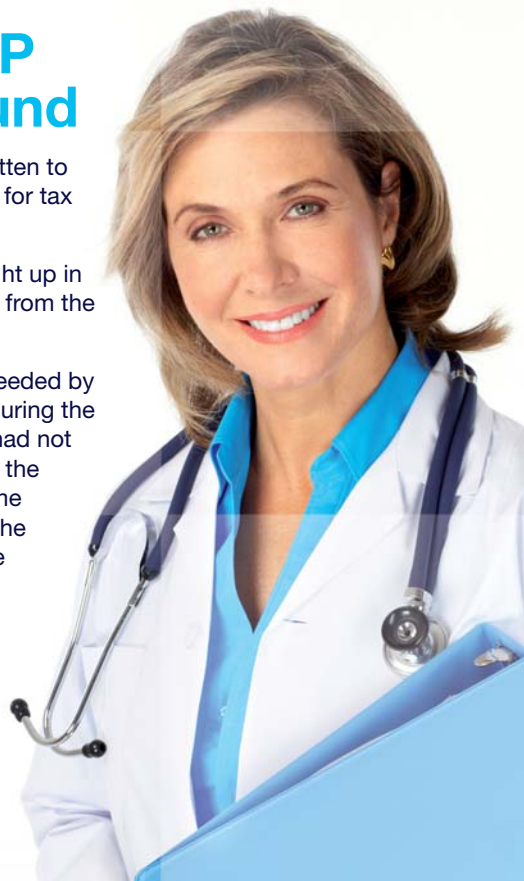
## BMA calls for GP pension tax refund

The BMA pensions department has written to Health Secretary Andy Burnham to call for tax refunds for some recently retired GPs.

It said some doctors had become caught up in unintentional tax consequences arising from the 2008 pensions judicial review victory.

The doctors' body said refunds were needed by some GPs with pensionable earnings during the tax years 2005-06 and 2007-08. They had not applied for enhanced protection during the phase-in period for the maximum lifetime allowance because they did not know the dynamising factor uprating would make them exceed the lifetime allowance.

Last year that funding had been put aside to pay back two groups. These were GPs who retired before 6 April 2006 and then had their benefits reassessed – pushing them over the lifetime allowance, and relatives of GPs who had died over two years before they received the recalculated lump-sum death benefits.



# Proposed New Regulatory Framework

The precursor to the extension of the Care Quality Commission (CQC) is CIAMS: The Commissioners' Investment and Asset Management Strategy. CIAMS is the DoH's guidance on estate strategy for PCTs. The intention is to create a 'Doomsday Book' of primary healthcare premises provision, and it was originally to be completed by April 2010. CIAMS will provide a comprehensive analysis of all primary care properties, together with a description of their condition, functionality and quality and so on. This information is a useful reference point for the CQC in deciding with which premises to start its appraisal.

From the GP's point of view, CIAMS has relevance in three ways.

- It engages in defining strategy – the purpose behind the gathering of factual information, and something which practice-based commissioning (PBC) clusters should involve themselves.
- Those practices that wish to consider whether to develop new surgery premises will have information available relating to neighbouring surgery premises.
- The information gathered will be a 'early warning' sign to particular practices as to whether or not they are likely to pass the CQC benchmarks.

## Licensing and revalidation

Over the next few years, the GMC will be changing the way in which UK doctors are regulated to practice medicine. From 16 November 2009, GPs were required to obtain a licence to practice. This license constitutes the 'first practical steps towards introduction of revalidation'. The start of 2010 has seen a new round of consultation on revalidation – the central element of which is the design and delivery of new appraisal arrangements in England.

As with so much other regulation, it is a key element of revalidation that there is 'unequivocal commitment from the highest levels of the responsible organisation to deliver a quality assured system of appraisal'. This means that all GPs **must** buy in to the process.

## Complaint handling

GPs will have to deal with complaints more effectively than in the past. These will be subject to external scrutiny, and

not merely be something that they have to do to comply with the terms of their contract, or to secure Quality and Outcomes Framework (QOF) points.

Dealing effectively with complaints will become even more important when the jurisdiction of CQC is exercised, as the regulator will have the power to make unannounced visits. Comprehensive guidance on the handling of complaints is given in the DoH's 2009 **Clarification of Complaints Regulations**. A useful source of reference is the State Government of Victoria's Department of Human Services *Guide to complaints handling in healthcare services* ([www.dhs.vic.gov.au/hsc/resources/guide.htm](http://www.dhs.vic.gov.au/hsc/resources/guide.htm)).

## The CQC's vision of the future

The most important new system of regulation will arrive when CQC jurisdiction is extended to GP practices in April 2012. It is important for GPs to know that they have to be registered in order legally to be authorised to provide services, and registration will no doubt be a prerequisite of retaining a PMS/GMS contract.

The CQC will deliver very comprehensive guidance as to what this system of regulation will comprise. It is important for GPs to understand that the regulation process will be continuous and that the ultimate enforcement sanction is to revoke registration, which means that a practice will lose its PMS/GMS contract.

However, the paper trail is critical. Policies need to be drafted, and procedures put in place. Recruitment processes have to be managed. Premises and equipment have to be 'safe and suitable'. Appraisals need to cover all staff, and be effective. Business plans need to be in place, and record keeping will need to be tightened up. It is therefore critical that practices plan ahead in order to understand the regulations and to commit to whatever is necessary.

It is hard to anticipate what the effect of CQC regulation will be. In areas such as social care and NHS Trusts, it is clear that the CGC takes its responsibilities very seriously. A number of critical reports have been issued and a number of social care providers have simply given up business, rather than attempt to comply. Yet, for a well-regulated, well-managed practice, there will be opportunities. Some estimates indicate that as many as 70% of primary healthcare practices will not meet CQC benchmark standards. Over time, there will be fallout and opportunities for practices to expand. Practices that do not comply may find that they don't get any help from PCTs – they are cash strapped, and will argue that it is up to individual practices to meet all external regulatory requirements.



## Seniority Pay Backs and Partnership Deeds

Solicitors are advising GP practices to amend their partnership deeds to ensure there is an agreement about what should happen if partnerships have to pay back seniority payments.

Lockharts, of London, warned in a newsletter to GPs that the PCT review of seniority payments heralded 'a nasty surprise for some practices, especially those with a GMS contract'.

The company said: 'PCTs are entitled to require payment of overpaid seniority by the practice which received it, rather than the partner that received it. If any partner who received overpayment is still a partner at the practice, or where the accounts remain to be agreed with a recently departed partner, then the current recovery of past overpayments could be appropriately dealt with in the accounts by the partnership accountants.'

'Where, however, there has been a change in the partners, or where a partner has died or moved abroad since receiving the payments, the current partners will face

the unenviable position of having the overpaid sum deducted from their present income and having to recover this from the departed partner or his estate. The PCT is given the express right to claw money back in this way in the SFE'.

Lockharts advised current partners looking to recover these sums from departed partners, especially where these GPs proved reluctant to reimburse the practice, to take advice on how best to proceed.

It added: 'Partnerships who believe there are particular reasons why they should not suffer these deductions, such as express representations by the PCT that no such reimbursements would be required, should also seek advice on their position'.

The solicitors said in the case of PMS practices, the position as to what entitlement the PCT has to claw overpaid seniority back will be governed by the PMS agreement itself. Practices should take legal advice if they were unsure.

## GP earnings 2007-08

Final results for GP Earnings and Expenses Enquiry 2007-08 are detailed below.

Average income before tax for contractor GPs in the UK in 2007-08:

- £100,324 for GP on a GMS contract.
- £116,059 for those with a PMS contract.
- £106,072 for those GPs working under either a GMS or PMS contract (GPMS) – decrease of 1.5% since 2006-07.
- Average gross earnings for GPMS contractor GPs in the UK in 2007-08 was £251,997 – an increase of 1.9% since 2006-07.
- Average expenses for GPMS contractor GPs in the UK in 2007-08 was £145,925 – an increase of 4.5% since 2006-07.
- The expenses to earnings ratio (EER) for GPMS contractor GPs in the UK in 2007-08, which represents the proportion of gross earnings taken up by expenses was 57.9% - an increase of 1.4 percentage points since 2006-07.

Average income before tax for contractor GPs in the UK in 2007-08, by dispensing practice status was:

- £121,753 for GMS dispensing GPs.
- £96,189 for GMS non-dispensing GPs.
- £132,222 for PMS dispensing GPs.
- £113,517 for PMS non-dispensing GPs.
- £125,165 for GPMS dispensing GPs – a decrease of 1.4% since 2006-07.
- £102,641 for GPMS non-dispensing GPs – a decrease of 1.4% since 2006-07.
- The average income before tax for salaried GPs in the UK in 2007-08 was £55,790 for those GPs working in either a GMS or PMS (GPMS) practice – an increase of 3.4% since 2006-07.
- Average income before tax for combined GPs (contractor + salaried) in the UK in 2007-08 was £99,436 for those GPs working in either a GMS or PMS (GPMS) practice – down 1.2% since 2006-07.

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If you would like to discuss any of the issues raised in the Newsletter or any other financial matter, please call Roger Cornes or Stella Rosthorn on

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