aisma
association of independent specialist medical accountants

Issue 47
Summer 2019

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AISMA Doctor Newsline

At the heart of medical finance...

Here's how to get your Primary Care Network off to a healthy start

So what is next for PCNs? **Alison Oliver** explores some of the issues for PCNs to consider in their early stages

Progress towards the deadline for Primary Care Networks in England (PCNs) to finalise their mandatory network agreement has not been as smooth as might have been hoped.

As I write this, some PCNs have not yet received confirmation that the composition of their PCN is approved - and some practices have still not found a PCN to join.

Hopefully, by the time this article is published, most of these issues will have been resolved and PCNs will have started delivering the NHS England Network Contract Directed Enhanced Service (Network DES).

But of course that is far from the end of the story.

While the focus has been very much on the formation of PCNs in time for the commencement of the Network DES, PCNs are now moving into the delivery and development phases, where the work really begins in earnest.

Some PCNs will already have addressed many of these issues in the course of finalising their Network Agreement, whereas others might not

yet have had the opportunity to do so and might need to revisit them to ensure they are robust enough to enable the PCN to deal with the challenges ahead.

Although this article focuses specifically on PCNs formed under the Network DES, many of these issues will be applicable to networks in other parts of the UK.

Leadership

The leadership role of the PCN's clinical director will be central to its success. However, the time and funding available for the clinical directors' roles will be limited and they will need to work closely with practice representatives.

Many PCNs will already have formed some kind of board or council of representatives. It is essential that the clinical director and board's respective roles, duties and how they work together is defined and agreed.

PCNs will also need to think about the appointment process for renewing or replacing the existing clinical director if they have been appointed for a fixed period or if they resign.

It is quite possible that the clinical director's job description and person specification may evolve as the PCN develops, and this will have to be kept under review.

Membership engagement and involvement

A key focus for PCNs in the early stages will be ensuring that member practices are engaged in discussions and involved in PCN activities. This will be particularly important where practices have been allocated to PCNs rather than membership having evolved through the choice of the member practices.

It is important that the PCN's communication and decision-making processes allow for the views of all the member practices to be heard.

The PCN will need to consider how frequently meetings of the whole PCN membership should be held and what decisions are to be reserved for decision by the general membership rather than being delegated to the board or clinical director.

Late sign-ups

Practices that did not meet the deadline for signing up to the Network DES or have not yet joined a PCN could still do so with commissioner approval and the agreement of other practices in the PCN.

"The PCN should have clear procedures for authorising payments out of the PCN account and systems to monitor the account and ensure that PCN funds are being used correctly."

They will need to either join an existing PCN or even form a new PCN (if there are other practices in a similar position within the same locality) and sign up to an existing or new network agreement.

Financial controls

The network DES requires that all payments are made to a single nominated practice on behalf of the PCN. It is important that the money is held in a separate bank account and subject to proper controls.

We are aware that at least two UK banks are enabling special arrangements for PCN accounts so that partners from other practices can be added to the bank mandate.

The PCN should have clear procedures for authorising payments out of the PCN account and systems to monitor the account and ensure that PCN funds are being used correctly.

Extended access delivery

The PCN is required to commence delivery of extended access services under the Network DES from 1 July.

PCNs will need to have a clear plan in place for which practices will be delivering what extended access services and on what terms, or whether there will be a single lead practice with overall responsibility for service delivery.

Alternatively, delivery might be subcontracted to a third party, such as the local GP federation. If so, an agreement must be put in place between the PCN and the federation which complies with the GMS/PMS subcontracting requirements.

The network agreement should set out arrangements for service delivery, or mechanisms for agreeing them, including arrangements for allocating payment for the services and any management costs.

If these matters are not dealt with adequately in the network agreement, the board will need to ensure that appropriate arrangements are agreed as soon as possible to minimise the risk of disputes.

Workforce

PCNs will need to consider if they wish to recruit clinical pharmacists and social prescribers which are funded in whole or in part by the Network DES, and any other roles that the practices wish to fund themselves.

Consideration must be given to the job descriptions and person specifications for the roles and who will employ them on behalf of the PCN. Will they be jointly employed by all the practices, employed by a lead practice on behalf of a PCN, or will a third party (such as the federation) employ them?

It is important to take specialist tax and accounting advice on the different options as well as legal advice because there are complex

"Ultimately, the PCN needs to be able to expel a practice that is in serious or persistent breach of the network agreement ."

considerations. Thought should be given to whether the employer can provide access to the NHS Pension Scheme for the PCN workforce.

Reporting and monitoring

PCNs will need to comply with the reporting and monitoring requirements in the Network DES. Systems should be put in place (if not already) to see that practices and any subcontractors comply with these to ensure Network DES requirements are satisfied.

Underperformance, breach, risk and liability sharing

PCNs will need to consider how they will deal with a situation where a practice underperforms against agreed Network DES targets, fails to comply with other issues, such as reporting requirements, or breaches the network agreement.

There might be both a carrot and stick approach in these situations. The PCN leadership may seek to support the practice to improve but ultimately the other practices are unlikely to be willing to suffer financial loss resulting from another practice's default.

So the network agreement should have provisions to enable the PCN to recover losses from a guilty practice.

Ultimately, the PCN needs to be able to expel a practice that is in serious or persistent breach of the network agreement and there should be provisions governing how and in what circumstances this can happen.

The network agreement also needs to address how losses and liabilities generally will be shared where these are not the responsibility of an individual practice. Will they be shared equally or according to patient list size or in some other proportions?

Engagement with patients and the wider system

NHS England has made it clear that PCNs are regarded as a building block towards greater integration between primary care and the wider healthcare system.

A key challenge for the PCN leadership will be to represent primary care in emerging integrated care systems and to build relationships with other health and social care providers, commissioners and other PCNs. The Network DES also foresees a role for PCNs in engaging with patients in developing new services and pathways.

Organisational development

Many PCNs have found the process of getting formed in time for the commencement of the Network DES very rushed. They have often not had adequate opportunity to consider the structure of their PCN or their governance systems and many have not included enough detail in their network agreement.

As PCNs are fledgling organisations, their structures and processes are likely to evolve over time. Some PCNs will need to do more work on their network agreements in the early stages to ensure they are robust enough to deal effectively with the various issues and challenges ahead.

As practices work more closely together within PCNs this might result in more fundamental organisational changes such as practice mergers or formation of super-partnerships which go beyond the scope of the Network DES activities.

Preparations for the 2020-21 Network DES... and beyond

New services will be added to the Network DES from April 2020. Once further details are available, PCNs will need to ensure arrangements are made to deliver them.

The network agreement might need to be updated accordingly, although a well drafted one should largely be future-proof and make it unnecessary to rewrite each time.

Alison Oliver is a partner at leading healthcare law firm Hempsons

This article is for general information purposes only and is not intended to be legal advice.

Another period of change for primary care

OPINION

Deborah Wood
vice chairman, AISMA

As you look through your copy of this publication, Primary Care Networks (PCNs) in England will have commenced their journey from inception on 15 May 2019 to financial payments available from 1 July 2019.

Change within the NHS is as ever at a fast pace and AISMA accountants have been busy alongside our practice and federation clients during the past few months trying to find pragmatic solutions to what is not always a straightforward arrangement.

The issues our clients have had to consider include:

- Funding streams available through the standard GMS/PMS/APMS practice contracts but paid into a PCN bank account on behalf of a network of practices that is not a separate legal entity
- Staff employed on behalf of the PCN by a single lead practice or perhaps a federation and then deployed back into the practices or facilitated as part of a sub-contracted service, when the staff will need access to membership of the NHS Pension Scheme
- Managing employer liability, CQC, indemnity insurance, and safeguarding funds
- A claims-based payment system for nine months which needs a transparent bookkeeping system to enable the transactions to be reflected into the accounts of the underlying practices
- Practices having to work together on a range of services including extended access, social prescribing, clinical pharmacist reviews - when historically their willingness to do so has been limited - and development of agreements to manage the relationships within the PCN
- The need for strategic planning around anticipated resources and systems covering a five-year contract plan with allocated funding ear-marked to be substantial, and
- Transaction flows that might no longer fall within the usual VAT exempt categories GP practices are used to, leading to additional 20% costs or new cost-sharing group arrangements.

I am sure that when NHSE and the GPC agreed the terms of the 2019-20 contract and the five -year plan, the principles behind PCNs were considered beneficial for the longer-term future of primary and community care.

However, it is disappointing that the practicalities to enable the new Network DES to be implemented had not been thought through sufficiently before the date of commencement, leaving many organisations struggling to establish what would be the best solutions for them.

AISMA accountants are therefore working together to develop suitable guidance and pragmatic solutions where possible for PCNs.

We are also collaborating directly with PCSE and NHS Pensions teams with respect to the historic problems relating to the processing of pension certificates for both GP principals and salaried GPs.

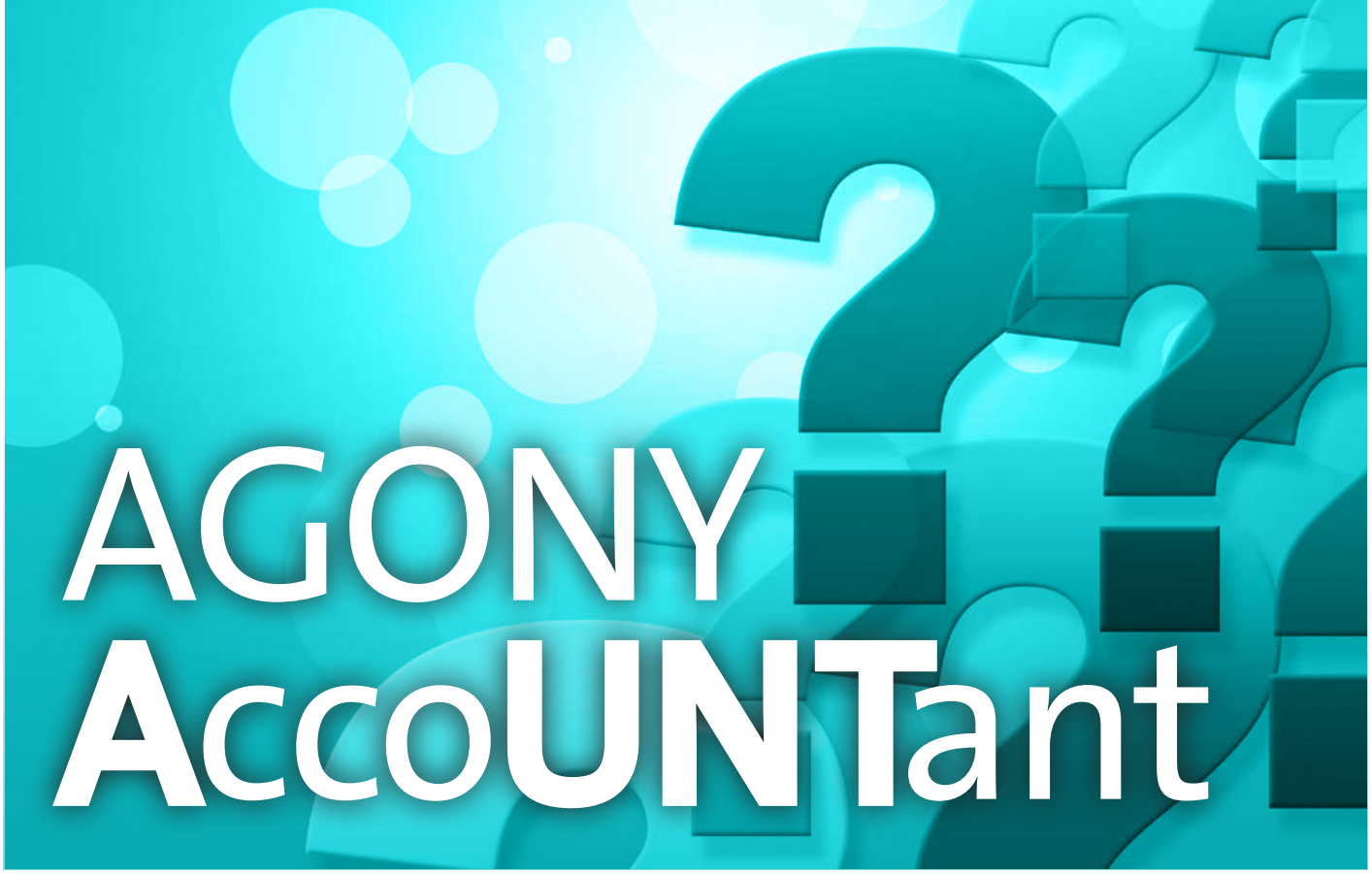
Our suggestions for system changes have been taken up by PCSE and communication amongst all parties is improving. Have a look at the PCSE website which contains a lot of useful FAQs and step-by-step guides to help things run more smoothly as we go forward.

PCSE WEBSITE

- https://pcse.england.nhs.uk/organisations/general-practices/

AISMA accountants are keen to help with the issues faced by our GP and practice manager clients.

Please keep your queries coming so that they can provide you with their expertise and continue to demonstrate the value of having an AISMA member firm on board with up-to-date advice and relevant information at a time of further change for the primary care sector.



AGONY AccoUNTant

Our Agony Accountant Abi Newbury* answers more of your questions about general practice financial issues.

You can ask a question by contacting your local AISMA accountant or messaging us through Twitter @aismanewsline.

In this issue our accountant deals with more GP pension issues

Q **I'm so worried about annual allowance pensions tax. Will dropping a session reduce my risk of charges?**

A Annual Allowance Charges (AACs) on pension growth may not have been something you needed to worry about in the past, but with reduced tapered allowance where taxable income is over £110,000 it is something even young doctors now need to be aware of.

Firstly you need to know what sort of tax charge might arise, based on current profit levels.

For GP partners, a cut in sessions to reduce profits, in turn reducing overall taxable income, could be seen to be an easy solution to reduce the chance of getting caught with charges. But unfortunately it is not quite that simple.

Will your partners accept the proposed session reduction? If locum cover is not available then your colleagues could be forced to cover with internal locum sessions, which will increase their exposure to pensions tax.

If others in your practice are looking to drop sessions too and replacement costs are less than the profit share lost, you could find yourself back in the same position.

Cutting a session will have the desired result of bringing down taxable income, but perhaps not as much as expected. There will be an impact on the employee and employer contributions that you are required to pay over, as pensionable income will also have reduced.

Less available tax relief on these contributions, likely to be at a marginal rate of 40%, will bump your taxable income back up again. There could be a timing delay, pushing the effect into the next tax year – remember you only get relief when the contributions are physically paid over.

Where you have an accounting date other than 31 March, there will be a delay in the effect of any changes. So, for example, dropping a session from 1 July 2019 affects the accounts to 30 June 2020, and thus the taxable income in 2020-21, so this would not solve a 2019-20 problem.

Lower sessions could result in lower personal expenses and with the reduction in indemnity

costs lowering claims from this year, this could leave partners with higher taxable income than anticipated.

However, while dropping a session may not always be enough to mitigate the tax on a pensions charge, remember that there are other benefits here. If you are unlucky enough to be losing your personal allowance, where the marginal tax rate is effectively 60%, then there could be some tax saving. You need to weigh up whether the extra earnings in your hand are worth the efforts you need to put in.

A reduction in your pensionable income will of course affect future benefits. As a GP in the NHS Pension Scheme you have no choice but to pension all your 'pensionable income' – you cannot pick and choose.

So, dropping a session is likely to mean less pension benefit in the long run, because that income, in the main, would have been pensioned. It may be preferable to reduce other sources of income, such as non-pensionable out of hours work, or locum income that has 'missed' the 10 weeks pensioning window.

If you are not likely to reach the lifetime allowance then the trick is to reduce your taxable income without affecting the level of pensionable pay - unless of course your potential charges are significant and you need to reduce both.

The complex nature of the AAC calculations, types of pensionable and non-pensionable income and the interaction of tax reliefs and personal income mean that there is no quick answer, and one size does not fit all.

Take some advice and invest in getting a good understanding of the level of charges likely to hit now and later. Your AISMA accountant should be able to estimate these for you, depending on the pension information available, and can then crunch the numbers to come up with some alternative options, of which a reduction in sessions may be one.

Q I'm not sure why my accountant is asking for my pension record. I'm having trouble getting hold of it. Is it necessary?

A A good specialist accountant will ask for details about your NHS and private pension each year so they can calculate your tax liabilities and see if there is any likelihood of an annual allowance charge.

This review of your NHS pension record for tax purposes is also an opportunity to ensure you are not missing out on future pension benefits.

It is not enough to assume that NHS Pensions will tell you if there is an annual allowance problem. If you have exceeded the £40,000 allowance you will receive a Pensions Savings Statement (PSS) at some point, but these can take many months to come through. And by then, HMRC will have already expected you to notify it of the charge and the related tax, accruing interest on any tax deemed due.

There are numerous circumstances where you won't receive a PSS but could be in line for charges, including entitlement to reduced allowances and personal pensions that NHS Pensions are unaware of.

However, all this assumes that your NHS pension record is complete, correct and up to date.

Year on year, medical professionals are completing forms and paying into their NHS pensions, assuming their pension 'record' - the history of pensionable earnings and contributions paid over for them personally - is updated to match.

Unfortunately, while this is the case for some, it is not the case for many others who find there are gaps in service, errors in levels of pensionable pay and in rare cases the pension record has disappeared completely.

The paperwork and contributions move through several different departments, and while every effort is made to ensure yours is not the one that goes wrong, there is no guarantee.

It is not always easy to obtain the pension information required. NHS Pensions won't update your pensions record if, for example, you have missed submitting type 1 or type 2 pension certificates, or the National Insurance number it holds for you is wrong or you have moved to a new house and not advised it.

You may feel you are banging your head against a brick wall trying to get hold of the necessary information, but it is imperative to resolve any issues and access the statements.

HMRC expects your tax return to be completed correctly to include any pension charges but it is much easier to check the completeness of your pension record now, rather than come retirement where you find you are receiving substantially less than anticipated and no longer hold the information to be able to rectify any problems.

Most specialist accountants will have had much experience in assisting others to get their pension records updated, and so long as

you have retained details of your pensionable earnings and contributions then it is possible – it may just take some time and patience.

The statements, once available, can be difficult to understand so do ask your accountants to interpret them for you and work with them to find explanations of those figures that do not look as expected.

Ask your accountant for this additional service, invest some time, and accept reasonable professional fees are worth it to ensure all is as it should be. Total Rewards Statements are a good way to do this. If you are unsure of how to access these then ask your accountant.

Good warning of potential annual allowance pension charges is vital, so you can plan to minimise tax and take relevant pensions advice. But it is just as important to be sure, rather than just assume, that the NHS pension you have been paying into through your career is there in full when the time comes to retire.

Q The partners' superannuation deductions are taken on the monthly statements – do I still need to check them?

A Pension contributions for GP partners and salaried doctors in a practice are taken via the monthly statements. Levels and tier rates are set for the year ahead by the legally required submission of the Estimate of Pensionable Pay (EPP) form by 1 March each year.

It is best practice to review the statements in full each month, including checking whether the right superannuation deductions have been taken for the right people on the right basis.

Timely notification to PCSE of any errors is imperative. The longer it is left the more complicated and costly it can be.

Lack of contributions taken for new partners can materially delay the tax relief they get, and if not anticipated by drawings adjustments can cause cash flow difficulties and overdrawn capital accounts.

Deductions continuing for partners who have left or come out of the pension scheme can be difficult to recoup – and can complicate the pay-outs of capital if they no longer work with you.

Pension pots for salaried doctors and partners are quite separate and it is most important to check the transfer from salaried to partner, or vice versa, has been correctly reflected on the monthly statement deductions.

It may be because a form (such as the NLP3 for new partners) has not been submitted – or that an updated EPP form was not sent in when there was a partner change. Resubmission is sometimes the answer.

Balancing adjustments to contributions will be made once the yearly Type 1 and Type 2 pension certificates are completed and submitted. But these forms are completed long after amounts may have been taken in error – an issue in May 2017 will be reported on a form with a deadline date of February 2019.

A good specialist accountant will pick up problems when drafting the accounts but from a business viewpoint it makes no sense to risk further errors occurring when they could have been spotted on a timely basis.

So, yes, check monthly if what has been taken is what you are expecting, and if not find out why and notify accordingly.

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www.aisma.org.uk

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STEM a managerial haemorrhage!

Fiona Dalziel sets out four important ways to support your practice manager in these fast-changing times

GP practices without practice managers are as hard to find as hen's teeth in 2019. However, even 30 years ago that was not the case.

Lots of people with the job title 'practice manager' were administrators but not managers or leaders.

The job description and managers' capabilities have moved on massively although many job-related issues have remained the same. And practices today are extremely dependent on the role.

Given this dependence, along with the changes in capability to match the job's needs, you might expect job satisfaction has increased. After all, the *GP Forward View* in England specifically recognised practice managers as a 'vital resource'.

But a recently published annual survey of primary care staff by the publishers Cogora suggests otherwise. Of around 400 practice managers who responded to the survey, 30% were considering leaving for reasons other than retirement, 90% found the job stressful, and more than 50% of managers worked unpaid overtime at least weekly if not daily.

Morale appears to be low in the profession. What is causing this?

The Cogora survey found that unrealistic patient expectations, bureaucracy, workload dumping from other sectors and feeling unappreciated by management were top stressors. Externally generated changes also have an impact; most managers are expected to just absorb them.

Practices find funding difficult and recruitment of GPs almost impossible. And now in England, the rapid introduction of Primary Care Networks (PCNs) has generated a new raft of pressures.

When I started as a practice manager in 1990, colleague managers in other practices were constantly saying 'I wish the pace of change would slow down a bit!' Change is not a new phenomenon.

But it does feel rather different now and the reason is that, eventually, the proverbial frog is boiled to death. That moment is clearly getting close for many. The question is, what should employers of practice managers be doing to ensure they stem a potential haemorrhage?

1 Know how your manager is coping

Do not make the mistake of assuming that your

manager is actually okay. Go and find out.

Sometimes the competing day-to-day pressures of the job mean that we feel too rushed to take time out to have a conversation. But after your manager has handed in their notice it is too late.

A simple chat may be all that is required to identify problems and look for solutions together. Obviously, if your manager is absent from work due to stress, then emergency action is called for.

2 Support your manager

Many practices still have a traditional staffing structure of one manager with maybe a senior receptionist/front office manager. Managers working within this structure, in comparison with managers working in larger practices, are often isolated within the organisation.

Although a very small number of managers are partners, most are not. Neither are they part of the reception team they manage.

What can partners do to minimise this sense of isolation?

Informally, your manager may have one partner with whom they tend to share issues. Consider formalising this role so that its importance is recognised.

Ensure the support partner and manager are clear about how to escalate issues which need wider consideration or where the support partner becomes conflicted.

3 Encourage networking and mentoring

Although there are formal structures for working closely with other managers in England, other countries in the UK differ. Make sure your manager is supported in taking time to network with other managers, get ideas and share issues.

If your manager is new to general practice it may be useful to ask a more experienced local manager to act in a mentoring role.

4 Training

A widening variety of training is now available for practice managers. Although attempts by various representative organisations have failed to define a universal level of attainment for practice management to demonstrate entry-level competence, several training providers do deliver accredited qualifications specifically in this field.

Training at all levels from new manager to masterclass are available from several sources.

NHS Education Scotland, for example, in partnership with the Institute of Healthcare Management, has offered a vocational training scheme (VTS) for practice managers for 14 years. Links to some of these are given in the box opposite. The list is not exhaustive.

I have deliberately not mentioned more money as a solution. Although I acknowledge that practice manager pay is not universally high, and that there is a gender pay gap within the profession, the management guru Charles Handy recognises money as being a short-term motivator. So, offer higher pay but back it up with something more.

The expense in time and money of supporting, mentoring and training your practice manager should be seen as an investment in the future both of the individual and of the practice.

If this article has made you think you could do more to look after your manager, then seize the day before it is too late!

Fiona Dalziel runs DL Practice Management Consultancy

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- One-day Masterclasses **https://www.rcgp.org.uk/primary-care-development/training-and-development/practice-manager-masterclasses.aspx**
- ILM and City and Guilds qualifications **https://practicemanagersuk.org/**
- Understanding Organisations, Charles Handy; Penguin

10 tips for GPs seeking a limited company status for their practice

There has been a surge in inquiries about the limited company option for GP practices. David Lockitt considers some key issues**

'Can I put my medical practice into a limited company?'

I have been asked this on numerous occasions over the last 18 months - and have also been asked to act for 'Ltds' that have already made the change. The simple answer is yes. But should you?

To help you and your partners decide, consider the 10 issues outlined below:

1 Is it easy to move our contract and employing authority status into a limited company?

With prior consultation with your CCG there is no reason why you cannot make this change, however it is not obliged to give prior consent and the process involves you effectively handing your contract back and then having it granted again to the new entity.

Although I have not seen this happen it does leave the risk that your contract could be put out to tender rather than automatically being granted to the Ltd. The CCG may want the contract to be an APMS one.

I have recently seen CCGs asking for personal guarantees or bank bonds from the shareholders to cover certain income that is being received.

Transferring your employer's authority status should not be an issue once the contract has been dealt with. But you must ensure this happens before your staff are transferred into the company because otherwise any contributions made to the NHS pension could be returned.

2 I have been told I can save tax by using a limited company

Correct, it is easier to save tax and manage income by using a Ltd, but this only works under certain circumstances and is more difficult than people realise.

Once you start using a Ltd the partners become employees and shareholders and the

"At some point the profits earned in the Ltd need to be distributed so you may just create a tax time bomb for the future where tax will eventually become payable anyway, possibly at a higher rate."

mechanisms for extracting profits are either as salaries, or through dividends.

Paying salaries to partners above the lower earnings limit of £118 per week would attract employers' national insurance of 13.8% which is counterproductive to saving tax, so dividends it is.

However, once you consider corporation tax of 19%, the amount of income distributable to the shareholders is much reduced.

While a tax saving may be available, the main issue is that very few partners in a practice would not want to draw all they can out of the business. The dividend policy would also have to be agreed by all the shareholders so where one partner might wish to minimise tax and another might want to maximise take home income, this would simply not be possible.

At some point the profits earned in the Ltd need to be distributed so you may just create a tax time bomb for the future where tax will eventually become payable anyway, possibly at a higher rate.

3 We have a complex profit-sharing arrangement - how does this work in a limited company?

On transferring into a Ltd each partner (shareholder) will be allocated shares based on their profit-sharing ratio as it was in the partnership. This then determines how much income they receive on each dividend declaration.

To keep it simple let us say that for each 1% you had in the partnership you would receive 100 shares in the new company. These could be A shares with voting rights.

Where prior shares exist you can issue B, C, and D shares on which further declarations can be made to accommodate specific shares. However these would have to be varied each year as prior shares would be in a partnership.

There is also the added complication that you cannot have negative dividends so where a practice has historically prior shared expenditure this would no longer be possible and another mechanism would have to be thought of.

4 What happens when a partner changes their number of sessions?

In this instance the A shares would have to be changed to reflect future dividends. However this means that the Ltd would have to review unpaid income (reserves) and declare these as dividends prior to the change in shares.

At this point any profits held in the Ltd and hence untaxed would become taxable. This could result in a large dividend being declared as a result of changes in a single partner's circumstance.

Other scenarios like this would be unpaid leave, maternity leave or sabbaticals. This is manageable if there are not too many changes, but in a partnership with more than four or five partners this is unlikely to be the case.

5 What about if we have a new partner join us, or one leaves?

When the Ltd is initially set up each A share issued to a partner can be valued at a nominal figure, say 1p each. However, at the point a major change occurs the company will need to be valued so that the new or exiting shareholder is given a valuation which is then payable/ receivable through the Ltd.

This is effectively the same as how capital and current accounts are dealt with in a partnership, but an agreed valuation method needs to be set up at the outset which all shareholders agree to, and which will not put off incoming GPs.

6 Can we remove a shareholder due to internal disputes?

Under the partnership model it is possible to exclude a partner from the practice and withhold their entitlement to shares of the practice's profits.

With a Ltd this is not as easy; a shareholder is entitled to a share of all dividends paid while they hold their shares. This includes if they are for any reason excluded from the surgery.

It is possible to put in place an agreement for such a scenario, but this would need to be agreed by all parties and a specialist solicitor used to put it in place.

7 Can we move our surgery into the limited company?

The simple answer is yes. But again, there are considerations that need to be looked at before making this decision, both for leased and owned property.

Where the premises used are leased you would need to have agreement from your landlord and the lease transferred into the Ltd's name.

This is a good way of solving the last man standing issue that many practices now face. But a landlord may still ask for a personal guarantee from directors to ensure that the lease cannot just be broken if the Ltd ceases.

Where the premises are owned by the partners prior to transfer there may be upfront costs before moving it into the Ltd. Capital Gains Tax could be realised on the sale of the property by individuals, Stamp Duty Land Tax is potentially payable by the Ltd on the purchase and this is further complicated if a loan/mortgage is currently secured on the property.

All these issues could possibly be mitigated but there will be additional legal and accountancy fees to pay in order to make sure the transfer is done correctly.

8 I have been told that using a limited company will help solve my current annual allowance and lifetime allowance problems

As with the idea of saving tax this is possibly the answer, but only if you can manage what you wish to take out of the Ltd each year and do not need to take everything you earn.

As I have also mentioned, you need to have an agreed dividend policy with all shareholders, with everyone looking for the same outcome for this to work as a strategy.

So for a current single-hander or two-partner practice this may be possible, but for a six or seven partner practice this is unlikely to be the case.

9 Will using a limited company affect my final pension?

When taking income from a Ltd instead of completing a Type 1 Annual Pensions Certificate you would complete a Ltd Certificate, or both if you have other superannuable income.

Therefore, your reported superannuable income would be based on your dividend policy. If the aim of using a company is to manage your tax bill then it is likely that there will be a reduction in reported income for superannuation purposes and as a result your final pension may be lower than it would have otherwise been.

10 Can I just make the decision to transfer my contract into a limited company?

There are complex issues here so consult your AISMA accountant, solicitor and financial adviser specialists first. Yes there are some advantages to using a Ltd but do look at your reasons for doing so and weigh up the advantages against the potential issues you may create.

You lose a lot of the partnership model flexibility, such as profit sharing and structure, and this may mean any advantages initially identified are no longer possible.

The NHSE would have to approve the change so you should assess how it, and the CCG, might react. Might they wish to put the contract out to tender or change its type?

Companies House format accounts - useless for managing the business and open to inspection - would be needed at extra cost as well as management accounts.