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association of independent specialist medical accountants

Issue 42
Summer 2018

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AISMA Doctor Newsline

At the heart of medical finance...

10 NHS pension tips for GPs

Pension advice can be long and complicated. You may not have time for that right now - so we have distilled some key issues down to easy, bite size chunks. **Luke Bennett** and **Sharon Austen*** report

1 Early pension? Get advice!

A startling 62% of GPs started taking their pensions before their normal retirement dates in 2016-17, up from 17% in 2007-08. Several factors may be driving this, including increased workloads, or doctors reaching their 'target' pension income.

But the potential tax hits of the lifetime allowance and annual allowance charges are undoubtedly having an impact on plans. Make sure you've taken advice!

2 Get your statement

Download your NHS Pension Total Reward Statement each year from https://www.totalrewardstatements.nhs.uk/

As well as giving you an update on the value of your pension, by comparing one year with the last you will be better able to check whether your pension record has been correctly updated.

The Total Reward Statements are usually updated each August. Not all GPs are able to access their Total Reward Statement, and if so you can request an estimate from NHS Pensions free of charge once each year.

3 Sign a nomination form

If you are not married, make sure you have completed the nomination form to say who you would like to receive your pension benefits in the event of your death.

Following a recent court case, non-married co-habitees may be entitled to receive benefits even where the nomination form has not been completed. But the process will be much quicker and smoother if that one piece of paper has been signed.

4 Don't think it's all over

If you are about to, or have recently drawn your pension, be aware that this is not a final figure and it will be adjusted up or down.

At the time of drawing your pension, your pensionable pay in the year(s) leading up to retirement will have been estimated.

As and when the actual data becomes available then the pension and lump sum will be amended, and the adjustment back-dated.

5 Get your calculator out

Work out how much of your lifetime allowance you have used.

Multiply your pension by 20 and add your lump sum to arrive at the capital value of your pension. Remember to include your pension from both the 1995-2008 Scheme and the 2015 Scheme and add the value of any private pension funds you may have.

The lifetime allowance is currently £1,030,000 but increases by inflation each year. If the capital value of all your pensions exceeds £1,030,000 then there will be a tax charge which will reduce your pension.

6 Save your protection statement

If you have been granted lifetime allowance protection keep the HMRC confirmation safe,

"GPs will increasingly start to see Annual Allowance charges bite, as the limits have decreased and unused allowances from previous years are likely to have been largely used up now."

AND ONE TIP FOR PRACTICE MANAGERS...

Final Pay Controls were introduced to combat unfairness and some abuse of the final salary rules where, for example, a GP principal would award a large pay increase to their practice manager spouse in the run up to retirement, triggering a significantly enhanced pension.

The rules may apply when officer members of the 1995 NHS Pension Scheme receive an above inflationary increase in pensionable pay in any of the three years leading up to retirement. The retiring member's pension won't be affected but the employing practice may have to pay an additional charge.

This can catch practices where there are non-GP providers who are part of the 1995 Scheme.

Fluctuations in their profits in the final years can lead to significant employer charges being levied, which opens a whole raft of questions; who pays, the retired partner or the remaining partners, and if the latter, is this an allowable expense for tax?

It is not a common situation, but it is one to watch if you have a practice manager who is a partner for example. More information is given in the NHS Pensions publication entitled *Final Pay Controls and employer charge factsheet.*

as you will need the reference number when you apply for your pension.

Then if the capital value of your pension benefits exceeded £1,000,000 at 5 April 2016 you can still apply for individual protection. Your accountant or financial advisor will be able to help you with this.

7 Give annual allowance statements to your accountant

Annual allowance statements for 2016-17 should have been issued to all GPs. Ensure that you pass this to your accountant promptly.

If you have not received a statement, this may be due to NHS Pensions not having received information from primary care support services, so check with NHS Pensions.

8 Can you cut your income?

The annual allowance of £40,000 may be reduced if your taxable income exceeds £110,000.

This is a critical figure, as just exceeding this limit by £1 can create an annual allowance tax charge of hundreds or thousands of pounds.

It is very difficult for GPs to accurately control their income to this degree of accuracy, but if you are going to be close to this limit discuss with your accountant whether it would be worth acting to try and keep your taxable income just below £110,000.

9 Beware being bitten

GPs will increasingly start to see Annual Allowance charges bite, as the limits have decreased and unused allowances from previous years are likely to have been largely used up now.

Scheme Pays Elections are popular, as they avoid the personal cash flow hit of having to pay the tax now. Instead, the pension scheme pays the tax, but this reduces future pension benefits.

However, Scheme Pays Elections cannot cover tax arising because of the tapering of the annual allowance for high earners. In a worst case, a GP could have a tax bill that must be funded from personal cash reserves of up to £13,500 each year.

Different rules apply in Scotland where a Scheme Pays Election can cover the whole of the tax, and while changes to the English rules are being considered, these won't come into effect until 2017-18 at the earliest, so too late for any 2016-17 tax charges.

10 Hit Scheme Pays deadlines

The normal deadline for submitting a Scheme Pays Election is 31 July 2018 for 2016-17 tax charges and 31 July 2019 for 2017-18 tax charges.

But a Scheme Pays Election must be made before a pension is drawn, so if you are about to apply for your pension consider whether you need to make any elections first.

Know what is due for the work you do

With the 2018-19 financial year now in quarter two, practices must be fully aware of contract changes and the impact these could have on funding and workload. Deborah Wood gives an expert round-up and commentary**

It continues to be difficult to plan for financial impact when at the end of June 2018 the outcome of the Doctors' and Dentists' Review Body (DDRB) award negotiations is not yet published.

From 1 April 2018 an interim 1% allowance for the pay award has been included for practices in England. It is hoped this will be increased when the DDRB's recommendations are known.

This is particularly important as the latest available statistics published last September by NHS Digital for 2015-16 show that average expenses are increasing faster than gross income.

Expenses rose by 2.8% while gross income increased by only 1.02%. The expenses to income ratio went up by 0.7% to 64.9%.

Contract uplift

There will be an investment of £256.3m into the core contract to cover:

- 1% interim pay uplift for GPs
- 3% inflationary increase to cover expenses
- 1% increase in locum allowances
- Increases to vaccination/immunisation payments
- QOF point values changed to reflect population ratios
- A new electronic referrals system payment.

Given a population total for registered patients across GP practices in England of 58.9m at 1 January 2018 this amounts to a total investment of £4.35 per patient.

The new global sum per weighted patient is set to rise by £2.57 from the 2017-18 figure of £85.35 to the current year's figure of £87.92.

Locum allowances

First week £1,143.06, then £1,751.52.

From 1 April 2018, if a contractor chooses to employ a salaried GP on a fixed-term contract to provide locum cover, NHS England will reimburse the cost of that cover to the same level as cover provided by a locum, or a performer or partner already employed or engaged by the contractor.

Quality and Outcomes Framework (QOF)

The value of a QOF point will be adjusted in 2018-19 to consider population growth and relative changes in practice list size using data at 1 January 2018.

Based on the data at January 2018 compared to January 2017, there has been an increase in average list size from 7,732 to 8,096. This means the value of a QOF point will rise from £171.20 to £179.26.

There are no changes to QOF thresholds in 2018-19.

QOF indicators continue unchanged except for a minor change to the clinical codes that make up the register for learning disabilities.

Indemnity costs

There is a non-recurrent investment of £60m, based on unweighted patient numbers, and paid before the end of March 2018 to cover the increased costs of indemnity for the year 2017-18.

This is a payment is £1.017 per registered patient which follows on from the £30m paid towards indemnity costs in March 2017.

Enhanced services

The learning disabilities health check scheme continues unchanged except for a minor change to the clinical codes that make up the register.

All other directed enhanced services continue unchanged.

Vaccinations and immunisations

The item of service fee for the following programmes is unchanged at £9.80 per dose:

- Childhood seasonal influenza
- Pertussis
- Seasonal influenza and pneumococcal polysaccharide.

The payment for pneumococcal PCV will remain at £15.02.

In addition, the following programme changes are made from April 2018:

- Hepatitis B (new-born babies) – programme name changed to Hepatitis B at-risk (new-born babies). Vaccine changes and number of recommended doses reduced to three, therefore the payment of the second dose has now been uncoupled from the third dose. This was an in-year change effective 30 October 2017, included for completeness.
- MenACWY 18 years on 31 August – programme removed.
- Meningococcal completing dose – cohort extended to include eligible school leavers previously covered by the 18 years programme. The eligibility is now 1 April 2012.
- Meningococcal B – programme moved in to the Statement of Financial Entitlements (SFE) but is not included in the childhood targeted programme (Annex I of the SFE). There are no changes to eligibility of payment requirements.
- Pneumococcal PCV three-month dose – removed from the targeted childhood programme, the date this change is effective from will be confirmed. The funding for the remaining dose will remain at £15.02.

The following programmes will roll forward unchanged:

Programmes in SFE

- Shingles routine programme for 70-year olds
- MMR over 16-year olds
- HPV completing dose for girls 14-18 years
- Rotavirus
- Pertussis

Programmes with service specifications -

- Shingles catch-up for 78 and 79-year olds
- MenACWY freshers
- Childhood influenza 2 and 3-year olds
- Seasonal influenza and pneumococcal polysaccharide

The item of service fee for nine vaccinations and immunisations programmes increased by 26% from £9.80 to £10.06. These are:

- Hepatitis B at-risk (new-born babies)
- HPV completing dose
- Meningococcal ACWY freshers
- Meningococcal B
- Meningococcal completing dose
- MMR
- Rotavirus
- Shingles routine
- Shingles catch-up

Seniority

As previously agreed, seniority payments will cease on 31 March 2020 and there will be a 15% reduction in seniority payments year-on-year.

Those GPs being paid or eligible for seniority payments on 31 March 2014 will continue to receive payments and progress as currently set out in the SFE during the phasing out process.

"As previously agreed, seniority payments will cease on 31 March 2020 and there will be a 15% reduction in seniority payments year-on-year."

The money from the seniority pot is recycled into the global sum.

There is still a time lag in finalising the amount of seniority a GP may be entitled to due to the link with final average superannuation and due to the problems being experienced with the GP payment system.

In theory the final factors are known to 2014-15 but Primary Care Support England may not yet have updated its systems to that date.

Interim seniority factors based on average NHS superannuable earnings:

- 2014-15 £96,097 (England) £84,012 (Wales)
- 2015-16 £95,001 (England) £86,926 (Wales)
- 2016-17 £94,982 (England) £87,219 (Wales)
- 2017/18 £93,540 (England) £89,047 (Wales)

Final seniority factors:

- 2014-15 £89,573 (England) £82,155 (Wales)

Changes due from October 2018

A few changes announced will not take place until October 2018. These will be covered in a special edition of *AISMA Doctor Newsline* after the DDRB report has been published.

AGONY AccoUNTant

In our new quarterly feature, our agony accountant answers 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 property related issues

SHOULD I BUY?

Q I am considering joining a GP practice which owns its building. I have no idea about the property world and am finding it confusing. What do I need to consider before agreeing?

A Buying into a GP practice is easier than you might think and if valued correctly the investment should be self-funding.

GP practices receive a rent reimbursement from the NHS. Generally, this will then be allocated to the property-owning partners in the accounts.

Like a buy-to-let scheme you then get a share of the rent to fund your loan – but in this case the tenant is effectively the NHS giving a secure income stream. Many practices also receive rent from other tenants such as pharmacies which is in addition to the NHS income.

Unlike buying a residential property in most cases GPs can borrow 100% of the buy-in cost. So there usually is no need to initially use your own money to fund a deposit or any initial bank charges.

If the property has been valued correctly then in most cases the rent you receive will cover the initial monthly cost required to pay off the loan. Over time the rent will hopefully increase with tri-annual reviews to a position where the rent income exceeds the outgoings. So not only can

> *" Unlike buying a residential property in most cases GPs can borrow 100% of the buy-in cost. So there usually is no need to initially use your own money to fund a deposit or any initial bank charges."*

you end up with a self-funding property purchase but also it starts to earn you surplus income.

So, what are the downsides to property ownership? The risk is in ensuring that you can eventually sell the property to someone else when you leave the practice or when the practice moves into new premises.

What you need to consider is the stability of the practice and whether recruitment has been an issue. If it can recruit then hopefully an incoming partner will buy your share when you leave.

You also need to consider if the property is suitable for alternative use if it ceases to be a GP practice. If it is then the value of the building should not go down significantly. But any property purchase has a risk.

It is a big decision so contact your AISMA accountant for more advice before committing to the investment.

We can't afford these charges!

Q Our practice occupies premises owned by NHS Property Services (NHSPS) and has faced significant increases in service and facilities management charges which we can't afford. What do we do?

A This is a common problem and one now recognised by NHSPS, NHS England (NHSE) and the GPC who are still working at a national solution.

Have the costs genuinely gone up? That's difficult to say as the information available is limited. NHSPS took over the running of a significant number of NHS properties when it was formed in 2013 and has inherited different accounting systems from across the country so has struggled with getting accurate costs for premises.

But logically, as one of the largest property-owning companies in Europe, they should be able to drive costs down from buying at scale.

So, if costs have not risen why are you faced with more charges? The problem falls into several areas:

1. In some cases, costs genuinely have gone up. Outsourcing facilities management to national contractors in some areas has not worked.
2. The accuracy of allocating costs to an individual site has been difficult in some areas – so we have clear cases where charges have been made due to incorrect allocations.
3. We have the question over whether a recharge is legal or fair? Many properties are occupied without documentation and in the absence of a lease there is no document setting out who is responsible for what cost.
4. Not to be underestimated is the role of CCGs and NHSE in all of this. NHSPS argues quite rightly that these costs are not new. They used to be paid by PCTs or in some cases Community Trusts with a recharge back to the practice of a share of the cost.

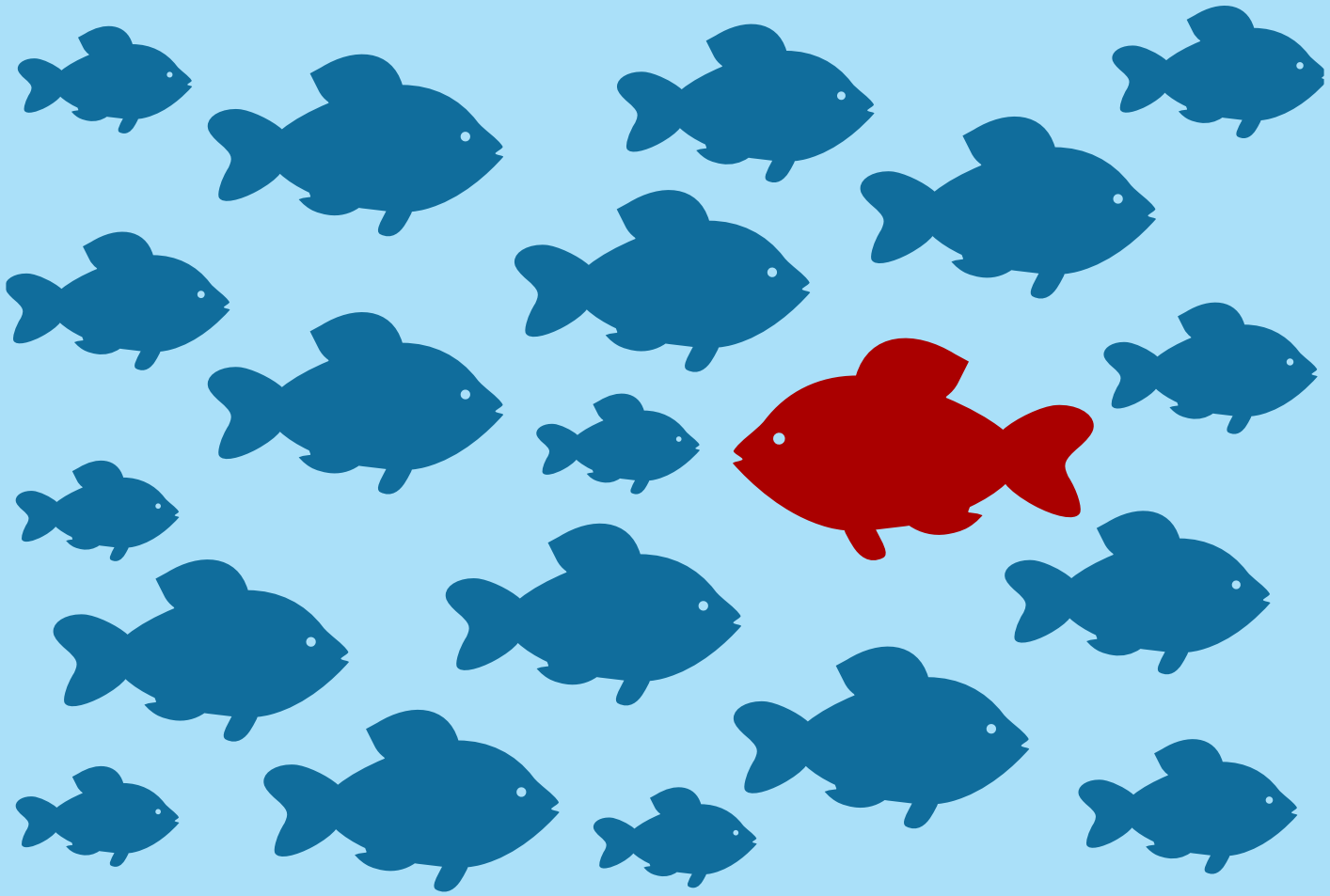
In many cases the recharges were subsidised legitimately. But in some areas with organisational change at commissioning level the subsidies have disappeared, and the practice now faces a full recharge of costs from NHSPS.

So, it is a mess – but one now accepted. NHSPS in conjunction with NHSE is now actively looking at some test sites across England to have a detailed understanding about what has gone wrong. At a local level practices need to:

1. Work with NHSPS to establish what services it provides and to ensure it records the cost correctly at each site. NHSPS is working with its contractors to try to drive costs down. If it can do this correctly then each site should have an accurate costing, but it is still likely to look higher than before.

2. Work with commissioners locally around affordability and ensure subsidies which existed in the system are passed on.

If this is done, then costs should come down to a more reasonable level.



Sort those staff issues!

Poor performing employees can be very disruptive to a practice, affecting services to patients and the workload and morale of other staff. It is important to deal with problems swiftly and effectively. Stuart Craig and Alison Oliver explore what is meant by 'poor performance' and how to address it. Performance issues can often be resolved quickly if they are addressed early

Poor performance can manifest itself in many ways, including frequent mistakes, lack of effort, inefficiency, inability to cope with workload or failure to follow the employer's reasonable instructions.

Poor conduct can be poor attitude, disruptive behaviour towards colleagues and wilful lack of care. It is not unusual for there to be a high degree of overlap between poor performance and poor conduct.

To determine if someone can be considered a 'problem employee', apply objective criteria that the employee is aware of. These could be in a job description, practice policies and procedures, specific targets identified at appraisals – or a combination of these.

Having objective standards of performance and conduct will allow both you and the employee to understand what is expected of them and to effectively review where they may have failed to meet expectations.

Once you identify poor performance or conduct, attempt to understand what the cause of this could be. Maybe the employee needs training to develop their skills. Or their poor performance could be due to an underlying health condition. The reason for the poor performance will affect how you deal with it. In

conduct matters it might be simply because the employee is not committed to the practice.

When the behaviour does not justify formal disciplinary action

Many employers believe performance and conduct issues can only be addressed through formal disciplinary action. Not true. In our experience issues can often be resolved through informal action; a more satisfactory way for both parties as it helps to maintain relationships.

But there is no obligation for an employer to deal with a matter informally if they do not wish to.

As a first step, you should have a conversation with the employee to discuss the issues, to try to discover why their performance/conduct is not at the standard expected of them, and what can be done to resolve the problems. This should be a two-way conversation and the purpose of informal action should always be to encourage and help employees improve, rather than disciplining them for their performance/conduct. Ensure the employee is aware of this.

"you should not delay discussing poor performance if the issues are significant and the next appraisal is some time away."

Routine performance reviews and appraisals are good vehicles for these conversations but you should not delay discussing poor performance if the issues are significant and the next appraisal is some time away.

Explain your concerns and ask the employee for their opinion on what may be causing the poor performance/conduct and, if relevant, what they feel you can do to assist them. Set out the improvement required, the time in which these improvements should occur, any extra training that can be offered to assist the employee and the consequences of failing to reach the expected performance/conduct levels. Keep a note of any agreed action so that any improvement can be assessed.

If these informal conversations do not resolve issues then you can move on to formal disciplinary action as set out in your staff handbook.

Handling difficult conversations

Some employers shy away from difficult conversations with employees, fearing conflict or saying the wrong thing. An informal discussion as described above might be daunting because of fear of how the employee will react. But having these conversations at the earliest opportunity can prevent problems escalating.

Firstly, consider who is the best person to deal with the issues. For example, if a receptionist is not working effectively with the practice manager, it might be more appropriate for a partner to lead the conversation. If the issues relate to a GP's clinical performance it might be more appropriate for a senior GP partner to address them.

Ensure you have all the relevant facts before the meeting, such as examples of the poor performance/conduct. And be able to explain how these fall below expected standards.

Remain as objective and calm as possible in the meeting. Explain clearly what your concerns are and what you believe they need to improve on. But do not stray into a formal disciplinary process in the first instance. Then listen to what the employee has to say and consider what you need to do to help them improve.

Afterwards, confirm any actions and keep a written note to refer to later. Check if the employee would like a written note of the actions and key dates arising from the meeting.

Formal performance and disciplinary proceedings

If informal measures do not resolve an employee's performance/conduct issues, it may be necessary to go down the route of formal disciplinary proceedings.

" Employers cannot force an employee to accept the terms on offer and leave, but if handled correctly, many employees can see the advantages of leaving amicably rather than eventually possibly being dismissed."

This should be done after an investigation has been conducted into the employee's performance/conduct. Comply with any disciplinary procedures you have and ensure you:

- Give the employee sufficient information regarding the concerns to allow them to defend their performance/conduct
- Inform them of their right to be accompanied at the meeting, and
- Explain the possible meeting outcomes.

Get another staff member to take notes at the meeting. These should be as comprehensive as possible and agreed with the employee afterwards. Conduct things calmly and give sufficient opportunity for the other party to put forward their view of events and raise any concerns.

After the meeting, assess what was said and decide if the performance/conduct issues were proven or not. If they were, decide what sanction is appropriate. This will depend on the employee's disciplinary history and mitigating circumstances and previous sanctions given to other employees for similar behaviour.

Protected conversations

Sometimes relationships with the employee may be so bad that the options above are just not feasible and an alternative solution has to be considered with a frank conversation about their future employment.

Protected conversations are a vehicle to allow parties to negotiate an offer of settlement to terminate the employee's employment where no previous dispute or issue exists.

Any protected conversation will be inadmissible in any future employment tribunal proceedings. If handled correctly, they allow an alternative to facing formal action in return for them essentially being paid for entering into a settlement agreement.

Some employers understandably feel uncomfortable at the thought of being seen as 'buying someone off' when they have performance or conduct concerns but they can be useful in situations where an employer wants to try and find a potentially quick solution.

Employers cannot force an employee to accept the terms on offer and leave, but if handled correctly, many employees can see the advantages of leaving amicably rather than eventually possibly being dismissed or trying to find work when they have a formal disciplinary sanction on their record which is likely to be referred to in references.

To be classified as a protected conversation there must be no 'improper behaviour' in the negotiating process. This will be highly fact sensitive but can include:

- harassment, bullying and intimidation
- physical assault or the threat of physical assault and other criminal behaviour
- all forms of victimisation
- discrimination because of age, sex, race, disability, sexual orientation, religion or belief, transgender, pregnancy and maternity and marriage or civil partnership; or
- putting undue pressure on an individual such as informing them they will be dismissed if they reject a settlement proposal

Where there is improper behaviour by an employer anything said or done in pre-termination negotiations will normally be admissible as evidence in a tribunal.

These conversations are helpful when there is no obvious issue between parties but an employer would like to dismiss a problem employee. However, they should be properly thought out in advance. Get legal advice before instigating a protected conversation.

We recommend that employers don't just ignore problem employees but deal with them as soon as possible. Careful consideration should be given to the route you take and often that decision is based on how you think the employee will receive the message and what you want to get out of it.

Stuart Craig is a partner at Ward Hadaway and advises GPs and other healthcare practices on a range of employment law matters. Alison Oliver is an associate solicitor in the healthcare practices team, advising GPs and other healthcare providers

It's time to make a start on freeing up your GPs

Many practices' management teams use this time of year to start looking forward. Reviewing the efficiency of systems should be at the top of every practice's 'must-do' list, says Fiona Dalziel

The *GP Forward View* plan for reviving general practice was announced two years ago. Although specifically an NHS England initiative, practices across the UK can benefit from considering the relevance of its ten 'High Impact Areas', which focus on releasing clinical time by up to 10%.

While at-scale working and online consultations may not be within every practice's grasp or even on their wish-list, most of the action areas can bring positive changes to most practices.

GPs in a quarter of England's CCGs (94 out of 176) have started to introduce improvements and, although concrete evidence of time being released is in short supply nationally, anecdotally many practices are making headway even if on a small scale.

Where can we start?

Several of the High Impact Areas are specific and achievable in most practices. Let us have a look at two of them: Active Signposting (AS) and Clinical Correspondence Management (CCM) (the latter is a subset of 'Productive Workflows').

Why these areas?

AS (as opposed to the more complex Care Navigation) involves identifying in your practice to which services, internal or external, you feel your non-clinical staff could guide patients as an alternative to a GP appointment.

Clinical Correspondence Management (CCM) involves identifying which incoming patient correspondence is safe to action without being read first by a GP. Introducing AS and/or CCM can have a direct impact on GP workload.

Both changes can be introduced in an incremental way and, although the team need to be involved in planning the changes, implementation is straightforward for a practice manager working with a lead GP.

Staff involved in delivering AS and CCM are given an opportunity to expand their skills and knowledge, improving motivation. Some staff may be able to move on to Care Navigation in the future (see reference below).

" practices across the UK can benefit from considering the relevance of its ten 'High Impact Areas', which focus on releasing clinical time by up to 10%. "

What are the challenges?

Both AS and CCM involve shifting work from trained clinicians to non-clinical team members and all practice managers and GPs are rightly cautious about potential risk to patient safety.

The shift in workload may involve a change in non-clinical staffing levels and some reorganisation. If administrative staff are now coding clinical correspondence and receptionists/patient services advisers spending time suggesting alternatives to patients who want a GP appointment then, evidently, the size and skills of these teams will need to cope with the change in work content.

With the introduction of receptionists asking patients about their problem, patient reaction looms large. But initial hostility does appear to lessen once patients are accustomed to the change.

Many practices feel it will be difficult to know if the change has made any difference.

Addressing the challenges

- Plan the introduction of these changes with the whole team and listen to what the issues are
- Ensure your plan includes risk management. This will involve:
  1. Identification of 'red flag' situations or symptoms
  2. Agreement of detailed protocols and flowcharts
  3. Comprehensive staff training and documentation, ensuring competence
  4. Ongoing staff support and troubleshooting
  5. Regular reviews of systems including significant event and data analysis
  6. Recording everything as CQC evidence.
- Identify and quantify how much work will move to the non-clinical staff. Think about which team members' skills to develop and how you will do this. Ensure all staff work to the top of their skillset and delegate safely.
- Discuss the impact on patients of AS with both the team and patients. Develop a script which speaks about 'the clinical team' and encourage the GPs themselves to deliver messages about the change. Plan how you will inform patients in written form.
- Using a 'Plan, Do, Study, Act' cycle, ensures you gather baseline data as well as on a continuing basis. Many practices fall down on this!

Fiona Dalziel runs DL Practice Management Consultancy

Getting further help

- The Productive General Practice (PGP) Quickstart Programme is available to practices in England taking part in a local Time to Care programme under GPFV. **http://gpip.co.uk/quickstart-programme**
- For help with surveying potentially avoidable appointments, go to: **http://www.primarycarefoundation.co.uk/overview-of-the-audit.html** . Again, this is free for practices in England.
- For guidance on using PDSA, a lot is available on line but you could start at: **https://improvement.nhs.uk/documents/2142/plan-do-study-act.pdf**
- Training is available commercially (some may be funded by your CCG or equivalent).

References

- General Practice Forward View, NHS England, April 2016 **https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf**
- High Impact Actions in detail **https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/documents/the-10-high-impact-actions-overview-slides**
- A quarter of CCGs begin to implement time to care **http://www.pulsetoday.co.uk/news/hot-topics/general-practice-forward-view/quarter-of-ccgs-begin-to-implement-time-for-care-gp-practice-changes/20036615.article**
- Care Navigation: A Competency Framework **https://hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf**

Valuing surgeries with abated rents

John Hearle advises on a costly premises issue

When surveyors assess the market value of a surgery owned by the GPs they must follow Royal Institution of Chartered Surveyors (RICS), and international, guidance - and assume vacant possession.

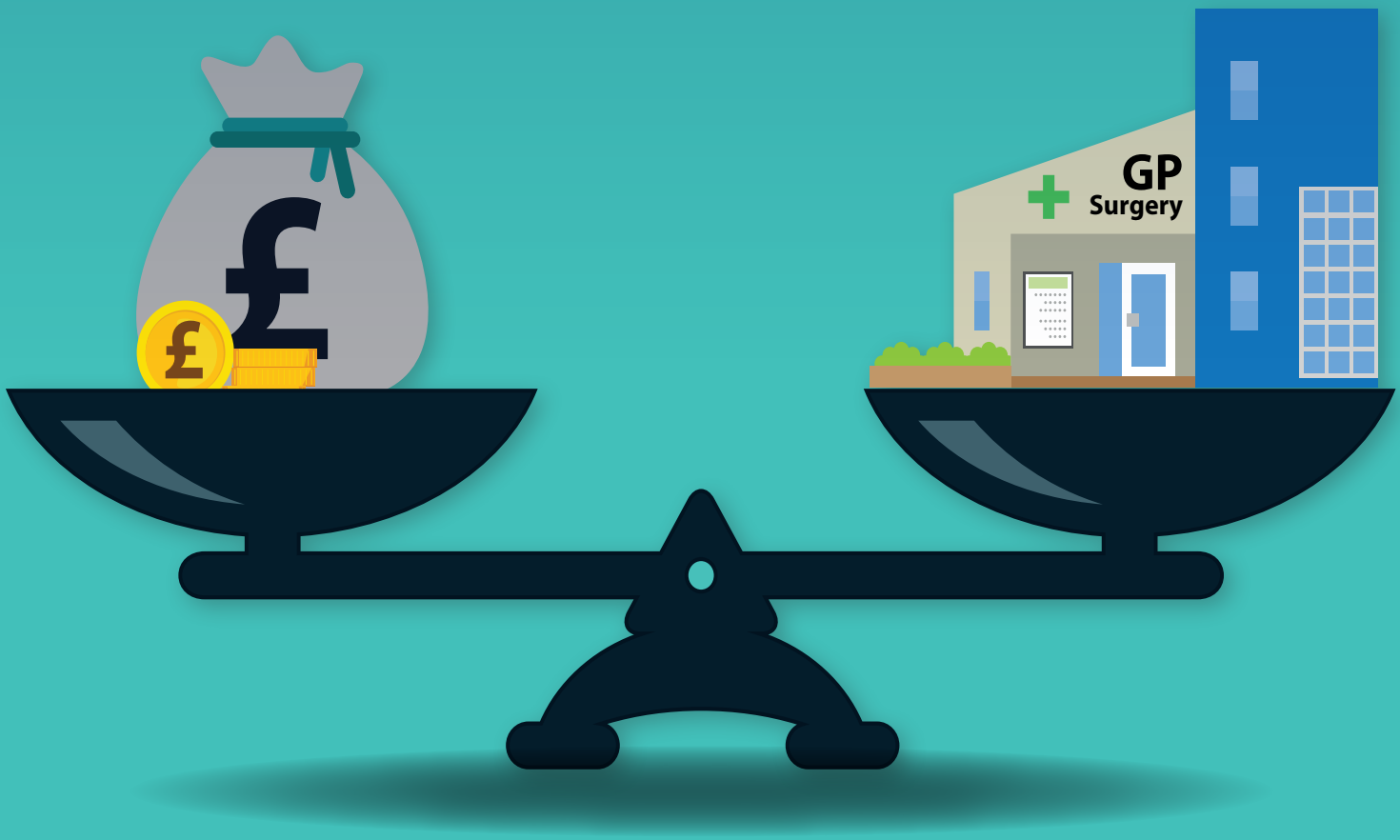
That means, unless instructed otherwise, the actual circumstances of notional rent reimbursement will be ignored. They will assess their own opinion of what rent reimbursement would be appropriate for an acquiring GP practice.

But this can cause problems where cost rents are being received or where the actual notional rent reimbursed has been abated due to the GPs receiving an NHS grant.

For example, if an NHS grant of between £100,000-£250,000 had been made to the GPs for a small extension, an abated notional rent would apply for 10 years. If a valuer is simply asked to provide a market value then that abatement would be ignored.

To resolve this problem, it is important the surveyor is given the right instructions. Many partnership deeds already cater for this in that instruction will be to provide a 'market value on the special assumption that the actual level of notional or cost rent reimbursement continues'.

The valuer can then assess the actual level of abated income for the remainder of the abatement period and then revert to their opinion of the full rent that should be available for reimbursement afterwards.



" For bank security purposes the valuer is usually asked to provide both 'market value assuming vacant possession' and 'market value on the special assumption that the actual level of notional or cost rent reimbursement continues'."

Where the purpose of the valuation is for a new partner entering the practice, who will also suffer the abatement, then this form of valuation is clearly the correct one.

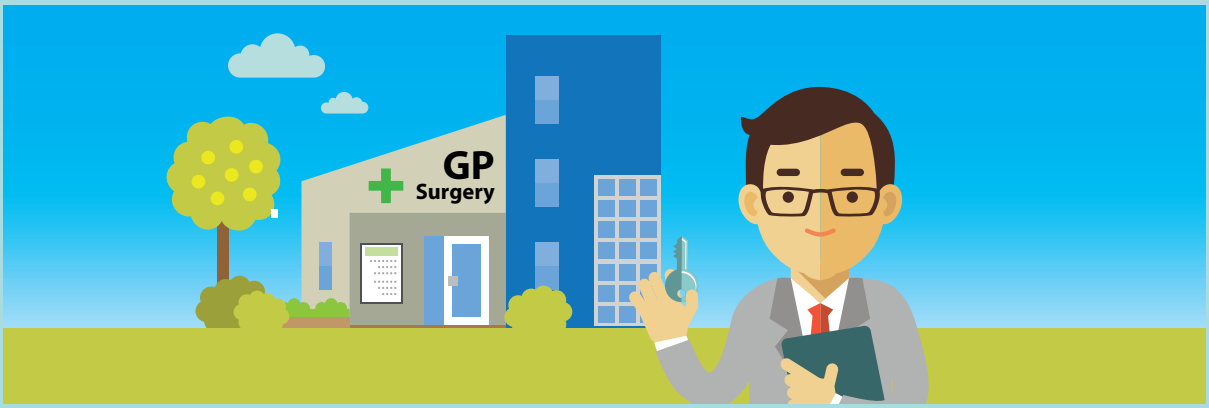
For bank security purposes the valuer is usually asked to provide both 'market value assuming vacant possession' and 'market value on the special assumption that the actual level of notional or cost rent reimbursement continues'.

To illustrate the above, consider a purpose-built surgery in the home counties originally of 250 sqm but extended to 350 sqm at a cost of just over £250,000 aided by a 66% NHS grant of £165,000.

The full notional rent of £70,000 a year has been abated to £58,600 annually for 15 years. The market value with vacant possession ignoring the abatement is £1.14m. But the market value on the special assumption that the actual level of notional rent reimbursement continues taking on board the abatement is £1.04m.

With RICS currently looking at updating its notes for surgery and medical premises it is hoped there will be more guidance on this issue soon.

John Hearle is medical premises consultant to the Aitchison Raffety Group



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

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