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Don't let quarterly tax returns take you by surprise!

Tax is going digital. **James Gransby*** explains why and what you can do to be prepared

In the March 2015 Budget the then Chancellor George Osborne announced the end of the personal tax return. Now, his successor Philip Hammond seems set on taking this forward.

Come forth 'Making Tax Digital' (MTD) which will mean that all GP practices will be required to make quarterly submissions to HM Revenue and Customs (HMRC).

Practices also face significant changes to the way they interact with HMRC as digital reporting and digital tax accounts become a reality.

What is HMRC proposing?

The vision for MTD is to have a digitalised tax system that is more effective, efficient and easier for taxpayers.

Digital records

Businesses will be required to maintain their records on apps or software that are compatible with HMRC's interfaces. Any practices still keeping records manually, or using a spreadsheet such as Excel, are likely to be forced to change.

Quarterly reporting and the year-end declaration

While it was widely publicised that the Government was looking to scrap the annual tax return, it now appears that it will simply be replaced using four quarterly 'updates' and one final year end declaration.

Voluntary pay-as-you-go

Businesses will be able to opt into a pay-as-you-go system for the collective payment of taxes.

It has been stated that quarterly tax payments will not be made mandatory during this Parliament but with discussions of an early general election, given the current political environment, this may come sooner than expected.

The cash flow effect of this being introduced could be very damaging when it happens.

Why is it changing?

- HMRC's aim is to reduce the burden for taxpayers and provide greater certainty over tax bills through direct prompts from HMRC.
- Businesses will not have to wait until the end of the year to know how much tax they will pay.
- Tax payers will be able to send and receive information from HMRC at the click of a button with alerts to help businesses with advice and queries.
- It will make it easier for businesses to comply with their reporting obligations and deliver accurate information to HMRC.

Who will Making Tax Digital apply to?

At this stage, the MTD proposals only apply to sole traders and partnerships and so GP surgeries will certainly be caught by this.

When will Making Tax Digital start?

There is a detailed timeline in the MTD roadmap. Key events are:

- On the current schedule, GP surgeries will be expected to update HMRC with business information at least quarterly from April 2018.
- Reporting information is to be brought closer to real-time which is likely to mean submission of figures within one month of the quarter ends.

These are very significant changes and there are many details yet to be decided. Consultation on these issues is ongoing. HMRC will be using an agile approach to development.

This means that changes can be introduced, as the result of feedback from users, on an ongoing basis during the development phase.

How will Making Tax Digital work?

MTD will not require GP practices to file four tax returns every year. Instead, businesses will send summary data to HMRC about their business each quarter, or more often if the business prefers.

The summary data will consist of total income and total expenditure, with the expenditure broken down into categories such as travel and advertising.

Businesses will need to send this information from online accounting software. HMRC has confirmed that it will not be providing its own bookkeeping/ accounting software and that the use of 'digital record keeping software that links to and updates businesses' digital accounts with HMRC' will be mandatory, except for taxpayers who are exempt from MTD (typically those with incomes below £10,000).

Each business will have a proposed nine months after the year end to file an 'end of year declaration', submitting final figures. If this takes effect then the filing deadline for GP practices with a March year end would be 31 December rather than 31 January, falling right into the Christmas and New Year period.

Here are a few details of note as specified by HMRC during this consultative phase:

- The business won't have to keep any additional paper records.
- If the business is registered for VAT, one report may cover both income tax and VAT reporting requirements.
- Allowances and reliefs, such as Annual Investment Allowance on the purchase of surgery equipment or cars, could also be notified to HMRC either in-year or at the end of the year. For instance, if an asset has been bought, the suggestion is that HMRC could be told at the time the asset is bought that it's going to be eligible for Annual Investment Allowance.
- HMRC believes that the cash basis of accounting should be extended to larger businesses, as this will be simpler for them to use. It has suggested doubling the current entry threshold, which matches the VAT registration threshold - so a business would be able to begin using the cash basis of accounting if it has income below £166,000, using today's VAT registration threshold. This will not be of benefit to GP practices with incomes above this level who will have to continue to account for their figures on the accruals basis (adjusting for income received after the quarter end but which relates to the quarter being submitted, for example QOF).

The move to cloud accounting

Looking at all of these changes being introduced, it really pushes GP practices down the route of using cloud based accounting systems if they are not already using them. I am sure we will shortly see a flurry of software providers making sure that their software will be MTD compatible.

Surgeries should either talk to their software provider, or accountant, to ensure that the method they are currently using for keeping practice records will not cause a headache quarterly when it is time to submit information digitally.

If you decide to look at a cloud accounting package for your surgery so you are ready for the Making Tax Digital initiative, you need to ensure that three criteria are met:

- The package should be user-friendly and straightforward to operate.
- Your chosen cloud accounting package needs to be compatible with HMRC.
- It is important that the package provides the ability to accurately report on the period required.

What do you need to do?

Start talking to your AISMA accountant about how your practice will be affected and what you can do to understand and embrace the changes as soon as possible. Change is coming and by taking proactive steps now you will be fully prepared for what lies ahead.

Devise a plan to see you through

A 'cunning plan' may not be necessary – just a plan would be enough for many practices, says **Fiona Dalziel**

Now, more than ever, practices across the UK are asking themselves extremely big questions. And many are asking something which would have been unthinkable a few years ago: can we continue as an organisation?

Many practices under extreme pressure find they are unable to answer that question with a 'yes'.

This is a traumatic event for these practices and their patients. The closure of a practice often has a knock-on effect on neighbouring practices, themselves possibly also under pressure but 'just about managing'. They may also become unstable as a consequence.

Clearly, a large number of practices are 'just about managing'.

Many feel powerless in the face of increasing patient age and morbidity, the financial attractiveness of retirement, and an inability to recruit.

In rural areas especially, but not exclusively, encouragement to recruit Advanced Nurse Practitioners, pharmacists and Emergency Care Practitioners are all very well but they depend on the availability of suitable candidates, who may be few and far between.

Each country's health service in the UK may be taking action. The RCGP and BMA are feeding in as much as possible to supporting increased funding and new approaches.

But what can practices do themselves while these changes from above hopefully work through? How can practices try to remain as stable and resilient as possible?

Strategies and plans

In this article, a 'strategy' defines the overall direction in ideal terms. A 'plan' refers to the detailed steps which would need to be taken to implement the strategy.

In a time of pressure and change, knowing your broad strategy is not optional. The time when everyone feels that all they can do is be reactive is precisely the time when we need to know what the strategy is. In a crisis, an effective leader looks ahead.

If Shackleton had no strategy with an implementation plan then none of the crew of *Endurance* would have survived.

Look ahead a couple of months for some time when key individuals in the practice can get together. Be as inclusive as possible when identifying who will contribute – good ideas often come from unexpected sources.

Spend time discussing your principles – these will help define the strategy.

- What's important in this practice?
- What must continue and what could we stop doing?
- What opportunities and threats are on the horizon and, if they happen, how should we respond?

Keeping it flexible

Many practices do not plan at a time of pressure because of a feeling of loss of control. This leads to a belief that a strategy will not work out and no plan will be worth the paper it is written on. But strategic planning can be realistic if we accept that the strategy and its implementation may need to be flexible.

Henry Minzberg, the renowned academic and business management expert, suggests that it is vital to have a strategy. He also states that an effective deliberate strategy can emerge by taking notice of opportunities which emerge while we are following the originally-agreed path. What is important is to have an agreed strategy and also to be open to opportunities while implementing it.

Your broad strategy may be to keep the practice at its present list size. It may be that Plan A is to recruit a partner as a replacement or to help with workload. You may also have got so far as to identify that Plan A is unlikely and that Plan B is to recruit an Advanced Nurse Practitioner.

While trying (unsuccessfully) to implement Plan B, you are presented with a chance to have several additional hours of a pharmacist in the practice.

You originally rejected this option and it is not in the plan. But many elements you need could be covered by a pharmacist, so you decide to put in a note of interest. Your deliberate strategy has absorbed an emergent strategy and, through the planning process, you may also have regained a small sense of control.

A word on effective implementation

Evidently, a strategy and implementation plan are most effective if they are not simply filed away once written. The success of any strategy is in its implementation.

According to Minzberg, the following rules apply:

- Good strategy + good implementation = success
- Poor strategy + good implementation = luck
- Good strategy + poor implementation = trouble
- Poor strategy + poor (or no) implementation = failure

And, finally

Having a good strategy with an effective implementation plan will not insure against the unexpected. But it may mean that, when the unexpected happens, you may be in a better position to cope as an organisation.

Fiona Dalziel runs DL Practice Management Consultancy

OPINION

No let-up in 2017 for GPs' pension and tax rises

Seamus Dawson, AISMA committee member

AISMA accountants have just returned from a special training day covering the latest developments in GP pensions and tax.

This event, and the Chancellor's autumn statement, highlighted areas which will impact not only GPs' personal finances but also the finance and profits of GP practices.

The key announcements in the autumn statement concentrate on increases in both the personal allowance and higher rate tax threshold.

And this is good news not only for GPs but also their staff as it will mean a bit more money in everyone's pocket.

But, upon scrutiny, other items within the statement do not make such pleasant reading.

Insurance premium tax continues its upward spiral to 12%. That's a 100% rise in less than two years. This follows the pattern of other indirect taxes such as VAT, stamp duty, and fuel tax. These were also introduced at a low rate and then steadily increased over the years.

The rises in both the national minimum wage and national living wage will assist the lower paid but will place added pressure on practices to increase salaries and wages across their workforce.

And hidden beyond the headline figures are also some further announcements which may have implications especially for doctors channelling all or part of their income through limited companies.

Indeed, the Chancellor indicated he was concerned by the continued rise in tax-driven incorporations. Add to this the proposed changes for off payroll working in the public sector to be introduced from April 2017 and it is imperative that doctors using limited companies seek expert advice from their AISMA accountant.

On pensions there was some good news that the autumn statement did not remove the higher rate tax relief for pension contributions. However, as highlighted during the AISMA training day, there is still plenty of change for GPs and their advisers to come to terms with.

We now have for the 2015-16 year an extended superannuation certificate - now 14 pages long in England and Wales - to complete as well as dealing with transition to the 2015 scheme and pension input periods being aligned to 5 April.

Also, the annual allowance and lifetime allowance will increasingly present GPs with challenges and decisions.

Adding to these changes we now have proposals from the NHS Pension Scheme to introduce an administration levy. This will mean more costs for GP practices.

And there is talk in the press that there are considerations to increase the state retirement age to 70.

So despite some good news in the autumn statement there is still plenty of change within pensions and tax. This makes it imperative for GPs to continue to review their personal position on an ongoing basis with their AISMA accountant.

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AISMA Doctor Newsline is edited by Robin Stride, a medical journalist. robin@robinstride.co.uk

*James Gransby is a partner with MHA MacIntyre Hudson (Kent) LLP
** Faye Armstrong is a partner with Dodd and Co

Top tax tips for 2017

Not paying a penny more in tax than you should and making your money work harder should be on your list of New Year's resolutions. **Faye Armstrong**** has five tips to get you started

1 Look at Lifetime ISAs

Lifetime ISAs are a very tax efficient way of saving and also have the added benefit of being topped up by the Government. Everybody aged between 18 and 40 can open a Lifetime ISA and contribute up to £4,000 a year, which the Government will top up by another 25%.

Any contributions to a Lifetime ISA will count towards the maximum amount that an individual can put into any type of ISA of £20,000 a year.

Although you have to be under 40 to open a Lifetime ISA, once you have done so you can carry on contributing until you are 50. The money can be taken out after the age of 60, when it will be tax free and won't count towards your pension lifetime allowance.

Alternatively a Lifetime ISA pot can be used to buy your first home, so it is also a good way to encourage your children to save to get on the property ladder.

2 Give a gift

Take a perk from your limited company, or give a gift to your staff. Small gifts to employees and company directors are now taxed much more generously under the new 'trivial benefit rules'.

The gift must be a genuine gift, so the employee cannot be entitled to receive it, nor should it be given in recognition of work done. The gift cannot be in cash, but could be in the form of a gift card and has to be under £50 a time.

If all these requirements are met, the employee pays no tax when they receive the gift, but the employer gets tax relief on the cost of giving it. You can make unlimited gifts to unconnected staff, but there is a limit of £300 a year for gifts to most company directors and their family members.

3 Beware of the forgotten taxes

Some of the most painful tax problems come from taxes which get forgotten about. A good example is Stamp Duty Land Tax (SDLT), which most people remember has to be paid when purchasing property, but which tenants often forget is also potentially payable when they are granted a new surgery lease.

The amount of SDLT depends on the length of the lease and the amount of rent and any premium paid, but can be fairly easily calculated.

The other tax often forgotten about is VAT, and as practices get larger it is very easy to unknowingly trip over the VAT registration threshold (currently £83,000) due to the level of private fee, medico-legal, non clinical work done for CCGs and other ad hoc work.

4 Plan for surgery sales

Practice mergers or reorganisations often result in the sale of surplus surgery buildings, and it is important to plan well ahead to minimise the capital gains tax due on these disposals.

The tax charge is based on the increase in value during the partner's ownership, and is not affected by any loans secured on the surgery as is often thought.

In any tax year the first £11,100 of gains are tax free, and capital gains tax rates have fallen so the full rate paid by higher rate tax payers on sales of commercial property will only be 20% compared to the previous rate of 28%.

The tax liability can be minimised further by transferring a share of the surgery to a spouse. This allows you to take advantage of their capital gains tax annual exemption, and potentially have some of the gain taxed at 10% rather than 20% if the spouse is a basic rate tax payer.

Your tax saving has to be weighed up against the legal cost of arranging the transfer, and if there is a loan secured on the surgery, the bank will need to be on board with the process.

Another opportunity to explore with your accountant is whether any of the gain qualifies for Entrepreneurs' Relief on the basis that an owner has recently dropped sessions and reduced their interest in the partnership.

5 Maximise The Residence Nil Rate Band

6 April 2017 will see the introduction of the Residence Nil Rate Band (RNRB). This is an additional inheritance tax exemption, and will apply to estates that include a residential property as long as the property has been occupied by the deceased as their home at some point.

The exemption will be £100,000 from 6 April 2017, thereby increasing the amount that can be passed on without paying inheritance tax to £425,000. The exemption will increase by £25,000 each year until it reaches £175,000 on 6 April 2020.

Two of the key points to remember if you hope to benefit from the relief are:

- The property must pass to direct lineal descendants (such as children, grandchildren) so check your will to make sure the property will be inherited in a way that makes the exemption available.
- The RNRB will be tapered where the death estate (before reliefs and exemptions) exceeds £2m. But, any gifts given during your lifetime are not included in the £2m limit, however long there is between it being made and the death of the donor. So gifts can be given close to the end of life to maximise the exemption.

A new model of care demands big decisions

Practices aiming for an MCP title face some huge steps. **Alison Oliver** gives an update and highlights legal areas to consider

It is now more than two years since the *NHS Five Year Forward View* was published, proposing new models of care aimed at achieving greater integration of health and social care services.

Vanguard sites across the country have been working to test the different models.

One of the main models of interest for general practice is the Multispecialty Community Provider (MCP) model, in which a single organisation or alliance of organisations provides a range of services in a community setting to a defined population, potentially encompassing primary care, community healthcare, mental health and social care services.

In this model, the local hospital would continue to provide the hospital services, other than those that were taken over by the MCP or other community provider.

In the summer of 2016, NHS England published its *MCP Emerging Care Model and Contract Framework*. This outlined three possible versions of the MCP model:

- Virtual
- Partially integrated
- Fully integrated

Contract versions

In the virtual version of the MCP model, existing providers would continue to provide services under traditional contracts (so, GMS, PMS or APMS for primary care providers and the NHS Standard Contract for other healthcare providers).

The MCP contract would overlay these other contracts, and would set out a shared vision and a mechanism for delivering services in a more integrated way.

The partially integrated version is a 'step beyond' the alliance approach. There would be a lead organisation (which might be an existing provider or a new joint venture formed by the MCP participants).

Services other than primary care would be re-procured under a single contract and the lead organisation would ensure integration with primary care and may subcontract the delivery of services to other organisations.

In the fully integrated version, all the services would be re-procured under a single contract and the MCP would administer a single whole population budget. This is the most radical of the three options and gives the greatest potential for the MCP to re-design care and workforce roles.

We had expected a new contract for the fully integrated version to be published in the autumn of 2016, but at time of writing, this had been delayed until the New Year. NHS England is working on developing the detail of the new contract with a number of the vanguard MCP sites.

But although the contract details are not known at the time of writing, NHS England has given an indication of some of the likely features of the new contract.

Integrated MCP contract – expected features

Voluntary: this is a voluntary contract. At least for the time being, GP practices will not be required to give up their GMS or PMS contracts to participate in a fully integrated MCP.

Hybrid: it will be a hybrid form of contract, encompassing the GMS/PMS/APMS and the NHS Standard Contract regimes.

Flexible: it is expected to focus on outcomes, giving the provider more flexibility to decide how best to deliver these. There will be scope for ongoing adaptation, for example to allow additional GP practices to join in-term.

Term: it has been suggested that the term will be 10-15 years, perhaps with a break option after two to three years. This is longer than some of the NHS contract terms, in order to provide some stability and encourage investment. However, it is not a perpetual contract like GMS and PMS.

Option to return to GMS/PMS: it is expected that GP practices participating in a fully integrated MCP will have the option to return to their GMS/PMS contracting arrangements, but this option is likely only to be exercisable at the break point in the MCP contract.

Considerations

Participating in a fully integrated version of the MCP is obviously a big step for GP practices and not one to be taken lightly. Some considerations include:

- **Practicality of return to GMS/PMS:** there is a question over how easy it will be in practice to disentangle primary care from a fully integrated MCP model. For example, patient lists will have merged, non-core primary care services will have been integrated into the MCP service and staff will have transferred from practices into the MCP.
- **Funding:** the fully integrated model is based on the concept of a single whole population budget covering primary care and the various integrated community services. Unless primary care funding is ring-fenced in some way, primary care services could be at risk if there are deficits or overspends in other areas of the budget.
- **Risk:** practices will need to ensure that they are not exposed to an unacceptable level of risk. It will be vital to look carefully at the legal structure of the MCP and its gain and risk sharing arrangements.
- **Independent contractor status:** it has been suggested that many MCPs will be built on the basis that they are largely a salaried service. GPs will need to consider carefully the implications of moving from independent contractor to salaried status.

There are, at the moment, still many unknowns. We will be able to provide a further update after the new MCP contract is published.

** Alison Oliver is an associate at Top 100 UK law firm Ward Hadaway.*